

Royal Trinity Hospice

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Letter from the Chief Inspector of Hospitals

Royal Trinity Hospice is operated by Royal Trinity Hospice. The service has 28 beds and provides care to patients in their own home or care home through their community teams. The service also provides dementia respite care in the inpatient unit. Facilities include an open art studio, community café, a large garden, patient and family services including bereavement support and welfare advice and a hairdresser.

The service provides hospice care for adults. We undertook an unannounced inspection of the inpatient and community services using our comprehensive inspection methodology. The inspection took place on 15 – 16 May 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospice was palliative care and care of the dying.

Services we rate

Our rating of this service improved. We rated it as **Outstanding** overall.

- Staff kept patients safe from avoidable harm and abuse. Risks were assessed, monitored and managed appropriately.
- Patients care, and treatment records were clearly detailed and accurate in content. They were stored securely and managed safely.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.
- Staff followed best practice in relation to infection prevention and control.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment. Care and treatment was delivered in line with evidence-based practice.
- Staff involved patients and carers in decisions about their care and treatment.
- Staff cared for patients with compassion, treating them with dignity and respect. Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional service.
- The services provided aimed to meet the needs of people from their whole community, and the needs of the population served, which ensured flexibility, choice and continuity of care.
- The service was proactive at engaging with groups that were hard to reach to ensure they could access its services.
- There were clear processes for staff to manage complaints and concerns.
- There was an open and transparent culture, with engaged and experienced leadership.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- Leaders were visible and approachable in the service for patients and staff.

Summary of findings

- The service had a clear vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

However, we also found the following issues that the service provider needs to improve:

- The management of the rotation of single use consumable equipment was not as good as it could be.
- Some areas of mandatory training completion did not meet the services own expected targets.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Outstanding	Hospices for adults was the only activity provided at this location.



Summary of findings

Contents

Summary of this inspection	Page
Background to Royal Trinity Hospice	7
Our inspection team	7
Information about Royal Trinity Hospice	7
The five questions we ask about services and what we found	9
<hr/>	
Detailed findings from this inspection	
Overview of ratings	12
Outstanding practice	31
Areas for improvement	31
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Outstanding



Royal Trinity Hospice

Services we looked at

Hospice services for adults.

Summary of this inspection

Background to Royal Trinity Hospice

Royal Trinity Hospice is operated by Royal Trinity Hospice, and is located in Clapham, south London. The hospice serves the communities of the London Borough of Wandsworth which makes up approximately 50% of the patient population with the remaining 50% of patients coming from other surrounding London boroughs including Lambeth, Hammersmith and Fulham, Kensington and Chelsea, Westminster, Richmond and Merton.

The service supports people in their own homes, through an outpatient service and at an inpatient centre in Clapham, south London.

The hospice runs several services including a 28 inpatient bedded unit and a specialist palliative community nursing team who carry out assessments and provide patients with advice in their own homes, in care homes and the outpatient facilities. The service delivers a dementia service which includes a respite service as part

of their inpatient offer. The service runs day hospice services from the Royal Trinity Hospice site. The hospice provided patient and family services which include bereavement support, welfare advice and a range of support service including bereavement support groups for children aged 8-12 years old.

The hospice has had a registered manager in post since May 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The hospice was inspected last in August 2014 and was rated the service as good over all with outstanding for caring. We inspected the service on 15 and 16 May 2019, our inspection was unannounced.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector, an assistant inspector and a specialist advisor with expertise in palliative care. The inspection team was overseen by Amanda Williams, Interim Head of Hospital Inspection.

Information about Royal Trinity Hospice

The hospice has one inpatient unit with 28 beds and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.

During our inspection, we visited the inpatient unit, the day therapy services and attended two home visits with a member of the specialist palliative care community nursing team. We spoke with 15 staff including registered nurses, health care assistants, reception staff, administration staff, medical staff, chaplaincy, housekeeping keeping, laundry staff, porters, and senior

managers. We spoke with three patients and two relatives. During our inspection, we reviewed five sets of patient records. We reviewed information sent to us by the service prior to the inspection and data requested during the inspection,

Activity (March 2018 to February 2019)

- In the reporting period March 2018 to February 2019, the service saw 2,229 patients.
- The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

Summary of this inspection

- Zero Never events
- Zero serious incidents
- Zero incidences of hospice acquired
meticillin-resistant Staphylococcus aureus (MRSA),
meticillin-sensitive Staphylococcus aureus (MSSA),
hospice acquired E-Coli, hospice acquired
Clostridium difficile (c.diff).

- 11 complaints received
- 319 compliments received

Services provided at the hospital under service level agreement:

- Cleaning services
- Pharmacy

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of safe stayed the same. We rated it as **Good** because:

- Staff we spoke with understood how to protect patients from abuse. Systems for the management and referral of safeguarding concerns reflected current best practice in relation to safeguarding adults and children
- The service controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection before and after the patient died.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Staff identified and quickly acted upon patients at risk of deterioration.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

However,

- Single use equipment was not always checked, replaced and disposed of.
- Mandatory training rates in some subjects required improvement.

Good



Are services effective?

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way
- The service made sure staff were competent for their roles.

Good



Are services caring?

Our rating of caring stayed the same. We rated it as **Outstanding** because:

- Staff truly cared for patients with compassion. Feedback from all patients and those close to them confirmed that staff treated them well and with kindness.

Outstanding



Summary of this inspection

- Staff understood the importance of providing emotional support to patients and those close to them.
- Staff always communicated with patients about their care and treatment in a way they could understand. Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Our rating of responsive improved. We rated it as **Outstanding** because:

- The service was planned and was proactive in meeting the needs of people from their whole community. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. It had a proactive approach to understanding individual needs, was accessible and promoted equality. Care plans were person-centred and took a holistic approach to patient care. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care in a timely way. Arrangements to admit and treat patients were in line with good practice.
- It was very easy for people to give feedback and raise concerns about care received.

Outstanding



Are services well-led?

Our rating of well-led improved. We rated it as **Outstanding** because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a clear vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were fully focused on the needs of patients receiving care. The service

Outstanding



Summary of this inspection

promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Detailed findings from this inspection






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	 Outstanding	 Outstanding	 Outstanding	 Outstanding
Overall	Good	Good	 Outstanding	 Outstanding	 Outstanding	 Outstanding

Notes

Hospice services for adults

Safe	Good 
Effective	Good 
Caring	Outstanding 
Responsive	Outstanding 
Well-led	Outstanding 

Are hospice services for adults safe?

Good 

Our rating of safe stayed the same. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- The service operated a full mandatory and statutory training programme for staff. This ensured relevant knowledge and competence was maintained and updated throughout their employment with the organisation.
- Mandatory training for all staff included equality and diversity, health and safety at work, control of substances hazardous to health (COSHH), Caldicott principles, fire safety awareness, infection control, information governance, manual handling, basic life support, safeguarding adults and children at level two and level three and conflict management.
- Each individual mandatory training topic had a compliance rate of over 80%, which was met in all subjects except for Computer Display Screen Equipment Safety. The completion rate for this was at 66% for nursing staff and 71% for Medical staff. Cardio-pulmonary resuscitation (CPR) training had been completed by 62% for nursing staff and patient handling by 61% for nursing staff. We spoke to nurses regarding their confidence is undertaking CPR should

an emergency situation arise and all the nurses we spoke with were confident in their ability to perform CPR. We observed nurse moving patients and found that all patients were moved safely and with dignity.

- There was a structured induction programme for staff to ensure they had the skills needed for their roles. The service's induction programme included ensuring new staff could access the computer systems, meeting with staff in different teams and dedicated time to complete mandatory training.

Safeguarding

Staff we spoke with understood how to protect patients from abuse. Systems for the management and referral of safeguarding concerns reflected current best practice in relation to safeguarding adults and children.

- The head of patient and family services was the service safeguarding lead. They had completed level three safeguarding adults training, as had the inpatient unit manager and other relevant key members of staff.
- Staff confirmed that they had received safeguarding training at a level relevant to their role and knew how to recognise abuse and neglect.
- The service had a formal system in place where alerts for known safeguarding concerns could be activated, and staff were aware of the correct pathways to follow to raise their concerns.
- Though the hospice was for adults only, it had recognised the area of children's safeguarding. In



Hospice services for adults

doing so, three members of staff had completed children's safeguarding Level 3. Volunteers within the service undertook face-to-face safeguarding Adults Level 1 training as part of their induction.

- Safety was promoted through the recruitment and induction of volunteers and staff. The service used an external company to determine which volunteer roles required a Disclosure and Barring Service (DBS) certificate. DBS checks involve a government department carrying out a criminal record check that results in a certificate being issued to an individual.

Cleanliness, infection control and hygiene

The service controlled infection risks well. Staff kept themselves, equipment and the premises clean.

They used control measures to prevent the spread of infection. They used control measures to prevent the spread of infection before and after the patient died.

- The clinical environment we visited during our inspection was visibly clean and tidy. All areas had evidence of a cleaning schedule, which was signed when staff had completed the cleaning duties.
- We checked monthly, weekly and daily cleaning schedules and associated audits, which showed that all areas of the service were cleaned as required.
- The service had a service level agreement with an external company to clean the inpatient unit. The service monitored the effectiveness of the cleaning through weekly audits that looked at the cleanliness of multiple areas including bed pans, commodes, medical equipment, floors, beds and toilets. Staff told us that they would challenge the external contractor if the results of the audit fell below an agreed standard. The external cleaning staff told us they felt part of the team and took pride in ensuring the unit was cleaned to high standard.
- There were effective arrangements in place to prevent the spread of infection when caring for patients who had died. Systems ensured deceased patients left the hospice in a timely and dignified way and any risks of cross-infection were appropriately managed.

- The service had an Infection prevention and control (IPC) lead and regular IPC and health and safety meetings were held. The meetings discussed IPC incidents and infection rates.
- The service undertook hand hygiene audits for the inpatient unit and the day therapy centre. We reviewed the last completed audit and it demonstrated compliance with the service's hand hygiene policy. There was an action to review the policy in line with the world health organisation guidance.
- The clinical areas had dedicated hand washing facilities. Staff had access to hand sanitizer and disposable wipes for the cleaning of surfaces, clinical rooms and inpatient bedrooms.
- Staff followed the service's arms bare below the elbows policy as well as using appropriate protective equipment (PPE) such as gloves, and aprons to deliver personal care. We observed staff washing their hands before and after patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe; however, single use equipment was not always checked, replaced and disposed of. Staff managed clinical waste well.

- The hospice was on two floors and there was an accessible lift, which was regularly serviced. The inpatient unit could be accessed from the ground floor so that patients arriving on stretchers could be accommodated. Accessible toilets were available for patients, staff and families.
- The ward area and patient rooms were uncluttered, visible clean and tidy. They were decorated to a high standard with lots of space for family members and friends to visit the patient as well as stay over night if they desired. Fold away beds were provided for people staying overnight with the patient
- We reviewed the records relating to maintenance and servicing of all equipment used by the service and saw most of the equipment servicing was up to date. We did find some syringe drivers that were past the date



Hospice services for adults

of service due and highlighted that to the facilities team. A syringe driver is a small infusion pump, used to gradually administer small amounts of fluid medication under the patient's skin.

- Syringe drivers were provided by the service but serviced annually and maintained by an external company. We saw that staff had been trained to use syringe drivers and their competency to do so assessed.
- Staff told us specialist equipment such as syringe drivers and hoists were readily available.
- Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection we saw service dates for the vast majority of equipment were within the last 12 months. We reviewed documents that showed the equipment had been serviced annually in line with the manufacturer's guidance. All electrical equipment had been tested for safety and the premises had an electrical safety check.
- We checked a large quantity of consumable equipment for example, needles and syringes and found that two bin liners of equipment had gone past their expiry date. There did not appear to be any processes in place in the inpatient unit to check that consumable equipment was in date. We raised this as a concern to the senior leadership team who removed the out of date equipment from circulation and informed us that a process would be devised to ensure expiry dates on consumable equipment was checked.
- The service had a maintenance team who were onsite during working hours and provided an on-call service out of hours. Staff told us the maintenance team were responsive to calls and fixed equipment promptly.
- Staff had access to specialist medical equipment such as profiling beds, pressure relieving mattresses and pressure relieving boots.
- Call bells were accessible for patients in their rooms to alert staff if a patient required assistance.
- The service had appropriate arrangements in place for the management of clinical waste and sharps. Arrangements for storing, classifying and labelling clinical waste kept patients and staff safe.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Staff identified and quickly acted upon patients at risk of deterioration.

- Inpatient records included for example; an integrated nursing and medical assessment, mental capacity assessment, do not attempt cardiopulmonary resuscitation form if appropriate, a risk assessment for pressure ulcers, and a nutrition screening tool. Patients were also assessed for their risk of falls, had a full cognitive assessment, and if bedrails were used this was clearly documented. There were review dates for all assessments, which were all dated and signed.
- The service positively managed risks that people might experience at the end of their life, including risk of pressure ulcer and falls. Staff used nationally recognised tools to assess each person's risk of developing pressure ulcers. This was re-assessed weekly. Each patient's skin integrity was checked and recorded three times a day and formed part of the services two-hourly comfort rounding. We saw the patients had the correct pressure relieving equipment in place according to their level of risk.
- Care plans were individualised to cover the psychological as well as physical needs of patients. Where a patient had changing needs, for example, becoming increasingly uncomfortable due to circumstance, staff adapted their care plan accordingly. There was a multidisciplinary team (MDT) meeting which provided an opportunity for further review and amendment of care plans.
- Staff could access medical review 24 hours a day. The inpatient service was staffed by nurse specialists who could call on doctors and consultants to provide specialist input as needed.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.



Hospice services for adults

- Nursing staff told us that they felt staffing levels were appropriate, and they had time to give compassionate care.
- Patient care was also supported by a wider team including healthcare assistants, therapists and domestic staff.
- The service had determined a minimum safe staffing level using a nationally recognised staffing tool.
- The service ensured a senior nurse was always on duty on the inpatient unit and that staff had access to an on-call manager in and out of hours to escalate any staffing concerns that arose.
- The service did not use agency staff unless in very unusual circumstances and had a strong bank of staff, largely their own staff, who filled in as needed. The service provided mandatory training to bank staff who were supernumerary for three shifts prior to their competency to work unsupervised being signed off.
- We saw the planned levels of staffing matched the actual staffing levels on the day of our inspections and there was a strong skill mix among the nursing team.
- Nurses in the community had a case load of approximately 30 patients per whole time equivalent. Caseloads were reviewed at weekly team meetings and at staff 1:1 meetings.
- There was always a clinical nurse specialist on call out of hours for patients in the community. Should the clinical nurse specialist need specialist medical advice they would contact the on-call doctor directly.
- The service had 7.4 whole time equivalent (WTE) registered nursing vacancies and 6 WTE Health Care Assistant (HCA) vacancies across the inpatient unit and the community service. The service was actively recruiting for these posts during our inspection. The service had also developed an HCA training programme. One housekeeping member of staff had been successful with their application to join this programme.
- The service had a sickness rate of 5% between December 2018 and February 2019 in relation to nursing and allied health professionals.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

- The service had access to appropriate medical input. There was one full time consultant and one doctor above foundation year one (FY1) on duty daily. Out of hours the first on call doctor was a registrar or specialist doctor. The second on call was always a consultant. The service's consultant out of hours rota was shared by consultants at the local hospital. Doctors within the service told us this was effective and gave the service access to consultants with a breadth of experience and allowed joined up working between the services.
- We saw from rotas that the planned medical staffing skill mix matched the actual, and flexed to meet patient need. Medical staff attended the MDT catch up meeting every day.
- The service had 1.2 whole time equivalent (WTE) registered medical staff vacancies. The sickness rate for medical staff between December 2018 and February 2019 was 1%.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- People's individual care records were written and managed in a way that kept people safe. Staff kept detailed records of patients' care and treatment, which enabled staff across the varying shifts to understand what was required of them.
- Patient records were stored securely in the nurse's station. The area where the notes were kept was kept locked and could only be accessed by authorised staff.
- We reviewed five patient care records. The records contained detailed person-centred care plans, which clearly identified patients' emotional, social and spiritual needs alongside their physical health needs.



Hospice services for adults

Staff completed care plans appropriately and we saw they recorded when care was carried out in line with the care plan. Staff reviewed care plans regularly or when a patient's circumstances changed.

- Staff could access patient specific information from the care plan which included information on communication, psychological and mental health and end of life care. All care records contained a 'getting to know me' document that detailed the patient's needs and preferences and took account of any additional needs such as dementia and behavioural needs. This was completed in all of the care records we reviewed.
- The information needed to deliver safe care and treatment was available to staff in a timely and accessible way. All services used a shared electronic patient record. The inpatient unit used paper-based drug charts, turning charts and observations charts.
- Information needed for each patient's ongoing care was shared appropriately in a timely way. The service sought and obtained patient consent to share information with other services such as GPs. The service sent discharge letters to patients GPs.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

- We looked at how medicines were managed at the service. We checked patient records and prescription chart for five patients as well as looking at the medicines management group agenda and minutes, medicines standard operating procedures and policies and controlled drug records and drugs audit records. We spoke with five members of staff in relation to the management of medicines, all were able to tell us about the services policies and procedures relating to medicines management.
- The service had a controlled drugs accountable officer. Controlled Drugs (CDs), medicines that require additional controls because of their potential for abuse, were managed effectively. The controlled drugs were stored appropriately. CDs were destroyed on the premises by a pharmacy technician and witnessed by a registered nurse. We saw that clear records of this were kept. Pharmacists carried out regular audits on controlled drugs.

- The service had a service level agreement with the local hospital for pharmacy support. Three pharmacy technicians worked part time on the inpatient unit and were available for support as part of the medicine's management team.
- Medicines were stored safely and securely, in locked medicine cupboards within storage rooms. There was a system in place to check that all medicines were within date and suitable for use.
- There were medicines available for use in an emergency and these were checked regularly. Medicines requiring cold storage were kept in a refrigerator within recommended temperature ranges and this was monitored regularly.
- Medicines were prescribed, prepared and administered by competent staff. Nurses' medicines management competencies, including CDs, are checked annually, and doctors were provided with training on prescribing and the services policies by a trained pharmacist on induction.
- Patients' prescriptions and administration records were accurate, complete, legible and stored securely. Allergy statuses of patients were recorded on prescription charts.
- For patients receiving medicines through a syringe pump, checks were carried out four-hourly by nurses and this was clearly documented.
- Staff had access to current references to ensure the correct and safe administration of medicines.
- The patients we spoke with felt they were given clear and accurate information on medicines they were given and their expected effect.
- Medicine related incidents were recorded and monitored, lessons were learnt, and action plans were in place to ensure recurrence of errors was minimised.
- There was a system in place to ensure that medicines alerts or recalls were actioned appropriately.
- Senior pharmacy technicians reviewed the prescribed medicines for patients regularly and were involved in the training of staff on medicines optimisation and attended multidisciplinary team meetings.



Hospice services for adults

- The service used one non-medical prescriber, who was a clinical nurse specialist and was supervised by the medical director. Formal supervision took place twice yearly the non-medical prescriber attended the monthly medicines management group meetings.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

- Staff were aware of their incident reporting roles and responsibilities. There was an incident reporting policy which explained the process.

Learning from incidents was discussed during team meetings. Lessons learnt, and actions plans had been developed as a result of the investigation were clearly documented. Staff reported all clinical incidents and near misses on the incident reporting system; these were checked monthly by the clinical risk management group.

- Staff we spoke to were aware of the principles of duty of candour and being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The manager told us duty of candour was covered as part of mandatory training and the staff we spoke with confirmed that duty of candour regulation was covered in their mandatory training. The service had invoked the duty of candour once during the period March 2018 to February 2019.
- The service reported no never events from March 2018 to February 2019. A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event reported type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- The service reported no serious incidents from March 2018 to February 2019.

Are hospice services for adults effective? (for example, treatment is effective)

Good



Our rating of effective stayed the same. We rated it as **good**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

- We saw anticipatory medicines for pain, breathlessness, pain management, nausea and vomiting, distress, agitation and seizures were prescribed. These were given in line with National Institute of Health and Care Excellence (NICE) guidelines for care of the dying adult in the last days of life and palliative care for adults.
- Patient's attending the hospice in both the day therapy service and inpatient unit had the opportunity to develop an advance care plan. We saw in patient records that they had the opportunity to create a specific guide to decision making in an emergency.
- Patients had a clear personalised care plan which reflected their needs and was up to date. Staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person'. Individual care plans took account of symptom control, psychological, social and spiritual support and we saw evidence of discussion with patients and relatives recorded in care plans. This gave us assurance that care plans were agreed and developed with the consent of the patient.
- The service used a carers support needs assessment tool (CSNAT) to ensure carers needs were also considered.
- The service used the outcome assessment and complexity collaborative suite of measures which included the integrated palliative outcome score (IPOS) to identify patient priorities of care and changes



Hospice services for adults

in patient's symptoms. The IPOS was a tool designed to create a standardised set of outcome measures for use in palliative care. The key focus was to promote a holistic and patient-centred approach, allowing for the involvement of the whole multidisciplinary team.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

They used special feeding and hydration techniques when necessary. The service adjusted for patient's needs, where they had specific religious or cultural needs.

- Kitchen staff provided a menu including hot and cold food options, soups, sandwiches and desserts. They had received training in the need for and administration of liquidised or soft diet options. These food options were readily available and specific needs such as vegan, gluten free or halal were catered for. If a patient did not find something on the menu that appealed to them, the kitchen staff would try their best to make anything the patient wanted to eat.
- Patients received a nutrition and hydration assessment on admission. Staff used a nutrition screening tool to assess the food and hydration needs of patients. The nutritional assessments were completed in all five of the patient records we reviewed.
- Patient's nutrition and hydration was assessed and monitored as part of patients personalised care for the last days of life plan. This also included a mouth care and oral hygiene plan. Discussions with patient's relatives about nutrition at the end of life were clearly documented in the plan.
- The service could refer patients to dietitians and speech and language therapists and staff were aware of how to access these services.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- The hospice managed the pain of people who were approaching the end of their life effectively. Staff assessed and monitored patients pain during comfort rounds as part of patients care.
- We reviewed five care records and saw patients had appropriate pain assessments and pain management care plans. Staff recorded when as required medicines were given for pain relief. Anticipatory medicines were prescribed appropriately in people identified as approaching the end of life.
- Staff used an appropriate tool to help assess the level of pain in patients who were unable to communicate verbally.
- We reviewed care records and saw patients had appropriate pain assessments and pain care plans. Staff recorded when as required medicines were prescribed and given for pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

They used the findings to make improvements and achieved good outcomes for patients.

- The service monitored and benchmarked the quality of the services and the outcomes for patients receiving care and treatment. The service participated in Hospice UK benchmarking for falls, pressure ulcers and medication incidents. This enabled the service to assess their practice against other similar providers.
- The service used the integrated palliative care outcome score (IPOS). This is a suite of tools that measure a patient's physical symptoms, psychological, emotional and spiritual, and information and support needs. Each patient's IPOS score was discussed at the multidisciplinary team meeting.
- The service had implemented the Outcome Assessment and Complexity Collaborative (OACC) initiative which aimed to implement outcome measures in routine palliative care. We saw the outcome measures of the integrated palliative care outcome scale (IPOS) being used to assess patients in the services multidisciplinary team meeting.
- The service conducted a regular programme of audits. The programme included annually, nutritional



Hospice services for adults

assessment tool audits; we saw that the service had an average score of 90% for the audit completed in October 2018. Clinical audits were linked to the policies, procedures and guidelines. Each audit proposal was reviewed by the audit and research group to ensure it was rigorous.

- Pharmacy audits were linked to national guidance for example the audit of controlled drugs on the inpatient unit demonstrated compliance with national best practice standards for controlled drugs.
- Audit outcomes were shared with the clinical teams and included any specific learning identified.
- Policies, procedure and guidelines were reviewed every two years or sooner if local or national practice changed.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and aid development.

- Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The service ensured that staff competencies were assessed regularly. Competency assessments for registered nurses included various skills around for example; medicines, intravenous lines, blood transfusions, naso-gastric tubes and syringe drivers.
- There was an induction program which ensured new staff were competent to perform their required role. For clinical staff this was supported by a comprehensive competency assessment which covered key areas applicable across all roles including equipment, and clinical competency skills relevant to their job role and experience.
- The service offered staff continuous learning opportunities to enhance their current roles. Courses provided included breaking bad news, communication skills and a range of other end of life and palliative care courses provided by an external organisational. Staff told us the training was extremely well received and had been useful for their role at the service.

- Volunteers were provided with appropriate training, supervision and support. The service had volunteer coordinators who supported volunteers by providing them with training and by offering telephone support. Volunteers had a full induction programme which included face-to-face safeguarding training.
- All staff and volunteers underwent equality and diversity training on induction which was repeated every two years.
- Staff were required to revalidate in accordance with their registration body.
- Six senior leaders of the service had undertaken a Hawk leadership programme, which was a level five programme. One head of service had undertaken the Mary Secole leadership programme and several members of staff were currently undertaking a level three leadership programme.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They

supported each other to provide good care and communicated effectively with other agencies.

- Multidisciplinary team working helped the effective planning and delivery of care and enabled the service to provide holistic support to patients.
- The hospice's multidisciplinary team represented all aspects of holistic care. The service ensured a patient's needs were met through medicine, physiotherapy, art therapy, dietitian, and psychologist support.
- The service participated in relevant external meetings including working together with the Gold Standards Framework (GSF) to deliver the GSF programme. The Gold Standards Framework provides training to all those providing end of life care to ensure better lives for people and recognised standards of care.
- The spiritual team supported the mental health needs of staff through offering drop in sessions and debriefs following significant events.
- Staff within the service told us they worked effectively with professionals from other services and could refer to mental health services if required; and provided examples of when they had done so.



Hospice services for adults

Seven-day services

Key services were available seven days a week to support timely patient care.

- The inpatient unit provided care and treatment across seven days. The service ran seven days a week, 365 days a year. People could access most of the services seven days a week.

Health promotion

Staff gave patients practical support to help them live well until they died.

- People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.
- The service focussed on enhancing quality of life for all patients using the service. The day therapy service identified patients in need of extra support and provided emotional support in addition to physiotherapy and care planning.
- The service ran healthy lifestyle workshops for patients and their families which included topics such as physical activity.
- The day therapy service had a gym with specialised equipment to allow patients to alleviate common palliative symptoms such as breathlessness and to support patients to maintain their own health and wellbeing.
- There were rooms in the hospice dedicated to complimentary therapies and art therapies.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Staff understood their roles and responsibilities in obtaining patients consent and their responsibilities under the Mental Capacity Act (MCA) 2005. They were able to describe the MCA and actions to take when assessing service users.

- The service looked at each patient's mental capacity as part of the personalised care for the last days of life plan. We saw evidence that capacity was assessed prior to decisions about end of life care being made.
- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were recorded on appropriate forms and completed accurately in all the patient records we reviewed.
- Staff within the hospice acknowledged they sought consent from patients before providing care and treatment. We saw written consent within the patients files we reviewed. Where a patient had been assessed as not having the capacity to consent to treatment, staff acted in their best interests and this was discussed and agreed at the multidisciplinary team meeting.

Are hospice services for adults caring?

Outstanding



Our rating of caring stayed the same. We rated it as **outstanding**.

Compassionate care

Staff truly cared for patients with compassion. Feedback from all patients and those close to them confirmed that staff treated them well and with kindness.

- Feedback from patients confirmed that staff treated them well and with kindness. The relationships between patient, relatives and staff were highly valued by staff and was encouraged and supported by the leadership.
- We observed staff being continually kind and compassionate as they put patients and their relatives at ease. We observed that patients, family members and friends were always treated with dignity and respect.
- The service encouraged patients to provide feedback from their experience after each visit. We were provided with results from this feedback which was all highly positive.



Hospice services for adults

- Patient's individual preferences and needs were always reflected in how care was delivered. For example, we saw a patient living with dementia had a list of things she like to eat and how she wished her hair to be styled.
- The service held birthday parties, weddings and other special occasions in the garden or in the day service room, so that patients could celebrate these special occasions with their loved ones.
- Nursing staff were passionate about creating positive memories for patients and their families when staying at the inpatient unit. Staff enabled families to eat together, if the patient was well enough they would eat at a table in the communal area away from the patient room.
- Staff consideration of people's privacy and dignity was consistently embedded in everything that staff did. Staff ensured they protected patient's dignity when providing personal care by closing doors and curtains to bedrooms.
- The dignity of deceased patients was maintained through the services processes for performing last offices and transferring the deceased person to the services cold room to await collection by a funeral home. Last offices is the process to prepare the deceased for a funeral home and involves washing the patient.
- Relatives could attend one on one bereavement sessions with a psychologist or bereavement support groups. One relative that we spoke with told us the nursing staff provided emotional support to them daily.
- Staff supported patients well and we saw they were communicating sensitively and thoroughly with patients and those close to them. Patients told us they could ask any questions and they were given support when they were upset.
- Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. The aim of the service was to relieve as many worries for a patient as possible, so they could concentrate on caring for the whole person and their relatives.
- Patient's emotional and social needs were seen as being as important as their physical needs.
- Staff recognised the need for patients and those close to have access to, and links with, their advocacy and support networks in the community and the service provided support to them to do this.
- The service ran a support group for bereaved children aged eight to twelve years old called 'Kaleidoscope' which also had an informal group for patents and guardian running at the same time. The group provided practical and creative activities to support bereaved children and the emotional needs.
- The complimentary therapy team offered a range of therapies to support patients and their relatives including massage and aromatherapy.
- The spiritual care team ran events to support and remember loved ones such as the annual Christmas tree lighting event and remembrance and thanksgiving events for relatives who lost a loved one in the last year.
- The service had a pets as therapy (PAT) dog service that attended the inpatient unit and day centre three times a week to allow patients and their relatives to pet dogs to improve wellbeing. The service encouraged patients to bring in their own pets also.

Emotional support

Staff understood the importance of providing emotional support to patients and those close to them.

- We saw staff were positive and attentive to the needs of patients at the hospice.
- We observed staff providing kind, thoughtful, supportive and empathetic care. Relatives also commented on how supportive the staff were. They provided them with assurance and reassurance which enabled patients to relax and settle well into the hospice and accept the care and support provided.



Hospice services for adults

- The day therapy service included the option to take part in wellbeing crafts including conducting life story work with patients which allowed them to create memory boxes, photobooks, video diaries and audio recordings of their lives. The service also provided music therapy sessions.

Understanding and involvement of patients and those close to them

Staff always communicated with patients about their care and treatment in a way they could understand. Staff involved patients and those close to them in decisions about their care and treatment.

- The service had a visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and independence where possible. Patients were actively involved in their care.
- Staff made sure that people who used services and those close to them were able to find further information, including community and advocacy services. They could ask questions about their care and treatment. Staff are fully committed to working in partnership with people and making this a reality for each patient.
- Staff routinely involved people who used services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment.
- People's carers, advocates and representatives including family members and friends, were identified, welcomed, and treated as important partners in the delivery of their care.
- Patients told us they valued the relationships they built with the staff and they felt staff often went 'the extra mile' for them when providing care and support.
- We saw evidence in patient care records that staff involved patients and those close to them in the decisions about the patients' care and treatment and in developing their care plans. Patients and their relatives told us the staff answered questions about care and treatment openly and the information

provided to them was clear. We observed the community nursing staff involving and engaging patients and their relatives in discussions about care planning.

- Staff supported patients to make advanced decisions about their care. Patients were provided with support and information about their options for care, and conversations were had with patients about their preferred place of care. We saw staff talking to patients and their families about death and the dying process. They were very compassionate and caring towards patients or family member who became upset. They enabled the family of patient to ask as many questions as they wanted to.

Are hospice services for adults responsive to people's needs? (for example, to feedback?)

Outstanding



Our rating of responsive improved. We rated it as **outstanding**.

Service delivery to meet the needs of local people

The service was planned and was proactive in meeting the needs of people from their whole community. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. It also worked with others in the wider system and local organisations to plan care.

- The service provided end of life care for individuals requiring care and support outside of their NHS care. This included respite care for patients living with dementia and those close to them.
- The community and day care services offered a range of appointments to meet the needs of the patients who used the service. The managers told us there was mixed demand for appointment times and they would offer appointments to suit the needs of patients. Appointments were available early in the morning or later in the evening to accommodate patient's schedules.



Hospice services for adults

- The service had engaged actively with different faith groups in the local community and had a group that met to look at how to reach different groups within the community.
- The service engaged with the local homeless shelter and had seen an increase in the use of the hospice by people from the homeless community. Staff from the hospice had attended the shelter to talk to staff and residents.
- The service had contributed to a research project on improving communication between clinicians and the lesbian, gay, bisexual, transgender, questioning (LGBTQ+) patients with serious illness. Potential issues for the LGBTQ+ patients were highlighted by the project advisory group. Relationships were established with Stonewall, Marie Curie and the LGBT Consortium and Foundation. Staff who we spoke with could identify potential issues for LGBTQ+ patients accessing services.
- The environment was appropriate, and patient centred with comfortable seating and access to facilities such as toilets, a space for teenagers with games consoles and a play area for young children. The design of the inpatient unit had been created with the needs of patients and their relatives at the forefront of planning. Most of the rooms were en-suite and spacious and allowed for several family members to attend. All rooms had access to outdoor space with view into the hospice's award-winning gardens.
- The service had a range of on-site facilities, which families could use. On the inpatient unit and the option of staying in the rooms with patients. Families were encouraged to use the communal kitchen areas to prepare beverages and could eat with their relatives by ordering meals from the services kitchen or on-site café. The service did the personal laundry for patients.
- The service had a multi-faith quiet space which was called the garden room, that was a quiet space which could be used by patients and their relatives to reflect, pray, mediate or just to sit in a quiet space.
- There was local access to the service by car or public transport with areas dedicated to car parking. The reception area was clean and tidy with access to leaflets about palliative care and fund-raising initiatives.
- The service had projects in place to improve end of life care in the community and to access patients that wouldn't usually access their services by providing teaching and education on end of life care to care homes and to other healthcare professionals.
- The service had arrangements in place to access translation services for patients. Staff we spoke with could tell us how they would access these services and provided examples of occasions that they had done so.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. It had a proactive approach to understanding individual needs, was accessible and promoted equality. Care plans were person-centred and took a holistic approach to patient care. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- We reviewed five care plans and saw that services were coordinated with other agencies to provide care to patients with more complex needs. Staff could give examples of when they had referred patients to community services.
- Staff had received training on working with patients with specific needs such as those living with dementia. The service provided a respite service for patients living with dementia and their families. The rooms used for patients living with dementia were dementia friendly with colourful bedding, floors and walls were different colours and memory boxes were used which contained old photos and pictures to engage the person living with dementia.
- A variety of leaflets were available on the inpatient unit including information about the last days of life. The leaflets had different languages on the back explaining that the leaflets were available in different languages and email and telephone details to have them printed and sent. The leaflets were also available in different formats such as large print or on audio tape for those with a sensory impairment.



Hospice services for adults

- Care plans were in place for inpatients, patients in the community and day-care patients. These were person centred and we could see that people and their carers had had the chance to discuss them and contribute.
- The service was piloting a new community services model called the 'team around the patient' (TAP) which was an integrated team working as a single point of contact for patients and their families. The team around the patient model enabled patient's and families to call one number to request assistance from a variety of people including nursing staff, occupational therapists, social workers and doctors.
- We observed a nurse specialist making an introductory visit to a patient. We found the nurse was very respectful of being in the patient's home and gave a full overview of services available including day-care, complimentary therapy and other services provided at the inpatient unit.
- The hospice was able to make reasonable adjustments for people with a disability. Training and support was available so staff were clear how to support someone with a learning or physical disability.
- The service focussed on individual needs and goals in planning care for patents in the community. Patients goals would be identified, and a plan put in place to achieve the goals.
- Staff monitored and reviewed the changing needs of patients through regular 'comfort rounds' and frequent medical reviews.
- The service had a complimentary therapy team who offered a range of therapies to both patients and relatives including aromatherapy, massage and Reiki. The service provided onsite hairdressing appointments to patients on the inpatient unit and for patients using the day hospice.
- Patient's pets were allowed to visit them on the inpatient unit. The service had unrestricted visiting hours to enable patients' families and loved one to visit them at any time. Patients were able to have visitors stay overnight. Visitors were permitted to bring their own food and drinks with them and the service provided complimentary hot drinks and biscuits that

patient's and visitors would access and make at any time. Visitors could order food from the hospice menu to eat with the patient, this was subject to a fee payable by the visitor.

- The service had an award-winning garden which was used by patients when they were well enough. The service had a business continuity plan that covered various issues including power failure and flood.
- The service had a patient's forum, which met monthly and was an opportunity for patients to share their views of the service. There was also a pre-agreed topic for discussion at each forum. The forum was open to all patients to attend.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Arrangements to admit and treat patients were in line with good practice.

- The service had processes in place to manage admission to the service. The service had an admissions and referrals team who monitored and forwarded referrals and admissions to the appropriate service. Referrals came through from the local hospitals and GPs.
- Referral into the inpatient unit were reviewed at twice daily admissions meetings held. Referrals for the inpatient unit were prioritised by need. Prioritisation was done on a case by case basis. Patients had fast track admissions 24/7, either direct from the community or transfer from hospital.
- Staff discussed service provision at weekly multidisciplinary meetings. Using the links the service had developed with community services, the end of life care co-ordination service and occupational therapy service work to ensure that appropriate patients were discharged to their preferred place of care. This meant freeing up capacity to admit those on the waiting list. Co-ordinate my care records supported patients to be enabled to die in their preferred place.
- In community the nurses had a maximum capacity caseload of 30 patients per whole time equivalent,



Hospice services for adults

however the caseloads were reviewed and adjusted depending on complexity of patient need. Case loads were reviewed weekly by the deputy team leader for community.

- The outpatient's services capacity was based on the maximum number of patients able to attend a group or service at one time.

Learning from complaints and concerns

It was very easy for people to give feedback and raise concerns about care received.

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

- People we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so. Staff understood the system and had access to policy and procedures to guide them in managing complaints.
 - People who used the system to make a complaint or raise concerns were treated compassionately and given the help and support. Staff received specific communication training to help them respond sympathetically to people who were distressed, or who were dissatisfied.
- During the period March 2018 and February 2019 to service received 11 complaints. Three complaints were upheld following the investigation and five were partially upheld. The service had a target of responding to complaints within 20 days and we saw evidence that the service had met this target in 10 out of the 11 complaints. The 11th complaint was responded to within 24 days.
- The service undertook a thematic analysis of the complaints in August 2018. They identified two overarching themes. Those were issues relating to discharge to home and care given on the inpatient unit. The service established a working group to deliver the action plan which was monitored by the clinical risk management group.
- Staff were expected to report and escalate any concerns so that they could be practically addressed

promptly and to provide an opportunity for a senior member of staff to explore these with patients or families if necessary where the concern was not resolved immediately.

- The service had a complaints policy which identified who to complain to and the code of practice for dealing with complaints. We saw documents at the service that told people how to and who to complain to. These were in the reception area and the inpatient areas where people could see them.
- The service had a clear process in place for capturing and learning from negative feedback which was not submitted as a complaint. The service captured this feedback as "concerns" and monitored and discussed both concerns and formal complaints clinical risk management group meetings. We saw that solutions to concerns were discussed and agreed actions were assigned to members of staff.
- During the period March 2018 to February 2019 the service received 319 compliments. All compliments were logged and feedback to the relevant staff members.

Are hospice services for adults well-led?

Outstanding



Our rating of well-led improved. We rated it as **outstanding**.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The management were committed and passionate about patient care and a high-quality service. They understood the challenges the service faced, in particular the national shortage of nurses and the impact this could have on the service.



Hospice services for adults

- Staff told us they felt supported by the management and that they were friendly and approachable. Staff felt confident in approaching them regarding issues to do with their professional or personal life.
- Leaders within the service went out of their way to ensure that they were visible and approachable. Staff told us that leaders from all levels within the organisation were approachable and supportive and that members of the senior leadership team could be seen regularly on the inpatient unit and would offer support if the unit was busy.
- Concerns raised by staff were always acted upon by managers, feedback was given, and learning was always disseminated staff.
- All staff felt valued and told us that they enjoyed working at the hospice. Throughout the inspection, we saw that staff assisted each other with tasks, and responded quickly to service needs.
- The registered manager was very committed to the staff, the patients and the service. This was reflected in the way the team was led and kept patients at the heart of service delivery. The manager felt strongly about trusting and empowering the staff team and advocated an autonomous approach to the work undertaken.
- Staff felt connected to other teams within the service and the organisation. The community nursing team told us they worked well with teams from the inpatient unit and the outpatient service.

Vision and strategy

The service had a clear vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- The service had a clear person-centred vision to offer a value-based service to meet the needs of all patients. The service's vision was 'To be the local hospice of

choice for all those who need us and an example of excellence in end of life care'. All the staff we spoke with were fully aware of and proud of the vision of the service.

- The service also had clear well-defined values and a mission statement.
- The service had an organisational objectives plan for 2018/2019 which were aligned to the five-year strategic plan 2018/2021, which encompassed all its services. The service had sought the views of patients and staff when creating the plan and endeavoured to align the plan with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care.
- The service displayed in the way they worked a strong clear emphasis on continual improvement and development.
- The service demonstrated they recognise the ongoing importance of ensuring staff had total buy in to the vision and values of the service, they ensured they were understood, implemented and communicated to people in meaningful and creative ways.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- The service had a whistleblowing policy which was available to all staff and information on how to raise whistleblowing concerns formed part of mandatory training. Staff we spoke to knew how to raise concerns.
- Teams worked collaboratively, and we saw examples of positive cross-team working to provide joined up care for patients. There were particularly strong links between those working in the community and inpatient staff, meaning that patients received a seamless service.
- The service had an in date lone working policy. Staff and volunteers working in the community had a



Hospice services for adults

buddy system with another worker who would call if they were not where they were supposed to be on time. Staff wore personal safety devices when entering people's homes and could call for assistance using these discretely if needed.

- All staff we spoke with were positive about working for the hospice. They described feeling valued and supported in their role. Staff who worked remotely said they felt connected to the team and to the organisation. The service valued the contribution of its volunteers.
- There was a universal recognition of the importance of ensuring patients received a good end of life care experience across all staff groups and services. Staff were fully engaged with the hospice and very proud of the care and treatment they provided for patients.
- The culture of the service encouraged openness and honesty. We reviewed incident and investigation reports and saw the service applied duty of candour appropriately. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke to were aware of the term and could give examples of when the duty of candour would be applied.
- The service had worked to increase their view of equality, diversity and inclusion to include fairness, respect and engagement. This system was known by the acronym FREDIE. This new system had been updated within the services equality and diversity policy, in their mandatory training and included in all managers briefings and formed part of the staff appraisal process.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- The governance structure enabled issues from team meetings to be escalated to the senior management and in turn information could be passed to the care team meetings.
- The service had a clear governance process to continually improve the quality of service provided. Staff understood their roles and responsibilities in relation to governance. Governance arrangements were clear and appropriate to the size of the service.
- The service had a strong governance structure that supported the feed of information from frontline staff to senior managers and trustees. The hospice held team meetings. These meetings in turn fed into the service's board meetings. The board meetings were attended by senior members of staff in the organisation including the chair, trustees, service leads, head of governance and head of finance.
- The service also held clinical governance committee meetings which were chaired by the medical director, these meetings were held four times per year.
- There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during board meetings.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service had a business continuity plan that covered various issues including loss of access to electronic patient records, loss of electricity, loss of water supply, and fire.
- The service had a risk register, the registered manager described the main risks to the service which we noted were on the risk register. Mitigating actions and responsible person in charge of the risk had been clearly noted, along with review dates.



Hospice services for adults

- The staff understood what its key risks were and there was good oversight of them. Feedback from people who used the services and those close to them was regularly discussed at MDT meetings. The service reviewed compliments, complaints and any concerns that had arisen. Concerns were discussed by the clinical lead and actions identified and assigned to senior staff members.
- There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during board meetings.
- We were not assured however that there was sufficient oversight of consumables in place. We found consumables that were past their expiry date. There was no formal system in place for rotation of single use consumables within the service. Further, there was no consideration of the cost implications of overstocking or a lack of stock rotation.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- Information governance training formed part of the mandatory training programme for the service, and staff we spoke with understood their responsibilities regarding information management.
- Staff had access to technology to help document patient care needs and outcomes, this included an electronic system, mobile computers and electronic care records. The IT system enabled sharing of records with community teams, which facilitated joined up care
- All IT systems were protected by security measures, all staff including bank staff had individual log on details and access to patient information was restricted depending on staff role. Computer screens were locked when staff were not sitting at their desks to prevent information breaches.

- The service was registered with the Information Commissioner's Office and the Medical Director was the nominated Caldicott guardian for the service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The service engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.
- Employees completed an annual staff survey. The results of the survey were largely positive with staff answering positively to questions asking if the service's vision, mission and values mattered to them, that the role they worked in was as they expected it to be and their colleagues were committed to doing quality work.
- The service ran a patient survey for service users to give their feedback about their experience, we saw the results from these feedbacks were overwhelmingly positive.
- We saw that the service responded to any comments made to improve the quality of the experience.
- There was regular communication with staff via the staff newsletter, the intranet page and kudos corner posters.
- The service held various staff awards to recognise staff contribution included long service awards for long serving staff members. The hospice sought out staff opinion through the use of a staff survey.
- We saw examples of positive engagement with the local community including Wimbledon mosque and a local homeless charity.
- The service ran a patient forum and a family and friends involvement group both of which were ways for people to have a way to help improve the quality of the existing services and be involved in the discussion about the development of future services.



Hospice services for adults

- The service provided a newly bereaved support group and a support group for bereaved children.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

- The service was committed to improving services by learning from when things went well or not so well and promoted training and innovation.
- The service was committed to providing regular training opportunities to staff. We saw information about education sessions including sage and thyme, introduction to end of life care for staff and volunteers, last days of life, symptoms management and drugs in end of life care. There were education workshops on 'everything you wanted to know about reading a scientific paper'. The service had also introduced Schwartz rounds, which was a programme designed to support staff and volunteers with discussing emotional and social issues arising from patient care.
- The service was proactive in seeking feedback from staff, volunteers and patients and could provide multiple examples of where service improvements had been implemented as the result of this engagement.
- The service had set up yoga sessions for staff and volunteers. There was a cycle to work scheme and staff had 24-hour access to a helpline counselling service. The service held a 'sing along at trinity sessions' which were open to patient, staff and volunteers who enjoyed music.
- The service had worked with a film company to develop a virtual reality (VR) opportunity for patients to see and hear using a VR visor and headphones realistic 3d and 360-degree images and sounds that gave patients the sense of physically being present in environment. This was used as a study to understand if VR could benefit and have a positive impact on patient's physical and psychological symptoms.
- The hospice had worked with other hospices in London to develop a network and a newsletter for the London Hospices LGBT network. This network was established to improve access and quality of staff and volunteer training.

Outstanding practice and areas for improvement

Outstanding practice

- The service took a proactive approach to understanding the needs and preferences of different groups of people to deliver care in a way which was accessible and promoted equality. The service engaged with multiple different faiths in the community and seldom heard groups such as the homeless to ensure access to services for all patients.
- Staff in the service demonstrated compassion and dedication to finding innovative ways to support patients with their end of life care. Staff and patients could provide many examples of how the service had ensured patients received care individualised to their holistic needs.
- People's individual needs and preferences were central to the delivery of tailored services.
- Staff within the service completed comprehensive and holistic end of life care plans. The care planning within the service focussed on all elements of the patients care including their spiritual and emotional needs.
- Staff within the service conducted carers support needs assessment tool to identify the needs of family and friends. This assessment was to systematically assess the needs of patients' informal carers in order to support them in their caring role.
- The hospice used engagement with staff, volunteers and patients to shape the services provided. Staff and patient feedback was collected in multiple ways and staff could provide many examples of services being planned and improved as a result of feedback.
- The service had developed a virtual reality system to review patient's physical and psychological symptoms.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that effective processes are in place to monitor the expiry date of consumables.
- The provider should improve mandatory training rates in Computer Display Screen Equipment Safety, Cardio-pulmonary resuscitation (CPR) and patient handling.