Medway Community Healthcare C.I.C

Wisdom Hospice

Inspection report

High Bank
Rochester
ME1 2NU
Tel: 01634830456
www.medwaycommunityhealthcare.nhs.uk

Date of inspection visit: 19 August and 23 August 2021
Date of publication: 28/10/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff had completed their mandatory training.
- Not all staff were clear on where they were required to put on PPE.
- The service did not have a system to record the monitoring of their cold storage facilities.
- The service did not audit patient's preferred place of death against their actual place of death.
- The service did not audit their use of do not attempt cardiopulmonary resuscitation orders.
- The service needed to improve the way it collected feedback from patients.
- The service did not complete all their routine audits.
- The service did not have structured engagement with their patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Wisdom Hospice

The Wisdom Hospice is operated by Medway Community Healthcare. Medway Community Healthcare is a community interest company. Community interest companies are social enterprises that use their profits and assets for the public good.

The Wisdom Hospice is primarily funded by the NHS but also received funding from charity donations. They provide a multi-disciplinary team approach to palliative care and support adult patients approaching the end of their lives. They also provide support for the family and friends of these patients.

The Wisdom Hospice had 15 beds on their inpatient ward, a community team to support patients in their own homes, and a team that visited the local acute hospital to offer palliative support to patients in hospital. The service provided training and education to people with palliative care needs.

The Wisdom Hospice had a day hospice that provided individual and group therapy. However, when we visited this was closed due to COVID-19 restrictions.

The location is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. They have legal responsibilities for meeting the requirements set out in the Health and Social Care Act 2008.

We last inspected this service in April 2016 when we rated it good overall and found no breaches of regulations.

How we carried out this inspection

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

During the inspection, we looked at care provided on the ward, in the community and spoke to staff about care provided in the hospital. We spoke to four patients and two relatives. We spoke to 16 members of staff. We looked at four patient records, four incident reports, and five complaints.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool called Talking Mats. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with two people to tell us their experience.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The service supported all their community nursing staff to become non-medical prescribers. This developed their skills and supported the region by reducing the need for GP prescriptions.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that all staff complete their mandatory training.
- The service should ensure that all staff are clear on where they are required to put on PPE.
- The service should ensure they collect patient feedback to monitor and improve their performance.
- The service should ensure they carry out their planned audit program to monitor their performance.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

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 most staff completed it.

Staff received and kept up to date with most of their mandatory training. The service had 31 mandatory and statutory training modules. Data showed 24 of the 38 modules met the services target of 85%. The three modules with the lowest compliance rates were anaphylaxis (clinical) (0%), anaphylaxis (40%) and tissue viability (50%). Managers told us the risk management training was new, so compliance was increasing as more staff complete this.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us they enjoyed completing their training and found this helpful in caring for patients. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff received training on the needs of these patients and how they may differ in their clinical mandatory training modules including; moving and handling, nutrition, and pain management.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received an automated reminder three months before their current training expired. Staff told us reminders from managers were helpful.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Clinical staff received training specific for their role on how to recognise and report abuse. The compliance rates for safeguarding training were; 96% for safeguarding adults level 1, 96% for safeguarding adults level 2, 86% for safeguarding adults level 3, 94% for safeguarding children level 1, 94% for safeguarding children level 2, and 83% for

safeguarding children level 3. Safeguarding children level 3 compliance was lower than their target of 85% however, this only represented one member of staff as there was only 7 staff required to complete this module. The service also provided 'prevent' training which clinical staff compliance was 100% for level two and 96.6% for level three. Prevent training aims to ensure the safeguarding of children, adults and communities from threat of terrorism.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to described how they identified risks of abuse. The service had up to date policies on safeguarding, self-neglect and chaperones. Staff we spoke to knew how to follow these policies.

Staff gave examples of how they had protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us they had worked with the police to protect people. The service also carried out one to one support with children of their patients. Staff told us this would often involve talking to them about their feelings and anything that was concerning them and knew how to identify concerns of abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would firstly discuss their concerns with their line manager and the services safeguarding team. Then when needed, they would report their concerns to the local authority. Staff knew how to access the service's safeguarding policy on their intranet to check anything they were unsure about. Staff told us they talked to their senior colleagues to get support with raising concerns of abuse. The service had a safeguarding lead to provide support for staff.

Staff followed safe procedures for children visiting the service. When visiting the ward children were always accompanied by an adult visitor. Staff knew the signs of abuse and how to raise their concerns about children visiting the service.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we inspected were visibly clean. The hospice had cold storage for eight patients after death; this area was visibly clean and there was a completed cleaning rota.

The service performed well for cleanliness. The service carried out audits of their cleanliness. In September 2020, the service achieved 97% compliance and created an action plan to improve the areas of noncompliance. They repeated this audit in June 2021, which showed improvements with the service achieving 99% compliance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw cleaning being performed and recorded, clearly indicating when cleaning was undertaken.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff cleaning equipment after use and labelling this to inform other staff when it was last cleaned.

Most staff followed infection control principles including the use of personal protective equipment (PPE). All staff were bare below the elbow. Staff used the correct PPE when providing care to patients. Staff were seen wearing face masks throughout the hospice in line with national guidance for healthcare settings. However, not all staff were clear where they were required to put on PPE. All staff took off PPE correctly and in line with the service's policy.

Staff completed training on infection prevention and control. Clinical staff compliance with these modules was; 89% for aseptic no touch technique, 100% for infection control, 93% for sepsis training, and 96% for hand hygiene.

All staff cleaned their hands before, during and after patient care in line with the World Health Organisation guidance on the "five moments for hand hygiene". We saw posters reminding staff of these five moments.

The service had enough sinks and alcohol hand rub dispensers to support compliance with hand hygiene. We saw no queues for sinks and saw alcohol hand rub was available throughout the hospice. All sinks had soap, disposable hand towels and posters displaying the correct hand washing technique.

Staff managed sharp clinical waste in a way that reduced the risk of spreading infections. Sharps bins were assembled correctly, and these were not overfilled. Staff used temporary closure lids to reduce the risk of accidental sharps injuries.

The service followed national and local policies to reduce the spread of infections. All patients were tested for COVID-19 on admission and re-tested on day five. Patients were kept in isolation rooms until they had confirmed a negative result. The service had not reported any outbreaks of COVID-19 and we looked at records for the past 12 weeks which showed no hospital associated transmission of COVID-19.

The service controlled and monitored healthcare associated infections. Staff informed the infection control team when there was a possible healthcare associated infection and the infection control team have an automated system that alerts them to patients with new infections such as methicillin-resistant staphylococcus aureus (MRSA) and *clostridium difficile*. In the last 12 months the hospice has had no healthcare associated infections including MRSA, *clostridium difficile*, and gram-negative bacteria.

The service had maximum occupancy signs to alert staff, visitors and patients to the maximum number of people that could safely socially distance in each room. All rooms had these signs displayed and staff were not entering rooms that were at their maximum occupancy.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Patients told us staff responded quickly when they pushed their call bells.

The design of the environment followed national guidance. The flooring was easily cleaned, and all corridors were wide enough to accommodate beds and wheelchairs. All fire exits were clearly marked and clear of obstructions.

The service had and maintained fire safety equipment to reduce the risk to patients from fire. The service had carried out yearly checks on fire extinguishers and these were secured to the wall where staff could access them quickly. All doors with "Fire door keep locked" signs were kept closed and locked.

The mortuary followed national guidance and had equipment which allowed staff to safely move deceased patients into fridges or into the viewing room. There was space for eight patients. Managers told us they had good relationships with local funeral directors to allow for the swift transfer of deceased patients when needed.

Staff carried out daily safety checks of specialist equipment. The temperature of the cold storage spaces for deceased patients was displayed and staff monitored this on entry to the area however the service did not record this information. Staff we spoke to knew to alert managers urgently if the temperature was out of the required range. Managers have immediately addressed this and started a twice daily recording of the temperatures. Since the inspection we saw evidence this was being completed. The cold storage record also reminds staff of what to do if the temperature is out of the required range.

The service had suitable facilities to meet the needs of patients' families. The hospice had a large communal area for family and friends including an area to make drinks and relax away from the ward. However, due to restricted visiting related to the pandemic, there was limited use of this area at the time of our inspection.

The service had enough suitable equipment to help them to safely care for patients. Staff told us they had the equipment they needed to care for patients. The service had enough syringe drivers and staff tracked when maintenance was due. Records showed all equipment/syringe drivers were serviced in the past 12 months.

Staff disposed of clinical waste safely. We saw all clinical waste was disposed of safely and segregated into the correct bins. These were routinely emptied by the cleaning staff and taken to the waste storage area for collection. The waste storage area was located outside the hospice and all bins were secure.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used a tool focused on the patient's symptoms such as pain, breathlessness and anxiety. This was more suited to palliative care as it focused on symptom relief. Staff completed a full set of observations for all patients on admission and then carried monitoring of blood sugar out twice a day for patients with diabetes and patients on high dose steroids. Staff carried out temperature monitoring twice a day. Staff told us they would complete a full set of observations if they saw an unexpected decline in a patient's condition.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. These included a falls risk assessment, infection control risk assessment, and pressure area risk assessment. We saw staff had completed these and taken action to reduce the risk to patients. Staff provided mouth care to patients to reduce the risk to patients of developing mouth ulcers. The assessment guided staff to look at their patient's lips, tongue, teeth and gums, cheeks and dentures. The tool then suggested what level of support to provide. We looked at five mouth care records that showed staff had assessed the risks to patients and recorded the care provided.

Staff knew about and dealt with any specific risk issues. They assessed patients for signs of sepsis, venous thromboembolism, falls and pressure ulcers. A venous thromboembolism is a blood clot that patients in hospices are at higher risk of due to reduced activity. Staff provided pressure relieving equipment for patients at risk of developing pressure ulcers. Staff completed an incident report for any patient with a grade two or worse pressure ulcer. Managers monitored these to look for any learning and to identify how many were acquired or worsened while patients were in their care. The service reported no service-acquired pressure ulcers in the past 12 months.

Staff completed psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff assessed the psychosocial health of patients on their admission to the service. Staff assessed relative's psychosocial health before and after the death of the patient to ensure the correct support was provided. The service had a counsellor for patients, relatives and staff.

The service had 24-hour access to mental health support if staff were concerned about a patient's mental health. Staff knew how to contact the local NHS mental health trust to seek specialist support when their patients needed it.

Staff shared key information to keep patients safe when handing over their care to others. Staff sent discharge letters on transfer of care to another provider. We saw these letters had information on the reason patients were inpatients at the Wisdom Hospice, why they needed to be transferred and what treatment they had given the patients.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers had information on inpatients on the ward including; information on their family dynamics, diagnosis, current condition, pressure area care, multi-disciplinary team involvement, infection status, and discharge planning.

Staffing

The service had enough 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 bank, agency and locum staff a full induction.

The service had enough medical, nursing, allied health professionals, support staff and volunteers to keep patients safe. The service had enough nursing and medical staff to fill their rotas including covering sickness and annual leave. The service also had allied health professionals to support patients and relatives including; physiotherapists, occupational therapists, councillors, and benefits advisors.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. We looked at four weeks of nursing rotas that showed there was at least two nurses on every day in the community including weekends. We looked at four weeks of nursing rotas for the hospice's hospital support team which showed there was at least two nurses each day Monday to Friday with one nurse attending at the weekends.

The number of nurses and healthcare assistants matched the planned numbers. We saw on the day we visited the hospice the number of nursing staff matched the planned level.

Managers adjusted staffing levels daily according to the needs of patients. Managers told us they had needed to use more bank and agency staff over the past 12 months due to extra patient needs. This was primarily due to the needs of patients with COVID-19 which required separate staffing from those patients who did not have COVID-19.

The service had reducing turnover rates. Their turnover rate in February 2021 was 21.9% and 19.7% in July 2021. These figures included internal job role moves as well as leavers.

The service had increasing sickness rates. Sickness rates in were 15.2% June 2021, 14.7% July 2021, and 12.8% August 2021 all were higher than their 12-month rolling average of 10.4%. This had slowly increased throughout the year from 7% in September 2020. Managers told us over the past 12 months there was more sickness leave due to isolation and stress caused by the pandemic. The service had counselling services for their staff to help support them.

The service had reducing vacancy rates. Managers told us they had recently been successful in recruiting medical and nursing staff.

Managers limited their use of bank and agency staff and asked for staff familiar with the service. The service had used no bank trained staff for October 2020, Nov 2020, December 2020. The service had used untrained bank staff when needed, in October 2020 they used 187 hours, in November 2020 they used 224 hours, and in December 2020 they used 200 hours.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers said although they tried to limit the number of agency staff used in the past 12 months, they had seen an increase during the pandemic. Managers ensured agency staff were always working with substantive staff to support them.

The service always had a consultant on call during evenings and weekends. Staff were able to contact medical staff for support 24 hours a day seven days a week. The service had employed one additional consultant to allow them to jointly cover Monday to Friday and two out of four weekends.

Managers could access locums when they needed additional medical staff. Staff told us they had a regular locum consultant that covered Fridays and three out of four weekends. Staff told us this worked very well, and consultants were always happy to provide advice. The service also had access to an agency to cover for sickness.

The service had planned to reduce their need for locum doctors. They had one substantive consultant that worked Monday to Thursday and covered one weekend out of four.

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.

Patient notes were comprehensive and all staff could access them. All records we looked at were complete, including risk assessments, plans of care and treatment escalation plans. Patient records were stored on an electronic system which allowed staff to access them remotely. However, staff reported this system was new and was slow to use. Managers told us they were aware of the issue with the adoption of this new records system. This was recorded on the service's risk register and actions were taken to reduce the effect on patient care.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients received from the local NHS hospital were seen by hospice staff before admission in the hospital. The hospice had a team of staff that delivered palliative care to inpatients in the local NHS hospital. This allowed them time to assess the patients' needs before admission and hospice staff had access to these records immediately.

Records were stored securely. The electronic record systems were secured with unique usernames and passwords for each member of staff. Staff logged out of the computer systems when not in use to prevent unauthorised access.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw medicine records were complete and up to date with clear recording of allergies and reasons if medicines were not given. Community prescription charts had allergies and sensitivities clearly recorded and included a conversation table for when changing between different opioid based pain relief medicines. The community prescription records also contained contact details of places to gain support with medicines management.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients told us they were provided with advice on their medicines. We saw advice given on anticipatory medicines. Anticipatory medicines are those prescribed in end of life care for likely symptoms and to prevent delay in administration these are prescribed for use if needed.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Access to medicines were restricted with access for authorised staff only. The fridge temperatures and ambient room temperatures were monitored daily and actions recorded when temperatures were outside of the recommended ranges.

The service conducted a yearly medicines assurance audit which looked at all aspects or prescribing, administration, training and recording. This was last completed in March 2021 which the service had developed an action plan to address areas identified for improvement. This included ensuring all staff were aware of the process for actioning and reviewing medicines alerts.

The service conducted a monthly cold chain audit. A cold chain audit was to review all aspects of cold storage of medicines. The compliance rates with this audit were 100% for March, April, and May 2021, 96% for July 2021. We saw the July audit identified errors in recording fridge temperatures and recorded actions taken to improve compliance.

Staff followed current national best practice to check patients had the correct medicines. Staff checked patient's identity and allergies before giving patients medicine. The service had access to pharmacy support and were able to order medicine up to midday for next day delivery. Community prescription records were revalidated by a prescriber every three months up to 12 months when a new record was started with all required medicine prescribed again. Medical staff completed a reconciliation of patient's medicines when they were admitted to the ward.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Medicine safety alerts were received from the Medicines and Healthcare products Regulatory Agency by the provider's patient's safety team. These were then reviewed by the community health services lead pharmacist. The pharmacist decides which services and staff needed to know about the alert. This was then shared by patient safety officer with these staff.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff were familiar with the side effects of medicines given to relieve symptoms of dying patients. Common side effect of some of these medicines reduce the conscious level of patients so staff carefully consider their benefits against these.

The service stored and monitored controlled drugs in line with national guidance. The service had a controls drugs accountable officer. The controlled drugs cupboard was secure and medicines we checked were signed for correctly with the correct count of the remaining amount of medicine. The service carried out a controlled drug audit every three months. These audits looked at security of storage, documentation, stock balance, the receipt and destruction process. Audit results showed good compliance and had action plans to monitor improvements and reinforce good practice from the staff. These action plans focused on reinforcing the good practice staff had shown.

Good

Hospice services for adults

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 knew what incidents to report and how to report them. Staff knew how to access the service's incident reporting tool on their intranet and told us they were confident in using this.

Staff raised concerns and reported incidents and near misses in line with provider policy. We looked at four incidents reports and saw staff reported a variety of patient safety concerns as well as non-clinical incidents.

The service had no never events or serious incidents in their service over the past 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff understood their responsibility to apologise to patients when things went wrong. Compliance was 100% for clinical staff with duty of candour training.

Managers debriefed and supported staff after any serious incident. The service ran structured reflection sessions after significant events. This included repeating these sessions to allow all staff to attend. They ran hospice wide reflection sessions and role specific reflection sessions. This included ones for clinical staff and ones for non-clinical staff. This allowed non-clinical staff time to reflect on how these incidents uniquely affect them in their roles.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We looked at four incidents which showed a thorough investigation was conducted and learning was identified. These had all been graded for their severity according to the provider's policy. Duty of candour was only recorded on their incident system when the formal duty of candour was required due to the information recorded. None of the incidents we reviewed required duty of candour to be completed.

Staff received feedback from investigation of incidents, both internal and external to the service. The service shared learning from incidents with staff in team meetings. They also shared urgent learning via a cascade of management which resulted in direct conversations with patient facing staff. Managers said this resulted in urgent messages being shared with staff in under an hour.

Staff met to discuss the feedback and look at improvements to patient care. Improvements were discussed in team meetings with staff. Managers reviewed incidents and learning to share before these meetings.

There was evidence that changes had been made as a result of feedback. In incident reports we saw learning was always taken from incidents. We looked at three medication incidents and these all documented that the staff involved had completed reflections on their practice to ensure they learnt from these. We also saw in these three records an action which arranged additional support to be put in place for junior staff to ensure patients received safe care and staff received support when needed. Junior staff told us they received the support they needed from managers.

Are Hospice services for adults effective?

Good

Hospice services for adults

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. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The hospice ran a service in the local hospital to swiftly identify patients that were approaching the end of life. This was in line with statement one of the National Institute for Health and Care Excellence (NICE) quality standard 13 on the care of adults at the end of life.

The hospice arranged spiritual and religious support for people approaching the end of life. The service held weekly prayer sessions in their multifaith space and contacted religious leaders to attend the hospice to meet the needs of individual patients. This was in line with statement six of the National Institute for Health and Care Excellence (NICE) quality standard 13 on the care of adults at the end of life.

Patients were prescribed anticipatory medicines and staff explained the reasoning for these prescriptions. This was in line with statement three of the National Institute for Health and Care Excellence (NICE) quality standard 144 on the care of adults in the last days of life and recommendation 1.5 of the National Institute for Health and Care Excellence (NICE) quality standard 31 on the care of adults in the last days of life.

Care was provided in line with the five priorities for end of life care. Staff identified patients in need of end of life care. We saw staff communicated with patients and relatives in a sensitive and supportive way. The service had a dedicated team to support families and friends of the patient. Staff created personalised care plans for their patients to receive individualised care.

The hospice used the Integrated Palliative Outcome Score (IPOS) which was a tool to identify patient priorities of care and changes in patient symptoms. The IPOS was designed to create a standardised set of outcome measures for use in palliative care and was focused on promoting a holistic and patient-centred approach.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had a good understanding of the key principles of the Mental Health Act and were supported by senior staff who had experience in the use of the Mental Health Act.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Ward staff completed patient records for monitoring patients' physical, psychological and emotional health. The service had a dedicated team to monitor and support family and friends.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and keep them comfortable. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Patients told us they had plenty of options and portion sizes were appropriate for them. Patients also reported having a wide choice of options for vegetarians. Snacks were available throughout the day for patients and visitors.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Integrated Palliative Outcome Score tool which identifies patients at risk of malnutrition due to a low appetite. Staff completed the Malnutrition Universal Screening Tool that assess patients' risk of malnutrition. Patients with a high risk of malnutrition were referred to a palliative dietician. The palliative dieticians used the Mid Upper Arm Circumference tool with patients that were unable to be weighed which allowed them to estimate the patients weight to monitor for weight loss and assess their level of malnutrition.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff monitored a patient's fluid and nutrition throughout the day to keep their patients as comfortable as possible. Staff undertook daily assessments to identify patients who needed assistance with drinking. The service used a tool that identified patients that needed assistance with drinking. This tool daily assessment looked at assistance needed to swallow, holding a cup and reminders to drink. Each level of assistance was assigned a colour. Staff knew which level of assistance patients needed by their colour coded lids and trays.

Specialist support from staff such as dieticians, and speech and language therapists were available for patients who needed it. Patients, relatives and staff told us the speech and language therapists provided advice tailored for each patient's needs in a way that was understandable to all.

There was a fully equipped kitchen with cooking facilities; patients and family caregivers could make themselves food and drink, and staff supported them if needed.

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.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The service used a tool to assess pain and other symptoms common in patients in end of life care. This included looking at shortness of breath, weakness, nausea, appetite, constipation, dry mouth and drowsiness. This tool was used weekly for patients on the ward and on each visit to patients in the community and those patients in hospital. This tool was used to focus the plan of palliative care for each patient.

Patients received pain relief soon after requesting it. Patients told us staff were always quick to supply them with pain relief when needed. Patients in the community also received advice on pain relief and hospice staff ensure they were receiving enough pain relief.

Staff prescribed, administered and recorded pain relief accurately. Staff recorded pain scores in patient records.

Medical staff prescribed anticipatory medicines for pain relief in patients approaching the end of life. Hospice staff based in the local hospital reviewed patients receiving palliative care and ensured they were prescribed anticipatory medicines. Hospice staff in the community gave advice on anticipatory medicines and arranged for these to be prescribed for their patients. Anticipatory medicines are prescribed before a patient requires them to ensure they are available once a patient does require them.

Staff supported patients with communication difficulties to communicate their pain levels. Patients told us staff took extra time to ensure they understood patients with communication difficulties. Staff used the Abbey pain scale that uses observations by staff to assess the pain level of patients unable to tell staff about their pain level in other ways. This tool looks at aspects of the patient presentation to indicate their level of pain including their; facial expression, behavioural changes, and changes in body language. Staff also used picture cards with text to allow patients that were unable to speak to communicate their pain levels. This included ones in other languages such as Punjabi as in the local population there were a large number of people that spoke this as their first language.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations.

Managers and staff used the results to improve patients' outcomes. The results of their fall risk reduction audit showed compliance rates of 94.6% in January 2020, 95.6% in August 2020 and 90.7% in February 2021. Staff had reviewed the drop in compliance within their falls working group which had identified the reduction in compliance was linked with a misunderstanding of the questions in their audit tool. They clarified the wording of their audit question to make the meaning clearer.

The documentation audit included looking at if advanced care planning was completed which was one of the nationally expected standards of care for hospice care. The last three audits for inpatient care showed compliance rates of 97.3% in April 2019, 96% in October 2019 and 93.8% in January 2020 which were all better than their target of 90%. However, due to the pandemic they had not complete this audit again since January 2020. Managers had an audit plan that included restarting this audit for the next 12 months.

Managers and staff carried out a programme of repeated audits to check improvement over time. These included audits of infection control practice, documentation and fall prevention.

The service participated in Hospice UK benchmarking for medicine incidents and infection prevention and control practice. They held meetings at local, regional and national level to discuss the Gold Standard Framework for palliative patients on the palliative register. They monitored their ethics practices with the local acute NHS trust's ethics committee. They discussed their performance at the Kent and Medway end of life care monthly meetings. The service had been participating in the national COVID-19 clinical echo knowledge network to share learning from the pandemic.

Managers used information from the audits to improve care and treatment. The service completed detailed controlled medicines audits. Staff then complete an action plan to target areas of noncompliance which in the September 2021 audit included calculation errors and record keeping errors. The action plan recorded actions to be taken to address these areas such as ensuring that the second witness always completes an independent calculation. This learning was share with staff via a one-page summary poster of the findings from the audit.

Managers shared and made sure staff understood information from the audits. Staff told us they received feedback about audit results.

The service participated in relevant national clinical audits. The service had submitted data to the National Audit of Care at the End of Life for the year of 2020 to 2021. However, this audit was paused by the national team in the past 12 months due to the pandemic.

Improvement is checked and monitored. The service had a comprehensive plan of audits for the next 12 months however they had not completed all their audits over the last 12 months due to the pressures of the pandemic. The service collected data on preferred place of death and had data on the actual place of death. However, due to a new digital records system, they were finding it difficult to process this information to compare the two in an audit. Leaders were working with their information team to develop an audit to show them this important outcome measure.

The service reviewed their patient's outcomes against their key performance indicators. These included monitoring the percentage of patients with an advance care plan and the time to receive an initial assessment after referral. These were below their targets and mangers told us this was due to changes to their own and external processes caused by the pandemic. They were working with their partner organisations to improve their performance.

The service did not have a formal way to collect patient or relative feedback. The service reviewed their complaints and compliments for themes. Leaders had planned to develop a tool to sensitively collect this feedback while respecting the relatives grieving. They were also working to develop a way to collect more feedback from their patients. Patients and relatives, we spoke with were very positive about the service. The hospice used the integrated palliative care outcome score (IPOS) to assess their effectiveness for individual patients. However, this was not used to review the services effectiveness on a wider scale.

The service took part in patient and relative feedback research projects to help them better understand their patient's needs. The latest of these was from January 2021 focused on opioid induced constipation.

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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Nursing, medical and allied health professionals had the required qualifications and had completed training in palliative care as part of their induction.

Managers identified poor staff performance promptly and supported staff to improve. Staff told us they were well supported if they were struggling to perform in their role.

Managers gave all new staff a full induction tailored to their role before they started work. Staff said they received an induction when starting with the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service had completed a yearly appraisal with 100% of their staff. Managers told us they did yearly appraisals with frequent check-in meetings with their staff to support their goals for that year.

The clinical educators supported the learning and development needs of staff. Staff with responsibilities for educating others told us they enjoyed this and were given enough time to complete this aspect of their role. Staff were eager to learn to improve their knowledge and skills.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meeting minutes were comprehensive with enough detail to follow the discussion that were held.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had conducted a training needs analysis for the financial year of 2020 to 2021 to identify areas to develop their staff which resulted in a list of potential training and development opportunities for different roles across the service. This included clinical staff developing their skills by completing non-medical prescribing, leg ulcer treatment training and dysphagia training. Two staff had completed their non-medical prescribing.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their managers listened to them, gave them the time they needed, and supported them to develop.

Managers made sure staff received any specialist training for their role. The service was supporting all their community nurses to complete their independent prescribing course at university. Senior clinical staff had completed advanced communications skills training. The service was supporting staff to complete the Good Clinical Practice programme from the National Institute for Health Research. This course provides an understanding of the international ethical, scientific and practical standard to which all clinical research is conducted.

Managers recruited, trained and supported volunteers to support patients in the service. They received an induction to the hospice which included infection prevention and control training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We looked at records showing the service held daily multidisciplinary team meetings which included doctors, nurses and therapy staff including staff from the community team and the hospice team.

Staff had a united approach to multidisciplinary working to ensure a holistic approach to the care delivered. We saw staff working together to meet the needs of patients. Staff said they worked together to meet the needs of their patients. All staff we spoke with said they gave and received support from one another.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff from the hospice worked well with each other and with the wider health community. Staff would contact the patient's GP when they were admitted into the hospice. Family and carers support team staff visited the local hospital to offer new patients and patients already under the care of the hospice with continuous palliative care support.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The service had in hospice councillors to support patients but also referred patients onto mental health services when they needed more specialist care.

Seven-day services

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

Consultants led daily ward rounds on the ward, including weekends. The service has a long-standing service level agreement that supplies them with a named consultant for cover on Fridays and three out of four weekends. The one remaining weekend is covered by the service's substantive consultant. Nursing and medical staff told us these were helpful and well structured.

Good

Hospice services for adults

The hospice was open 24 hours a day, seven-days a week to support patients and family caregivers who needed help with their care. Nursing and healthcare staff provided care to patients 24 hours a day.

Staff could call for support from doctors and other disciplines, including mental health services and chaplaincy support, 24 hours a day, seven days a week. Staff told us they had a list of contacts for different religions and they were always able to attend the hospice.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in the hospice. They had leaflets about what to expect in the last months, weeks and hours of life. These included a leaflet about changes to skin which highlighted the causes, those at risk, how to minimise the effects, and contact details for additional support.

Staff assessed each patient's health upon admission and provided support for any individual to live as comfortably as they could.

The service also provided psychological support to the friends and families of patients. They had a team dedicated to supporting these people with the emotional, physical and financial effects of facing the loss of someone close to them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff could describe the principles of the Mental Capacity Act. Staff contacted their manager or the family and friends if they needed support with assessing capacity the family and carers support team supported ward staff to understand the complexities of these Acts.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients told us staff always explained care options and confirmed they were consenting to receive it before delivering care.

Staff clearly recorded consent in the patients' records. We saw patient consent was recorded clearly in patient's records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to describe the principles of accessing mental capacity and knew to seek support if they needed it.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Patients told us staff made sure they understood their care before consenting to receive it.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff covered this training in their safeguarding adults training compliance for clinical staff was; 97% for safeguarding adults level 1, 97% for safeguarding adults level 2, 86% for safeguarding adults level 3.

Good

Hospice services for adults

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Managers submitted documentation to the local authority to seek approval to deprive patients of their liberty when this was in the best interest of the patients.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew they could ask for advice from the family and carers support team as they had more experience in the application of the Mental Capacity Act and Deprivation of Liberty Safeguards. The family and carers support team had a clear understanding of how to implement to Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew how to assess their policy's on the service's intranet.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The service completed a yearly audit on their compliance with the Mental Capacity Act.

Staff supported patients and families with discussions about do not attempt cardiopulmonary resuscitation (DNACPR) orders. The four inpatient record we looked at had a completed DNACPR order including a record of discussion with the patient and family or friends.

Managers did not monitor the use of do not attempt cardiopulmonary resuscitation (DNACPR) orders. Managers told us they intended to restart this audit last year however due to pressures from the pandemic this had not been completed. The service's yearly audit plan for the 12 months following our inspection included auditing the use of DNACPR orders.

Staff support patients to make advanced care plans. These were completed with patients on their admission to the service. An advanced care plan allows patients to make choices about the way they receive care when they are unable to make these choice for themselves due to the progression of their disease. The four records we looked at included a completed advanced care plan.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff applied to the local authority for approval to deprive patients of their liberty in their best interests.

Are Hospice services for adults caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Relatives told us the staff were caring and attentive to them and their loved ones. We saw staff gave patients all the time they needed including taking time to talk with patients.

Patients said staff treated them well and with kindness. A patient told us they felt like they were staying in a five-star hotel as staff were so attentive and kind to them.

Staff followed policy to keep patient care and treatment confidential. Staff logged off computers when not using them to prevent access to confidential information to unauthorised people. Staff spoke quietly when discussing patient information to prevent others overhearing personal information. Staff used curtains when carrying out personal care to protect patient's dignity.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us about how they supported people with mental health conditions and gave examples where they needed to not allow their personal feelings effect the care they provided. Staff told us how they would spend time listening to patients and relatives and comfort them. We saw many compliment cards talking about how much staff listening and talking with the patients and relatives had helped them.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff made sure they had up to date information about the patient's wishes which were recorded on their 'my wishes' record. The service used 'my wishes' records to talk with patients in a sensitive way about how they would like to be cared for and then this information was shared with the team, so the patient did not have to repeat this information. Patients and relatives told us they felt staff really understood their needs.

The service had a clear procedure for looking after a patient after death and staff followed this. Staff discussed if the family wanted to be involved in the cleaning of the body after death and made plans before death to respect the wishes of the patient and family. The service had effective arrangements with undertakers and the service reported no delays in transfers. This prevented the families of the deceased having unnecessary waits to make the funeral arrangements.

There were many examples of staff going above and beyond to care for their patients. We saw thank you cards which include people saying how grateful they were that their loves ones spent their last days with the support of the hospice staff. Staff had arranged short notice wedding ceremonies and blessings. Staff described working with a charity group to help track long lost relatives that their patients wanted to reunite with before passing away. Staff told us about a patient that had wanted to have a family Christmas celebration, but this was postponed due to COVID-19 restrictions. Staff made arrangements to hold a special Christmas for this patient in spring instead.

During the pandemic the service had restricted visiting for relatives. This was in line with the government guidance. The service had produced leaflets to keep relatives and patients up to date with current visiting rules. They also had electronic tablets to allow patients to video call their loved ones. Staff discussed the restrictions to visiting restrictions with patients and relatives before admission to the hospice so they were able to make an informed decision on the best place for their relative to receive care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service had councillors to support the mental wellbeing of patients and their families.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff described how they would help patients that became distressed in a public space and take them to a quiet and private space to talk with them. No patients became distress in public space during our inspection.

Staff took time to speak with relatives of patients that had passed away. Relatives appreciated still being involved with the hospice after the passing of their loved ones. Staff spoke with them for as long as they wanted and asked them about their emotional wellbeing.

The service acknowledged the stress placed on their patients and families by financial worries. The service had benefit officers to help support with financial advice to patients and families.

There were many thank you cards saying the support provided to their loved ones in their final days and their family was excellent. One of these cards said, "We just wanted to thank you and express our sincere thanks for providing our mum, with such good care and providing such support to her and our family at such a difficult time."

Staff had arranged with a local charity group to organise a support group meeting for patients with motor neurone disease. The hospice provided the space for the group to meet and hospice staff supported any attendees needing help with personal care. This group was set up to help patients support each other at this difficult stage of their lives.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Patients told us staff had explained their prognosis in a sensitive way while making the information about their condition clear.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us they spoke to patients to understand what was important to their emotional wellbeing. A member of staff told us they had asked a patient that was clearly distressed about their concerns which included a misunderstanding about their condition and the process of dying. The staff member explained this to the patient and clarified any points to make the patient feel at ease.

Staff arranged for religious leaders to attend the hospice to provide emotional support. The service had links with religious leaders from many different faiths and kept a list of contact details. The family and carers support team were arranging a memorial service for people that had lost a loved one during the pandemic. They hoped this would offer them an opportunity to reflect on the loss which they may have missed due to the restrictions during the peak of the pandemic.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients and relatives told us staff told them about the care and treatment being provided. They also said they felt involved in the decision making about care choices.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service had picture cards to help them communicate with patients that had communication difficulties. A patient with communication difficulties told us staff communicated well with them to understand them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients told us they knew how to raise concerns and provide feedback on their treatment if needed. All patients we spoke to told us how happy they were with the service and one patient told us how they had chosen to go to the hospice because of its brilliant reputation.

Good

Hospice services for adults

Staff supported patients to make advanced decisions about their care. All patient records had 'my wishes' records completed. These detailed what care and the way patients wanted to receive it. Staff support patients without a will that wanted to create one access solicitors to complete one. Staff told us this could be arranged on the same day.

Staff supported patients to make informed decisions about their care.

The hospice had a clear patient-centred culture with the family and friends around the patient all being supported by the service. Staff told us how they tailored their care to the needs of each patient and while doing this supported all the family and friends around the patient. Staff told us about a patient that did not want to see their partner during their last weeks of life. Staff told us they supported the patient and arranged for other relatives to visit the patient. While doing this a separate team supported the partner with their grief of loss and rejection. They told us it was important for them to deliver care to all people around the patient in a non-judgemental way.

The service supported family and friends to remember their loved ones after they passed away. The service worked with patients, family and friends to create memory boxes. The family and carers support team worked with children close to the patient. This included working through activity books that focused on working through the emotional and practical element of losing someone close to them. This allowed the children to create something they could look back at later in life to help them remember their loved one.

The service offered bereavement support to adults after their loved one had passed away. The service would contact relatives eight weeks after the patient's death as they have found this is the period where grieving people were most receptive to receiving help. They offered a face to face session with them to offer support and look for signs of mental health concerns including reviewing if they had any suicidal ideation or self-harm thoughts. Bereavement support for children after the death of a relative was commissioned separately to the hospice.

Are Hospice services for adults responsive?

Good

Our rating of responsive went down. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The hospice provided a joined up palliative care service across multiple care settings. They provided an inpatient hospice ward, a community palliative care service, and a team working within the local acute hospital to provide palliative and end of life care. This allowed patients to be seen by the same service throughout their palliative care delivered in all these settings. The hospice also had facilities to run a day hospice service for patients to visit for support groups and activity sessions. However, at the time of our inspection this was closed due to COVID-19 restrictions.

The hospice had facilities to support families. They had a family and carers support team to provide care to them. They had a kitchen and rest area with comfortable seating. The service had facilities for families to stay overnight however during the pandemic this was not used.

Good

Hospice services for adults

Facilities and premises were appropriate for the services being delivered. The setting was well designed, welcoming and well maintained. Facilities and premises were designed to meet the needs of patients receiving palliative care and their family and friends. All areas of the hospice had enough space for patients to independently mobilise. They had a wide-open terrace area that could accommodate patients in beds as well as those with a wide range of mobility difficulties. This outside area had many plants, had a scenic view across the valley and was not overlooked by the surrounding houses.

The hospice focused on living well in the last months of life. They had a team of therapy staff to maximise patient mobility and independence.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service had three bays for four patients and staff only used these with the same sex patients.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff had access to dieticians, physiotherapists, and occupational therapists to help support patients. Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff knew how to access support from the local NHS mental health trust for their patients.

The service relieved pressure on other services when they could care for patients. The hospice supported the local acute hospitals by providing step down beds for patients needing rehabilitation during the pandemic. This acted as additional capacity to care for patients that were ready to be discharged from hospital but were not ready to go home.

The hospice worked with other local hospices to offer patients waiting for inpatient hospice care in neighbouring areas. This allowed patients on other hospice's waiting lists quicker access to hospice care.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff assessed patients and supported them to express there needs. This included using nonverbal communication tools including the Pain Assessment in Advanced Dementia tool. This tool was designed to look at a patient's pain level through their expressions and behaviours.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The family and carers support team supported patients by acting as an advocate for their views and acted as a resource for staff to provide support with the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Wards were designed to meet the needs of patients living with dementia. The ward setting was calm and quiet. There was good natural light in all ward areas and social spaces, flooring was matte and not overly patterned, there were places for patients to rest in communal areas and signs were clear with an easy to read font.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had picture cards to help communication with patients. Patients with communication difficulties told us staff communicated with them effectively.

The service had information leaflets available in languages spoken by the patients and local community. We saw many leaflets providing advice to patients including those on skin care, pressure ulcers, and physiotherapy services.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had a telephone interpreting service to support staff to communicate with their patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients said there was a wide range of delicious food choices that met their needs.

Staff had access to communication aids to help patients become partners in their care and treatment. Patients with communication difficulties told us communication with staff was good.

People's individual needs and preferences were central to the planning and delivery of a tailored service. Staff told us about a patient that wanted to smoke but was unable to leave their bed. Staff worked with the health and safety team and the fire service to allow them to smoke safely while in bed with oxygen therapy. They were able to move their bed outside to a secluded part of their outdoor terrace and used a fire-resistant blanket.

Staff arranged to meet the wishes of patients with complex needs. Staff told us about a patient that wanted to visit a local show. Staff arranged with their multidisciplinary team along with an ambulance service for the patient to attend their show safely and return to the hospice afterwards. They also told us about arranging for patients with a passion for sport to visit their favourite athletes or visit the home stadium of their favourite team.

People using wheelchairs could easily access all areas of the hospice, all patient services were on the ground floor with step free access at all entrances and out to the terrace area.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. At the time of our inspection, the service had no waiting list and had capacity that it offered to other services to help support the health system.

The service had an established process for admission to the unit. People could self-refer to the palliative care service. The hospice also received referrals from GPs, the wider hospice care team, local hospitals and any health and social care provider. The hospice provided a palliative care and end of life care service in the local acute NHS hospital. This allowed staff to identify patients in need of palliative care on discharge from hospital and provide a seamless approach to transfers from the hospital to inpatient care in the hospice.

The service made patients aware of the service they offered, and limitation placed on them by restrictions related to the pandemic. Managers and staff told us how they made patients aware of what inpatient hospice care would be like before admission or transfer from an acute hospital. They said this made sure patients could decide where to received care to best meet their needs. Leaders told us more people were choosing to have care at home due to the restrictions on visiting in care settings during the pandemic. They said they were working with their infection control team to allow visiting. We saw relative visiting was discussed at the hospice's team meeting in March, April and June 2021.

When patients wanted to pass away at home, the service worked to make this possible. The service made sure patients understood what care would be available at home and if this was the correct choice for them. They arranged support for the patient and their family. They also liaised with other local services such as the district nursing service to provide the patient with the best possible care at home.

The service did not move patients during the night, unless there was a clear medical reason or in their best interest. If needed, staff would discuss it with a hospice doctor for agreement.

Staff supported patients when they were referred or transferred between services. The service had advanced nurse practitioners that worked across both the acute hospital and the hospice inpatient unit. Patients who needed emergency end of life care support were admitted from their own homes in a timely manner. They worked with the local ambulance service to take direct admissions when appropriate from the community.

Learning from complaints and concerns

It was 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.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke to were happy with their care but said they knew there was information displayed about the complaints process.

The service clearly displayed information about how to raise a concern in patient areas. There were posters telling patients and visitors how to raise a complaint.

Staff understood the policy on complaints and knew how to handle them. Between 19 April 2021 and 24 August 2021, the service had received five complaints. All of these had received an acknowledgement within the services target of three days. The service had sent a resolution response to one of the five within the service's target of 25 days. There was a variety of reasons for delays with the remaining four complaints. These included complex complaints where the service offered a face to face resolution meeting however these took more time to arrange. There were also complaints that needed more time to resolve data privacy concerns.

Managers investigated complaints and identified themes. Several of the complaints related to communication with the patient and relatives. Managers and staff discussed complaints in their team meetings. They identified ways to improve their service together including closer working with the out of hours GP service to provide a joined-up process of care for patients. This improvement was focused around the way patients and relatives would assess the hospice team if they phoned into the out of hours GP service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us they knew how to accept a formal complaint although they would attempt to resolve the concerns immediately first. We saw in the complaints records managers sent a resolution letter to the complainant explaining what was done as a result of their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw an example of a family that struggled to access support on discharge from hospital. Staff had identified that the cause of this was a lack of communication from the out of hours GP service to the hospice. Staff agreed to work with the district nursing team and the out of hours GP service to ensure they all had the correct contact information for the hospice.

Good

Hospice services for adults

Staff told us they knew about the duty of candour. Staff said if things go wrong, they would apologise to the patients and families. Staff and managers told us they tried to resolve concerns at the earliest opportunity. Managers supported people to make formal complaints if they were unable to resolve their concerns immediately.

The service reviewed their complaints and compliments which was then shared with the team. However, as this information was not audited it was not possible to show an improvement over previous care provided.

Are Hospice services for adults well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the 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 leadership structure for hospice services. This was led by the registered manager. They had a head of service that managed day to day service leadership. It also had a ward manager, an office manager and leaders within each of their specialist services. The service had one consultant that supported the leadership team leading the medical team. All staff felt well supported by the service leaders.

The service leaders told us they felt the board knew about their needs and responded to their requests. They told us that executives would listen to their requests for service developments and approve most requests and offer constructive criticism when needed. They said when they had taken on these criticisms and addressed the concerns, they would approve their plans.

Leaders were visible and approachable. Staff spoke highly of the leadership at all levels and described them as approachable, knowledgeable and supportive.

Leaders supported staff to develop their skills and take on more senior roles. Staff and leaders told us about opportunities for additional training offered to staff. They had development opportunities for staff wanting to develop their clinical skill, leadership skill and take on professional qualifications. The service had one healthcare assistant they were supporting through their nursing apprenticeship and they were supporting other nurses to become independent prescribers.

Vision and Strategy

The service had a 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 provider had a service wide strategic plan for the 2019 to 2025 period. This included more involvement of patients and stakeholders in decisions on their vision, values and culture. They also wanted to work closer with their partner organisations including having more integrated clinical information systems. We saw they had started this work with the introduction of a new clinical records system used in other part of the health service allowing faster access to clinical information across services.

The service had a vision for what it wanted to achieve. The service had a vision displayed but leaders told us this was not up to date. The service was developing another vision. They had a vision shared with the local commissioning group of 'I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)'. This vision was in draft form when we inspected. The service had worked with other stakeholder organisations to develop this.

The service also had three values 'caring compassionately, quality and value, working in partnership'. Staff understood the ideas of these values and vision to provide joined up compassionate care to the patient and everyone around them.

The service had a strategy to turn their vision into action. They had a joint strategy with the local providers of palliative care and the local commissioning group to provide a joined-up experience of palliative care for their patients. Leaders had a local strategy to manage developments and improvements to their service. This local strategy included a focus on providing more training on specialist palliative care to care home staff, prison staff, primary and secondary care staff.

Leaders monitored progress against their strategy. They had expected timescales for development to me implemented and recorded key risks to delivering these improvements.

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.

Staff felt respected, supported and valued. All staff told us they felt leaders and other staff respected them. There were signs telling people to respect everyone and that abusive behaviour was not acceptable and would not be tolerated. The service completed a staff survey and in 2020 78% of staff felt respected by other staff and 81% of staff felt respected by their manager.

Staff were focused on the needs of patients receiving care. They told us they worked together to support one another to meet the needs of their patients.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff told us they provided care in a non-judgement way to everyone. Staff received diversity training and compliance was 100% for clinical staff.

The service had an open culture to reporting incidents and had a whistleblowing policy including advice on their freedom to speak up guardian process. This included advice on how to raise a concern and where to raise different types of concern.

The service had an open culture where patients, their families and staff could raise concerns without fear. There were posters inviting patients and visitors to discuss their concerns with staff. Staff told us they were happy to discuss

concerns and wanted to resolve these as quickly as possible. The service held supported reflections with staff which supported staff to talk openly. Staff told us leaders viewed concerns as an opportunity to learn and improve the service. We saw in complaint staff had recorded being open with patients about when things had gone wrong and apologising to them.

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.

Leaders operated an effective governance process. They had a clear structure with separate meetings focused on specific aspects of care. These included; infection prevention and control, clinical advisory group, preventing harm oversight group and medicines management. These subcommittee meetings reported into the quality assurance committee that then report to the board of the provider. There was a separate subcommittee and committee meeting for looking at operational risk.

Meetings were well attended, and all staff were clear about their role and accountabilities. Local leaders told us they were given time and support to discuss the performance and improvement opportunities within the hospice services.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. Attendance of partner organisations were present where expected including the local out of hours GP service attending the community end of life care subgroup and the preventing harm oversight group.

We saw in meeting minutes that managers discussed their audits and updates to national guidance in their governance meetings. In their October 2020 preventing harm oversight group, they discussed their falls audit results and lessons learnt from COVID-19. In their July 2021 quality assurance committee meeting minutes, we saw discussion had taken place on their quality priorities for the next year, their medical devices report, and clinical risk register. Their quality priorities for the next year we focused around CQC key questions including a focus on patient experience and public engagement centred around the caring key question.

Management of risk, 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 an effective process to identify, understand, monitor and address current and future risks. Leaders recorded risks on their risk register. We looked at their risk register that showed they kept these up to date with actions recorded to minimise their risks. The service had a safeguarding lead.

Leaders and staff knew about the risks facing their service. We asked managers about their top two risks which were recruiting to specialist roles and sustainability of their finances. They also noted a risk with their new digital records system. Staff concerns matched these risks.

The service had a clear escalation and review process for monitoring risks. Leaders held two meetings to review risks monthly one focused on operational risk and another to focus on organisational risks. Risks were rated for their likelihood and severity with those scoring above 16 being escalated to senior management.

The service was committed to continually improving their risk monitoring. It had started a training program for the leaders to gain more understanding of monitoring and lessen risks compliance for this was 50%.

The service monitored the key performance indicators and worked to improve their performance. However, the service did not monitor the performance from the perspective of their patients. Leaders had plans to develop a method of sensitively gaining their patients prospective on the service's performance.

Staff were not constrained by financial pressures from delivering safe care and quality improvements. Staff knew they needed to offer value for money especially in quality improvement but did not feel additional cost was a barrier to pursuing improvements as long as they justified the need for them.

The service had major incident plans to ensure the continuity of care for patients. These plans included; a fuel shortage plan, a severe weather plan, and a mass casualty incidents plan.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, 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. However, information was not always easily assessible.

The service collected reliable data and analysed it to improve their performance. The collected information on infection prevention and control, falls risks, incidents and medicines management. Improvement plans and progress was recorded.

The information systems were integrated and secure. All digital record systems were secured with unique usernames and passwords for each member of staff that allowed them access to the data they needed while restricting their access to information not relevant to their role. Staff logged out of computers when they had finished using them preventing unauthorised access to information.

Staff could find the data they needed, to understand performance, make decisions and improvements. All patient information was stored on the services digital systems that allowed staff to access all relevant information when they needed it.

Staff told us the new digital information system was very different and took them time to find the information needed. Managers told us some information they needed for performance monitoring such as actual place of death was not easily accessible from this new system. Leaders had recorded this on their risk register and were working with their digital team to resolve the issues faced by them and their staff. Staff received information governance training as part of their mandatory training which showed compliance of 93% for clinical staff.

The service submitted information to external organisations. The service submitted notification to CQC when required. Managers told us they submitted information to the local commissioning group.

Good

Hospice services for adults

Engagement

Leaders and staff actively and openly engaged with staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, they did not have a structured engagement with their patients.

The service did not have a system to routinely gather feedback from their patients. However, the service reviewed themes from their complaints and compliments to gain insight into what their patients thought of their service. These were then discussed at staff meetings. The service also conducted research projects that included gaining feedback from patients about their experiences which was then used to make improvement to care with the latest being published in January 2021.

The service engaged with their local community. The service had a joint working arrangement with a charity that provided some of the funding for the service. This charity arranged events with the local community to raise awareness of the work done by the hospice.

Leaders engaged with their staff. They held monthly staff meetings with each of the teams within the hospice. These meetings were used to discuss updates with staff and to listen to their concerns. One of the most discussed topics in recent meetings was visiting rules for patients in the hospice ward. Leaders had listened to staff concerns and had continued to work to improve visitor access while remaining in line with their infection prevention and control policy.

The service collaborated with their partner organisations to help improve services for patients. Leaders held quarterly meetings with the local commissioning group and had external representatives present in relevant meetings. Staff also worked with the local out of hours GP service and the NHS ambulance service to make sure suitable patients were directly referred to the hospice instead of being taken to a hospital.

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.

All staff were committed to continually learning and improving services. They conducted audits and identified opportunities for service improvement. This included looking at failures to complete checks on fridge temperatures. We saw this was quickly identified in their audits, investigated with the cause identified. Staff were reminded of the importance of this being completed and then was completed without fault. They had also identified noncompliance in their cleanliness audits including areas of damaged paint. Damaged paint results in reduced effectiveness of cleaning. These defects were put onto their action plans and fixed.

They had a good understanding of quality improvement methods and the skills to use them. The service had training for managers in quality improvement and leadership skills. Leaders were always willing to support with quality improvement projects. Junior managers told us senior management support was always available to them. Staff were supported to complete training in best practice for clinical research.

Leaders encouraged innovation and participation in research. The service was involved in research projects including their latest published in January 2021 ‘Opioid-induced constipation in patients with cancer: a “real-world,” multicentre, observational study of diagnostic criteria and clinical features’ and ‘The prevalence of alcohol and drug use disorders in

cancer patients and their caregivers, and the effects on caregiver burden'. We saw in the July 2021 quality assurance committee meeting minutes they discussed research project they were supporting and looking for more to be involved in. They noted that many projects were paused due to the pandemic but were restarting soon so were keen to be involved in them again.