Lindsey Lodge Limited

Lindsey Lodge Hospice

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

We undertook this unannounced inspection on 18 August 2015. At our last inspection which took place on 2 January 2014 we found the service was compliant with the regulations that we inspected.

Lindsey Lodge is a purpose built hospice that provides inpatient care and treatment for a maximum of 10 people who have a life limiting condition. The service can also provide day care support for up to 14 people each day. Accommodation is provided on the ground floor with all rooms having good access to gardens and patio areas. En suite and communal bathrooms with shower and assisted bathing facilities are provided, some with overhead hoist facilities to help meet people needs. There are two shared occupancy rooms which can be opened up to create a four bedded unit this area can be changed to make two large bedrooms where family can stay close to their relative. There is a separate outpatient suite with craft rooms, communal areas and therapy rooms. Separate family accommodation has been built recently which is available for use; these facilities are en suite with televisions and tea making equipment. During our inspection there were three people being cared for on the in-patient unit and the out-patient clinic was

Summary of findings

supporting up to fourteen people. Car parking facilities are provided with disabled parking by the entrances to the in-patient and out-patient facilities. There are local amenities, shops, a pub and garage nearby.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The hospice director was also the registered manager of this service.

People were looked after by staff who understood they had a duty to protect people from harm and abuse. Staff knew how to report abuse and said they would raise issues with the registered manager who would report these to the local authority.

Staff knew people's needs well and were aware of risks to their health and wellbeing. This ensured staff were able to support people effectively. People were encouraged to make decisions about their care. Where people were not able to do this, staff worked within the guidance of the Mental Capacity Act 2005 to ensure decisions were made in the people's best interests and that the least restrictive options were in place. Family representatives were involved in this process to make sure people's rights were protected.

Training was provided to staff in a variety of subjects which included the specific needs of people with life limiting conditions and the care people needed to receive at the end of their life. This ensured effective care was delivered and helped to maintain and develop the staff's skills.

Recruitment processes in place were thorough. Staffing levels provided were flexible and were increased if the service was busy with multiple people who needed end of life care. Skilled and knowledgeable staff were available to support people and their relations and friends at this time.

Medication systems in place required improving in some areas. The issues we found did not directly affect patient care or their symptom control. We found the registered provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the end of this report.

People's food and fluid intake was monitored to make sure their nutritional needs were met. They were provided with home cooked food. Those who required prompting or support to eat and drink were assisted by patient and attentive staff. Advice was gained from relevant health care professionals to maintain people's dietary needs and hydration.

Health care professionals supporting the service were available to give staff help and advice at any time. Staff followed medical instructions and used their professional skills to support people and keep them comfortable.

People were supported by kind, caring and empathetic staff. People's privacy and dignity was respected. Staff supported people effectively and were able to give them information about their care and condition. Staff were skilled at supporting people, their family and visitors; they saw this as essential to ensure holistic care was provided to each person who used the service.

People's wishes for their end of life care were documented and were followed by the staff. Family members were offered a place on a bereavement support course which staff from the service provided over a period of a few weeks. This helped people to express their grief and feelings and gain professional help and support at this time.

The service was clean and infection control policies and procedures were in place. There was a member of staff who took the lead for infection control to ensure staff maintained a high standard of cleanliness. The building was well maintained, door wedges in use in none patient areas were removed on the day of our inspection to help maintain fire safety at the service.

There was a complaints procedure in place which was displayed in reception. Complaints received were investigated and people were informed of the outcome of the complaint. Issues raised were dealt with in a timely way.

People and their relatives were asked for their opinions about the service provided. The quality of the service was audited and the registered manager and head of

Summary of findings

departments took on board any feedback they received to improve it. A new clinical lead was about to commence work at the hospice. The registered manager told us this was an exciting time because they would then be able to develop the service further once this person was in post.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not always safe. We found there were shortfalls in the recording of some medicines that were controlled drugs and a robust policy was not in place. Medicine storage and monitoring of the temperature of the medicine refrigerator required improvement.

We found that door wedges were in use in some non-patient areas, these were removed by the registered manager on the day of the inspection to help to maintain fire safety.

People were cared for by staff who knew about the risks which were present to each person's health and wellbeing.

Staff knew what action they must take if they suspected abuse was occurring, which helped to protect people.

Is the service effective?

Good 

The service was effective. Staff and volunteers undertook a programme of training to help them to deliver effective care and support to people with life limiting conditions.

People's mental capacity was assessed. Correct action was taken to ensure people were not deprived of their liberty unlawfully. This helped to protect their rights.

People's hydration and nutritional needs were assessed and were monitored. Special requests for different foods were catered for to encourage people to eat. Food provided looked nutritious and appetising.

People were supported by relevant health care professionals and complimentary therapists.

Is the service caring?

Good 

The service was caring. People told us they were well cared for. We observed that the staff and volunteers supported people with kindness and compassion.

Staff supported people's family and friends during their illness and after the person had died. People's religious needs were known and were provided. The service had a 'contemplation room' for quiet reflection and prayer.

People and their relations were treated with dignity and respect.

Is the service responsive?

Good 

The service was responsive. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Summary of findings

People had their needs assessed on admission and their care records were continually updated as their needs changed. This ensured people received the care and support they required.

The service provided complimentary therapies and specialist clinics to help people with symptom control, such as pain and swollen limbs. Services were available to provide psychological support to people and their family.

Multi-disciplinary team meetings were held to discuss people's conditions and needs. This allowed a variety of therapists and specialist health care professionals to give their views on the support and treatments available.

Effective complaints procedures were in place. Issues raised were investigated and resolved.

Is the service well-led?

Requires improvement

The service was generally well led. People we spoke with and their relatives told us the service was well led.

The ethos of the service was positive; there was an open and transparent culture and a friendly, welcoming environment. Staff understood the management structure of the service, their roles and responsibilities.

Quality monitoring of the service took place; this included a range of audits. However, the medicine management audit was not robust and the controlled drugs policy, for staff to refer to, lacked detail.

We found there were limited times when people could be admitted to the service. This was to be reviewed when the head of care commenced in post in September 2015.

People were asked for their views about the service informally on a daily basis by staff and formally by way of questionnaires. Feedback received was acted upon.

Lindsey Lodge Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 August 2015 and was unannounced. It was carried out by one adult social care inspector, a pharmacist inspector and a specialist professional advisor in palliative care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the notifications and all the intelligence we held about this service. This information helped us plan the inspection and make a judgement about the service.

On the day of the inspection we spoke with one person from the medical team, the hospice director/registered manager, two senior nurse's in charge of the in-patient and out-patient units and three other nursing staff. We also spoke with three people using the out-patient service, two relatives of people on the in-patient unit, a chaplain who was also the vice chairman of the board of Trustees, the financial director and two staff from the kitchen team. We spoke with three volunteers and attended a multi-disciplinary team meeting and staff handover meeting. We also gained the views of two complimentary therapists who gave their services voluntarily to the hospice; they provided Reiki and hypnotherapy to people who used the service.

We inspected all of the three people's care records on the in-patient unit which included care plans and risk assessments. We inspected medicine records and storage. We looked at a range of audits and records that demonstrated how the service was run, these included policies and procedures, minutes of meetings, staff rotas and maintenance checks undertaken. Three staff files were inspected; they included recruitment information, contracts and confidentiality policies. Staff training and supervision records were also inspected. We looked at how the Mental Capacity Act 2005 was used within the service to protect people's rights.

We were shown around the hospice and introduced to people, where this was appropriate. We observed how staff supported and interacted people and their relatives. The specialist professional advisor observed how lunch was served in the main dining room. This helped us to make a judgement about people's experiences of this service.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and comforted by the staff at the service. One person, said, “They are caring and compassionate, staff really look after me well.” Another person said, “The care is very good. It has done me good coming her; they [staff] understand my illness and I am not bottling things up.” We observed interactions between staff, volunteers, people who used the service and family members; these demonstrated easy communication, compassion, care and support.

Relatives told us they felt safe and were supported by the staff and hospice environment.

People’s care records contained information which told staff about the individual risks to their health and wellbeing. We found this information was personalised and detailed. For example, it identified risks to people’s wellbeing such as the risk of falling or developing tissue damage due to immobility or because people were not able to eat.

Staff we spoke with told us they had received training in how to protect people from abuse. They could describe the different types of abuse that may occur. A member of staff said, “We have a policy in place for abuse, I have had training in the past about this.” Staff confirmed they would raise issues immediately with the registered manager or local authority safeguarding team if they suspected abuse was occurring.

Staff told us they regularly undertook a fifteen minute moving and handling update to help staff reassess people’s moving and handling needs especially when they received end of life care. They told us this helped to maintain people’s safety and to protect the staff from acquiring work place injuries.

Robust recruitment procedures were in place for all staff including volunteers. This included completed application forms, references and police checks with the disclosure and barring service [DBS]. Nurses had their registration checked with the Nursing and Midwifery Council and medical staff had their credentials checked with the General Medical Council; this ensured these staff were registered and were fit to practice. Staff were provided with job descriptions and contracts so they were aware of their responsibilities, terms and conditions.

The registered manager told us how they monitored the care that needed to be provided to people and then placed the right number of staff on duty to meet their needs. This was confirmed with staff we spoke with. On-call medical staff provided support out of hours and they were available to see people, if this was necessary. On call rotas were provided so that staff knew who they should contact for help and advice.

The service had been inspected by the local authority environmental health officer; a five star rating had been awarded for food hygiene. There was a designated member of staff in place to advise and monitor infection control within the hospice.

Maintenance and safety checks of the service had been completed for areas such electricity supply, portable appliance tests, water temperatures and fire safety. Issues found had been recorded and were acted upon. The fire alarm tests were carried out by activating different points to ensure they worked. Where issues were found these were reported and action was taken to repair any faulty equipment. We saw there was a fire risk assessments in place and people had personal evacuation plans for staff to follow to evacuate the service safely in the event of a fire. Regular fire drills had been undertaken to ensure staff were competent in this.

During our visit we saw some doors were wedged open in non-patient areas. We discussed this with the registered manager. They told us staff had strict instructions that if they left their office they had to remove the wedge and closed the door. After further consideration these door wedges were removed by the registered manager on the day of our inspection. This helped to maintain the fire safety at the hospice.

The service had a handyman who was available to carry out repairs to maintain the premises. The environment was well-maintained and clean with good infection prevention and control measures in place.

Staff had access to information about contractors they could contact in the event of utilities being affected at the service. There were contracts in place to monitor and maintain equipment. A receptionist was present in the main entrance of the hospice to welcome people and monitor who gained access, security cameras were used to monitor the outside entrance and car parks to help to maintain security.

Requires improvement

Is the service safe?

The pharmacist inspector looked at the medicine management system and records. Medicines were supplied by a local pharmacy, either as stock medicines or dispensed for a particular person. The arrangement included support for ordering medicines but no provision of clinical advice from a specialist palliative care pharmacist. Some medicines were not kept safely because the cupboards in which they were stored were not fit for purpose. In addition, the temperature of the medicine refrigerator was not monitored properly.

Our pharmacist inspector looked at the medicine records of two of the three people staying in the hospice at the time of the inspection. We found that the receipt of medicines, including controlled drugs, for these people was not recorded properly. The administration of a controlled drug to one person was not recorded in the controlled drugs register, as required by law. This meant that medicines could not be accounted for and there was a risk of mishandling or misuse.

Prescription charts were audited regularly to check that all the necessary information was recorded. Learning from the audit in July 2015 and recommendations for improvement had been shared with staff. Oxygen was prescribed on people's medicine charts, if needed. The hospice had a medical gases policy and medical gas cylinders were stored safely.

The hospice had a standard operating procedure for the disposal of controlled drugs, but no detailed procedures for ordering, storing, administering or recording controlled drugs. We found two discrepancies in the stock level of a controlled drug when compared to the records. One error had not been noticed and the other not fully investigated. The hospice's accountable officer was on holiday on the day of our visit so we could not discuss our findings with them. The hospice director reported the incidents to NHS England after the inspection.

These shortfalls in medicine management constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the end of this report.

Good

Is the service effective?

Our findings

All the people we spoke with told us they felt their needs were met and said the service was effective at supporting them. One person said, "If you are not able to get in to see your GP, staff here ring and you are in to see them the next day; the staff are on the ball here." Another person said, "It [the service] is effective at supporting my mind, body and soul. I can't fault it."

Relatives we spoke with told us the service was effective at meeting their relations needs and theirs too. We attended a multi-disciplinary team meeting where we saw health care professionals were updated on people's condition and need for in or out patient services. Staff were made aware of new referrals or people who may be referred to the service in the near future so that their needs could be considered.

The registered manager made sure staff with the right competencies, knowledge, qualifications, skills and experience were on duty to support people and their relatives. Staff we spoke with confirmed this. There was a bank of staff registered to work as and when required at the service who maintained their skills in palliative care so they could be effective in meeting people's needs.

The registered manager told us there were very few vacancies for staff at the hospice because people who came to work at the service usually worked there for a long time because they enjoyed their work. We found when speaking with staff and volunteers that this was the case.

The registered manager told us that during recruitment when staff were interviewed, they looked for people who had a caring attitude and a desire to support people during their illness and at the end of their life. We saw from staff files that new staff had a period of induction where they worked alongside other more experienced staff. This provided new staff with time to understand their role and gain the support they needed before being allowed to care for people themselves. Staff said their induction had given them the confidence and skills needed to support people effectively. Volunteers who worked for the service were taken through the same induction process. Induction training covered confidentiality, palliative care, fire safety, infection control hand hygiene, safeguarding, communication skills and an introduction to Lindsay Lodge Hospice.

Training and development was provided to all staff working in all departments. Staff told us they never stopped learning and they confirmed that if they wanted extra training about new therapies or people's medical conditions they only had to ask and it would be provided. We saw training updates were provided for training in palliative care, non-cancer illnesses; neurological illnesses and wound care. There was also moving and handling training which covered the use of hoists and transferring patients. This helped staff to maintained their skills and develop their knowledge and expertise. Part-time staff and volunteers we spoke with suggested that if training was recorded or placed on-line then they may be able to access this information in a more timely way.

Group or one to one supervisions were provided for staff. These were held with a psychologist so that staff could talk of their experiences and gain support about their training or speak about difficult experiences they had dealt with. Staff said this was appreciated and necessary working in this setting. Appraisals were undertaken for all staff so they could gain feedback about their performance and allow them to raise their views.

Everyone who used the service had their dietary and fluid intake monitored. Food served was home cooked, looked nutritious and was presented well. People we spoke with could not fault the food provided. Staff went out of their way to make sure that if someone fancied something to eat this was served. For example, a person had requested lamb chops which the chef bought and prepared especially for this person to enjoy. Special diets were catered for; if people were unable to drink they were kept hydrated so that they remained comfortable.

There was a care plan to use for 'the dying patient'. This document was in place to support the doctors and nurses to give the best quality of care they could, it explained why people had a reduced need for food and drink at this time and how the provision of relevant care would be discussed with all parties to help keep people comfortable at this time.

Staff were knowledgeable about people's preferences, likes and dislikes regarding their care and support. They gained people's verbal consent to support and assist them, where this was possible.

The Care Quality Commission [CQC] is required by law to monitor the operation of the Deprivation of Liberty

Good

Is the service effective?

Safeguards. People at the service had their mental capacity assessed. There were policies and procedures relating to this. Staff had an understanding of the Mental Capacity Act 2005. They told us how they cared for people using least restrictive practice and told us how they always acted in the person's best interests by gaining input from relevant people, if a person lacked capacity or was unable to make decisions for themselves. This ensured people were not deprived of their liberty unlawfully and helped to protect their rights.

People gave consent to receive their care and treatment, where this was possible. We saw that best interest meetings were undertaken and these involved people's family and relevant professionals. This helped to protect people's rights. The consideration of people's lasting power of attorneys, living wills, do not attempt cardio-pulmonary resuscitation authorisations and wishes following their death were followed by staff.

Bedrooms provided were assessed for people's needs to make sure staff had room for equipment needed such as hoists, special beds or pressure relieving mattresses, where this had been assessed as being required to maintain people's health and wellbeing. Records we looked at confirmed relevant health care professionals reassessed people conditions as they changed to ensure staff could effectively continue to meet people's needs.

Good

Is the service caring?

Our findings

All the people we spoke with told us the staff were caring and respectful. They said the care they received met their needs. We received the following comments: “Staff are naturally caring so support us well.” “The staff are so caring they are marvellous. You don’t ever see anyone with a frown on their face, everyone is so kind.” “It’s absolutely wonderful here. I did not want to come through the door, but once you come it’s like a holiday camp. You get a little counselling at your own pace. I visit the out-patient service one day a week. I always get the best night’s sleep that night. Things go through your mind. I was never a touchy feely person but you end up hugging, no one is morbid. The helpers and care is very good. If I am in hospital I get a card. I won’t be afraid at the end of my life now.” and, “From the minute you walk in you are enveloped in the care. I get amazing psychological support.”

A person on the day care unit who had been attending the hospice for over a year one day a week, could not speak highly enough about the service and staff. He told us he was a private person and that he was allowed the space he needed to come to terms with his challenging diagnosis which the staff had helped him through. He pointed out that no other service he used thought about or provided the excellent psychological and emotional support that the hospice provided. He told us this had helped him enormously.

A relative we spoke with said, “The nurses can actually nurse. We are being cared for, fed well and accommodated; information is given as required. Mother is being kept comfortable and getting excellent care at the end of her life.”

During our inspection we observed there was a calm and relaxed atmosphere throughout the hospice. We saw that the staff and volunteers spent quality time with people and with their relatives. Staff asked people if they needed any help or assistance and checked if they were alright.

We observed, in the communal areas of the service, that people received the care and support they needed to receive. People chose what they wanted to do and how they wished to be supported. We saw staff knocked on bedroom doors before being invited to enter. This protected people’s privacy and dignity.

We saw that people and their family members were supported effectively by staff and by the service. Family members were offered accommodation so that they could be present at the end of their loved ones life. Family rooms were provided and refreshments and meals were available. There was a bereavement support group that relatives could attend over a number of weeks to help them understand the grieving process and support them through their loss.

We saw that that there was plenty of information available to people about their different illnesses and about the support that could be provided to them and their relatives. We saw leaflets about complementary therapies. These described what the therapies were and how they may help. We did not observe this information being displayed in different formats or languages but what was available did meet the needs of the people that the hospice were supporting at the time of our visit.

Staff we spoke with on the in-patient unit told us how they cared for everyone at the service. For example the people who used the service, their relatives and the other members of the staff team in every department. A member of staff said, “As a team we get to know people, we engage with them and we monitor each other. We pay attention to the little things, for example a very poorly lady did not like to have facial hair so I ensured she was free from facial hair. A relative who was staying with their loved one had no clean clothes so I did their washing to ensure they felt comfortable.” Another said, “We are very caring, we always sit and spend time with people. We have a contemplation room; we can sit with people and put them at their ease.” A third said, “We are a close knit team because we have worked together for so long. We support people in their illness through to the in patient service. This reduces people’s anxiety. It is a nice place to work. I love the work. It is so rewarding, but it can be upsetting as we can nurse people for months or years. It is a calling, but enjoyable.”

Staff told us how they respected people’s privacy and dignity. A member of staff said, “I make sure when giving care curtains are closed. I cover them when giving care. We have screens if people want to take their covers off. I keep people’s conditions private.” They also said, “We treat people holistically. We have complimentary therapies to help people relax and ease body, mind and soul.” Facilities were provided to meet each person’s individual needs for their care at the end of their life. For example, during our

Good

Is the service caring?

inspection one person had eight members of their family present. They were staying in the family accommodation and were being supported by staff. People's needs and preferences for their care, support and end of life needs were known by the staff.

People told us they felt cared for because staff helped guide them towards treatments and services that may support them, for example, the complimentary therapy services and health care clinics. People were introduced over time to the in-patient staff and facilities so they became familiar with the support available to them in this department, which helped ease people's minds.

Staff told us how they personalised the hospice facilities to make sure they met the needs of younger and older people so they felt 'at home'. Pets were welcome at the service. After people had died relatives could spend as long as they wished with the person to say goodbye.

Staff we spoke with understood the need to maintain people's confidentiality. We did observe that people's care records were kept in filing cabinets in the nursing team's offices but these cabinets were not kept locked during visit.

The service had a mission statement and the ethos of the service was to provide, comfort, support advice and effective care for all people and their relations leading up to and at the end of life. People's wishes for the end of their life were recorded. Chaplain's visited the service and just sat and spoke with people or they could be requested to attend. Staff told us when people died they performed the last offices; this ensured the person was cared for and presented well after their death. They said this was the last caring responsibility they had and took great pride in this. There was no time limit imposed before the undertakers were called to take the person to the Chapel of Rest.

The service was supported by a very large team of volunteers in a variety of roles. These were to help to maintain the grounds, work at reception, undertake fund raising or assist in the services charity shops. We spoke with three volunteers all of whom had volunteered for a number of years. They all cared about supporting Lindsay Lodge. A volunteer said, "It is lovely here, a wonderful place the staff and patients make it wonderful with lots of banter and fun." Another said, "The hospice helps people live the best lives they can. I go home upbeat and happy. People care, compassion and empathy are intrinsic."

The volunteers we spoke with told us one of the patients who attended out-patients had put on limousines for them to attend a brass band concert they were conducting to raise money for the service. They told us it was so nice that the people receiving a service valued their caring enough to return the care in this way to them.

The registered manager told they had an excellent team of staff, patients, relatives and volunteers all supporting each other which helped to make Lindsay Lodge hospice the best it could be. There were a lot of thank you cards that had been received from people and their relatives displayed at the service. These helped to confirmed that people felt well cared for. A Christmas meal was provided for the volunteers and the hospice staff served them, this was to thank the volunteers for all the different roles they undertook to support the hospice.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. People we spoke with confirmed this and said their physical, psychological and spiritual needs were met. One person we spoke with said, "You can ask any questions and the staff answer them. Staff try not to overwhelm you, they take things at your pace." Another person said, "They [staff] know my needs well and give me the support I need at each visit and as my condition changes." Another person said, "Staff did a home visit first, they said come in to the day unit tomorrow. I had no time to chicken out. My care plan stated I would want to be at Lindsay Lodge but at home for as long as possible."

Relatives we spoke with told us they were clear about their relations condition and had been fully informed about the care and support their loved one was to receive. They told us that any changes in their relations condition was monitored and acted upon to make sure they remained comfortable and pain free. A relative said, "The hospice picks things up and refers patients back to hospital. Things are often missed by GPs and the hospital; but not by the hospice. The hospice helps communication with GPs and the acute community services." Relatives confirmed staff constantly communicated with them to keep them informed.

During our inspection we saw evidence that people's needs and their condition were assessed by both the nursing and medical staff. The assessments were undertaken as people arrived on the in-patient unit. The service used the 'integrated care pathways' [specific guidance] to identify people's care and support needs. For those attending the out patient service they were assessed by staff who undertook home visits prior to people using the service.

When people started to be supported by the service as out-patients or in-patient's staff carried out a full assessments of their needs. At every visit or change in the person's condition care records were updated so staff could provide effective care. We saw from the care records that we looked at throughout the service this information was completed and reviewed. We noted that in places a little more detail could have been recorded for some people, for example, in regards to people's social needs and activities. However, this information may not have been appropriate to ask for when the person had come in to receive end of life care. We discussed this with the registered manager who asked the nursing staff to monitor this documentation in further detail.

Care records we inspected of people receiving treatment on the in-patient unit contained care plans which were generic; these were altered to reflect people's individual needs, which ensured they were person-centred. Staff spoke with people and their relatives to make sure they were aware of their condition, treatment and support. There was a wide range of leaflets available which helped to explain different conditions and symptoms. As people's needs changed staff discussed treatment and symptom control options with them and their relatives so they could make an informed decision about their care.

The care records we looked at included information such as 'What is important to me'. Everyone had pain assessment records, skin care and nutrition and hydration assessments in place. This helped the staff to respond to people's changing needs. A member of staff said, "We update care plans and risk assessment, skin assessments and dietary information as people's needs change. We encourage people to do a bit for themselves and respond to their changing needs every hour. In the first twenty four hours we are getting to know people. This helps the family when they see staff responding to the patient. We deal with people on an individual basis and we always make staff available." Another member of staff said, "We treat people holistically, we have complimentary therapists and hairdressers, to help people relax and ease body, mind and soul."

Staff we spoke with told us they read people's care plans. They said they tried to make the care records as detailed as possible, but if someone came to the service at the end of their life and was very ill, it was best to ensure their physical and emotional needs were fully met and gain essential information at this time; to prevent distressing the person or their relatives. Staff we spoke with said they always considered how to approach people for information and said they took their time, so they adopted the right approach so as not to upset people. This helped staff to gain the right information to be able to respond to people's needs.

People received person centred care. The staff assessed any risks present to people's wellbeing. Risks were recorded and were monitored by staff who took corrective

Good

Is the service responsive?

action. People had their nutritional needs and their skin condition assessed. Special mattresses were used and special beds for people who were at risk of sustaining skin damage due to being immobile or suffering from swollen limbs. People's food and fluid intake was monitored and recorded for every person on the in-patient unit to help to maintain their nutrition and hydration. If people were not able to drink then action was taken to make sure the person remained hydrated.

A medical practitioner was available to reassess people in the in-patient unit if their needs or symptoms changed. Pain relief and symptom control was provided promptly to keep people comfortable.

The out-patient service had nursing staff available to provide help and advice to people when their needs changed. The doctor on duty was available to reassess people's condition and provide help advice and support. People we spoke with told us this was very comforting for them.

We saw staff liaised with other agencies when people moved between services. We attended a multi-disciplinary meeting where people's care was reviewed by a panel of health care professionals. Discussion was held about the care and support people were receiving and suggestions were made by all team members to improve people's care. This discussion covered people who were known by the service and those who may need the service shortly. Macmillan Nurses in the community and hospital were involved in these discussions and reviews. This approach helped to ensure that wherever people were, the health care professionals could respond to their needs in a timely way.

Information was made available to local GP's who had people under their care who needed this service. Hospital staff could also access this information which helped people be supported in different services or through different agencies. This ensured up to date information was available to relevant health care professionals, including the treatment the person had received, discharge notes from hospital and latest notes from their GP's.

The service worked with the North Lincolnshire hospitals, local GP's, MacMillan Nurses and district nurses. We were informed that people could also refer themselves to the hospice for an assessment of their condition. We met one person who had done this successfully and they told us how supportive the service had been to them over the last few months. We did gain some feedback that stated referrals to the hospice could be very late in people's condition. To improve this, the hospice's clinical trainer was setting up scenarios for health care professionals about how to make more timely referrals to the service.

The service provided a range of therapies such as Reiki, massage, aromatherapy, reflexology, relaxation and lymphoedema therapy. People could access complimentary therapies; a team of therapists were in place to support people and their relations. Before treatment was received a full assessment of the person was carried out by the therapist and they had to sign a consent form to receive treatment. There were arts and crafts available to people, talking books and a library.

The day unit provided different services to different groups of people on different days. For example, one day a week the service looked after younger people so that they could mix with people of a similar age.

During our inspection we spoke with one of the five volunteer chaplains who provided spiritual support for the service. He told us he liaised with people and their family members of all faiths, and with those without faith, to help support people's spiritual needs. He also said they had conducted baptisms, confirmations and renewal of marriage vows at the service. Muslim and Sheikh leaders also attended to offer support.

We observed staff asking people if they were alright or if they needed anything. People were supported by kind staff who knew people's needs well. We saw staff observed people and took note of their body language and mood. They responded to this to make sure the care they offered was what people needed, at the time. For example, one person, when leaving the service became anxious and did not feel well. Staff immediately supported them and their relative in the privacy of a separate room, giving medical attention and reassurance to help calm them.

There was a complaints policy and procedure in place and information about how to make a complaint was displayed within the service. We looked at the complaints that had been received these had been investigated and had been dealt with appropriately. We observed that people were

Good

Is the service responsive?

encouraged by staff to say if they were not happy with something so any small issues could be dealt with swiftly. This helped people to remain satisfied with the service they received.

Requires improvement

Is the service well-led?

Our findings

People we spoke with told us they felt the service was run effectively and was developed to meet and support their needs. One person said, "It is absolutely wonderful here."

Relatives we spoke with also held this view and they confirmed that they had been looked after well by the service and staff.

There was a board of eight trustees at the hospice who met quarterly, they delegated the operational management to the hospice director who was also the registered manager. They linked into sub-committees to look at human resources, finance and fundraising, auditing and quality assurance and hospice development. We found the culture of the service to be open and transparent.

The registered manager held internal meetings and attended clinical handovers to monitor the service. There was a clear management structure which included a medical director, finance manager, volunteer's manager, heads of departments and senior nurses. All department heads monitored their department and reported to the hospice director and to each other. The head of each department had supporting ancillary staff. The departmental managers deputised for the registered manager which enhanced their management skills and helped them to make organisational decisions. Departmental and staff meetings were held; the minutes of these meetings were made available to staff that could not attend to help keep them informed.

The hospice had a mission statement, which included how they would provide a caring supportive service to everyone who required this and to their family. Staff we spoke with understood the mission statement and the ethos of the service. They told us they worked every day to make people's experiences the best they could be. Staff we spoke with said, "We have regular team meetings, I know I can speak with senior staff at any time. We are paid to attend meetings on our days off. They are open to suggestions; it is a good place to work with lots of training and support." And, "Staff meetings are held regularly, we can voice our views. I am aware of the management structure. The service is well run generally." A volunteer we spoke with told us, "My manager is really helpful and our work is very structured. I feel well supported in all that I do.

The registered manager monitoring research and relevant guidance. They had links with organisations that promoted good practice. For example, staff had been trying to implement Enternox therapy to help people who had symptoms of pain. This new treatment had not quite been introduced but staff were working hard to ensure his could be provided for people soon.

The registered manager had an open door policy so that people could speak with them at any time. A member of staff said, "The registered manager has a 24 hour open door policy." Senior staff and medical staff were on call to provide advice, support and reassurance to people and staff using the service. De-briefing sessions were held with all staff involved in patient care after difficult situations had occurred so that learning for similar future events could occur.

The registered manager and senior staff undertook audits to monitor the quality of the service provided. There was an audit group in place which was made up of the infection control lead, nurses, health care assistants, head of fundraising and a member of the board of trustees. We looked at the audits undertaken; they covered breathlessness, sharps [injection needles and cannulas], corticosteroids use, medicine prescription charts, care records, falls, nutrition and hydration, accidents, incidents, complaints and compliments. We looked at the minutes from the audit group meeting dated 8 July 2015. We saw that a decision had been made to look at the controlled drugs usage and systems at the service. The audit group had considered using guidance from 'Hospice UK' which provides a national audit tool for the management of controlled medicines, however this audit had not been undertaken.

We found that there were no audits in place to monitor the controlled medicines usage and their recording. The policy relating to controlled medication was brief and did not guide staff effectively to ensure that errors did not occur. If an audit had taken place it may have identified the shortfalls that we found during our inspection. The registered manager took our findings on board and started to take action to address the medicine issues.

During our inspection we noted that the inpatient unit seemed quiet. We discussed this with the registered manager. They confirmed that, at present, new admissions were undertaken from 9am to 5pm on weekdays only and not out of hours or at weekends. The out-patient service

Requires improvement

Is the service well-led?

also ran during these times. The registered manager told us that a new medical director was about to start work at the service. They were going to reassess the position regarding admissions to the service to help increase the times and days when people could be admitted. This would help to benefit more people.

Surveys were undertaken to gain people's feedback. People using the service and bereaved relatives were asked for their opinions about their experiences at the hospice. They were asked to give feedback about all aspects of the service including the complimentary therapies provided. This information was reviewed by the management team to see if they could improve any aspect of the service.

The service liaised with other health care professionals in the community who were supporting people. For example, district nurses, GPs, MacMillan nurses, the local Clinical Commissioning Group [CCG] and local hospital staff. There was a Palliative Care Strategy in place with involvement from NHS North Lincolnshire, North Lincolnshire Local Authority, Lindsay Lodge Hospice, Northern Lincolnshire & Goole Hospitals Foundation Trust. There were clear goals set out for the group to work towards; the aim was to achieve the best quality of life for palliative care patients.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected, because the proper and safe management of medicines was not in place. Regulation 12 (2) (g)