

# Duchess of Kent Hospice

## Quality Report

Dellwood Community Hospital  
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Reading  
Berkshire  
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Website: [www.suerydercare.org](http://www.suerydercare.org)

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

### Ratings

#### Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Outstanding 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Duchess of Kent Hospice is operated by Sue Ryder a national charitable organisation which specialises in providing palliative and neurological care to people living with life-limiting conditions.

The hospice has 15 inpatient beds. Facilities include an inpatient unit, day therapy unit, lymphoedema service, community specialist palliative care to patients at home service, and a bereavement service. Duchess of Kent hospice operated from a location in Reading and had satellite centres in Wokingham and Newbury.

The hospice provides end of life and palliative care for adults.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 7th and 8th November 2019. We gave staff two days' notice that we were coming to ensure that everyone we needed to talk to was available. We inspected services at Reading and Wokingham.

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

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

### Services we rate

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

We found outstanding practice in relation to:

- Staff treated patients and their families with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- It was easy for people to give feedback. Concerns and complaints were taken seriously and investigated, and improvements were made in response to feedback where possible. Patients could access services when they needed them.
- Leaders ran services well using best practice information systems and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

We found good practice in relation to:

# Summary of findings

- Despite some staff vacancies, the service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients and acted on them. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- The service provided care and treatment based on national guidance and best practice. Staff 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, supported them to make decisions about their care and had access to good information. Key services were available seven days a week.
- The service planned care to meet the needs of local people, took account of patients' individual needs and wishes, and made it easy for people to give feedback. Concerns and complaints were taken seriously and investigated, and improvements were made in response to feedback where possible. Patients could access services when they needed them.

We found areas of practice that require improvement:

- Clinical and pharmaceutical waste was not always stored securely.
- ReSPECT forms were not audited to check for completeness.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
<b>Hospice services for adults</b>	Outstanding	We rated this service as outstanding for caring and well-led and good for safe, effective and responsive.



# Summary of findings

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Outstanding



# Duchess of Kent Hospice

## Services we looked at

Hospice services for adults

# Summary of this inspection

## Background to Duchess of Kent Hospice

Duchess of Kent is operated by Sue Ryder a national charitable organisation which offers palliative care and treatment for adults living with life-limiting conditions. The hospice opened in 1992 as a NHS organisation, however was taken over by the Sue Ryder organisation in 2011. The service covers a catchment area in West Berkshire, including Reading, Wokingham and Newbury. The main hospice is located in Reading where the inpatient facility is located, day services are run from here and two satellite centres in Wokingham and Newbury.

The hospice has had several registered managers in post since 2011. At the time of the inspection, the current registered manager had been in post and registered with the CQC since January 2019.

The registered manager is the hospice's accountable officer for controlled drugs.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in end of life and palliative care. The inspection team was overseen by Cath Campbell, Head of Hospital Inspection.

## How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 7th and 8th November 2019.

We gave staff two days' notice that we were coming to ensure that everyone we needed to talk with was available. We inspected services at Reading and Wokingham.

## Information about Duchess of Kent Hospice

The Duchess of Kent Hospice is a local service run by the Sue Ryder charity.

The hospice service provides specialist palliative care, advice and clinical support for adults with

life limiting illness and their families. They deliver physical, emotional and holistic care through teams of nurses, doctors, counsellors, chaplains and other professionals including therapists. The service cares for people in three types of settings: at the hospice in 15 beds 'In-Patient Unit', or in their 'Hospice day service' that welcomes up to 10 people per day, and in people's own homes through their community service. The service provides specialist advice and input, symptom control and liaison with healthcare professionals. Services are

free to people. The Duchess of Kent hospice is part funded by an NHS contract agreement but is dependent on donations and fund-raising by dedicated staff and volunteers in the community.

The services provided include counselling and bereavement support, family support, clinical psychology, chaplaincy, an out-patient clinic, occupational therapy, physiotherapy, dietetics, befriending, complementary therapies and diversional therapies and a lymphoedema service (for people who experience swellings and inflammation, usually to their limbs, after cancer treatments).

The hospice accepts both male and female adult patients.

# Summary of this inspection

The hospice is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we inspected the inpatient unit at Reading and the day therapy unit, lymphoedema service, and community services at Reading and Wokingham. We spoke with 38 staff including registered nurses, nursing assistants, medical staff, therapists, the chaplain, volunteers, social worker, team leaders and senior managers. We spoke with 8 patients and 3 relatives. We observed the environment and care provided to patients in the hospice setting and one home visit. We reviewed four patient records. We also reviewed information that we held about the hospice and information requested from the hospice, including performance data, policies and meeting minutes.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time or during the 12 months before this inspection. The hospice has been inspected three times, and the most recent inspection took place in December 2015, which found that the hospice was meeting all standards of quality and safety it was inspected against. We rated the hospice good for safe, effective, caring, responsive and well-led. The hospice was rated good overall.

## Activity (July 2018 to June 2019)

- In the reporting period July 2018 to June 2019, 1,843 patients were treated for palliative care. Of these, 1,351 (73%) were aged between 18 and 65 years, and 492 (27%) were aged over 65 years.

Track record on safety:

- Zero Never events
- Zero serious incidents
- Zero incidences of healthcare associated MRSA
- Zero incidences of healthcare associated Clostridium difficile (C. diff)
- Zero complaints

## Services provided at the hospice under service level agreement:

- Clinical and or non-clinical waste removal
- Laundry
- Maintenance of medical equipment
- Pathology, histology and microbiology
- Pharmacy
- Medical gases



# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

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

Good



- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.
- 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.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- 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.
- Despite some nurse staffing vacancies, the service had enough nursing and support 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 and agency staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. 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.

# Summary of this inspection

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.

However,

- Clinical and pharmaceutical waste was not always stored securely.

## Are services effective?

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

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- 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 monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support to help them live well until they died.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the hospice's policy and procedures when a patient could not give consent.

However,

- ReSPECT forms were not audited to check for completeness.

Good



## Are services caring?

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

Outstanding



# Summary of this inspection

- Staff treated patients and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond expectations to meet their individual needs and wishes. Patients and their families were truly respected and valued as individuals by an exceptional service.
- Staff were devoted to doing all they could to support the emotional support to patients, families and carers to minimise their distress. People's emotional and social needs were seen as being as important as their physical needs.
- Staff supported and involved patients, families and carers to understand their condition and ensure they were active partners in their care and treatment. Staff helped patients live every day to the fullest.

## Are services responsive?

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

- 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.
- 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.
- 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.
- 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.

**Good**



## Are services well-led?

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

- Leaders at all levels had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced and had successful leadership strategies in place to ensure sustainability in the desired

**Outstanding**



# Summary of this inspection

culture. They were highly visible and approachable in the service for patients and staff. They supported staff to develop their skills, including management and leadership skills and take on more senior roles.

- The service had a clear vision for what it wanted to achieve and a detailed 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 and national plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued with an emphasis on strong collaboration and team-working. Staff were very proud to work for the hospice and could articulate why. There was a common focus on providing the best possible care to patients and continually improving the quality of care and people's experiences. 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 and were confident to do so. The service used these as an opportunity to learn and improve the service.
- Leaders operated highly effective, proactive 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 and teams used systems to manage performance effectively. They proactively identified and escalated relevant risks and issues and identified actions to reduce their impact. They had clear and tested plans to cope with unexpected events, which were understood by staff at all levels. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable, detailed data and analysed it to drive forward improvements. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They proactively collaborated with partner organisations to help improve services for patients.

# Summary of this inspection

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

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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



# Hospice services for adults

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

## Are hospice services for adults safe?

Good

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

### Mandatory training

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

The Sue Ryder central mandatory training policy defined the mandatory training requirements of staff including bank workers. This included a mandatory training matrix which identified the mandatory training required dependent on job role.

The mandatory training requirements met the needs of patients and staff. Courses covered key areas such as fire safety, health and safety, basic life support and infection prevention and control. Staff understood their responsibility to complete mandatory training and told us the training was relevant to their roles.

The Duchess of Kent hospice set a target of 90% for completion of mandatory training. Training modules were a mix of e-learning and face-to-face practical sessions. There was an on-site practice education team who could provide much of the face-to-face training. This meant courses could be arranged when needed and at a time suitable for staff. Staff we spoke with told us there were no barriers to accessing mandatory training.

Staff could monitor their own training needs via the hospice's electronic system. The system would send an email alert to the individual when training was due. This gave staff ownership for their training.

In addition, the practice education team and line managers monitored mandatory training compliance and would also alert staff when they needed to update. Managers received regular reports about mandatory training compliance. This meant they had oversight of staff compliance and could address any areas of non-compliance when needed.

Most staff were up-to-date with their mandatory training. As of October 2019, compliance with mandatory training for staff working across the whole hospice was 90%.

### 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.**

The Sue Ryder central policy for safeguarding adults provided staff with guidance on the prevention of abuse of service users in all Sue Ryder care environments in England (which included Hospices and services in the community) and those individuals who have contact with Sue Ryder either as supporters or members of the public. There were clear systems, processes and practices in place for reporting safeguarding concerns which reflected legislation and local requirements. Safeguarding policies and pathways were in-date and were accessible to staff.

The Duchess of Kent hospice had a designated lead for safeguarding adults and another lead for safeguarding children. Although the hospice did not provide services



# Hospice services for adults

for patients under the age of 18, they recognised their responsibilities to identify and report safeguarding concerns in children that might be visiting service users at the hospice. The safeguarding leads were available to provide support, supervision, training and updates for staff.

We saw safeguarding information displayed in locations we visited during the inspection indicating the actions needed to be taken by staff if there was a safeguarding concern.

All staff we spoke with were aware of the signs of abuse and demonstrated an understanding about safeguarding adults and child and young people processes. They knew who the safeguarding leads were at the hospice and how to escalate if they had concerns. We were given examples when staff had needed to raise concerns and the actions that they had taken.

Staff liaised with other professionals and agencies, such as GPs, the police and the local authority safeguarding leads, when needed. The safeguarding lead attended regular meetings with their counterparts from other Sue Ryder hospice sites and local authority safeguarding meetings. Topics discussed included national safeguarding guidance and learning from serious case reviews.

Staff received safeguarding training appropriate for their role and according to Sue Ryder central policies. Safeguarding level 3 training was completed by the safeguarding lead for adults and the head of clinical services. Safeguarding level 2 was completed by the lead for children and young people and all other staff working with patients. The hospice set a target of 90% for completion of safeguarding training. As of October 2019, 97% of staff had completed safeguarding training.

## 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.**

Sue Ryder had central infection control policies to help control infection risk, these included the Infection prevention and control policy, uniform and appearance policy, waste management policy and procedure and

safer sharps policy. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection in Sue Ryder hospices, homecare services, outpatient and satellite services.

The inpatient unit, clinic areas and other areas where patients visited were visibly clean and tidy and had suitable furnishings which were clean and well-maintained. The hospice had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. We reviewed these records during the inspection and found them to be up-to-date and complete. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

Staff cleaned equipment after patient contact and labelled equipment to show when this had last been done. We saw all equipment not in use had a dated, 'I am clean' label to indicate to staff when it was last cleaned and was ready for use. We inspected equipment including mattresses and commodes and found them to be clean.

Staff were observed following good infection control practices to help stop the spread of infection such as 'bare below the elbow' and cleaning their hands before and after contact with patients. Staff also had access to hand washing facilities and personal protective equipment, such as gloves and aprons in a variety of sizes. In addition, hand sanitiser gel dispensers were available throughout the hospice, such as reception, corridors, bedrooms and clinical areas. Community staff carried a supply of infection, prevention and control (IPC) equipment for use when they visited patients at home, such as hand sanitising gel, gloves and cleaning wipes.

Effective measures were in place to ensure the health and safety of everyone who came into contact with a deceased person's body after death. Staff we spoke with were knowledgeable about these IPC measures and could describe how they washed and prepared the body after death.

Staff were required to complete IPC training during their induction and then annually at the level appropriate to their role as part of their mandatory training. As of October 2019, 93% of staff had completed IPC training.





# Hospice services for adults

There was a service level agreement with the local community trust infection control team, whom the hospice worked closely with when required. This included an annual audit of the hospice with recommendations and suggestions to help improve the overall IPC standards.

The hospice had a designated lead for IPC who was available to provide support, advice, training and updates for staff and monitored compliance with IPC policies. They also held three-monthly meetings with the IPC link nurses who were responsible for overseeing IPC practices in their area. The IPC lead reported to the hospice's senior management team (SMT) via the monthly Quality Improvement Group meeting. This meant there was good oversight of IPC practices throughout the hospice and its services.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve IPC practices if needed. An audit programme was used to increase and maintain standards and help prevent the spread of infection. Audits included, monthly hand hygiene audits and waste management audits and three-monthly inpatient unit infection control audits.

Post inspection we reviewed audit reports and any resulting action plans. From January to October 2019, hand hygiene audits results were >93% except from August 2019. Following August's results an action plan had been put in place which included emailing staff about their practices, additional training and information posted on the IPC noticeboard. Audits results from the following months, September and October 2019 showed increased results of 90% and 96% respectively. From March to September 2019 the three-monthly inpatient unit IPC audits, which looked at all areas of the unit, including patient bedrooms, medical equipment, laundry and housekeeping facilities, showed results over the hospice compliance rate of 85% for all three months. 91%, 89% and 85% respectively. From the action plan we could see the IPC lead was working with the Head of support services to work with staff on areas where IPC standards had started to drop.

During the inspection we saw the correct management of containers for sharps and the use of coloured bags to correctly segregate hazardous and non-hazardous waste. However, on each day of the inspection, the outside

yellow bin used for storing infected waste before collection, although [MS1] closed had not been pushed down to make sure it was locked. This meant clinical waste was not stored according to the Sue Ryder central policy.

From November 2018 to October 2019, the hospice reported zero incidences of healthcare acquired infection

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.**

On entering the hospice, there was a reception desk where day patients and visitors were required to sign in/out. Access to and from the inpatient unit, clinical areas and the day hospice was secured with an intercom/key pad to prevent access by unauthorised persons.

We observed during the inspection that meeting rooms, cleaning and storage cupboards and utility rooms were kept locked and secured at all times. This meant that access to areas unsuitable for patients and visitors was controlled.

There were 15 bedrooms on the inpatient unit. All rooms were ensuite with 11 bedrooms having shower facilities and four having smaller bathrooms with a sink and toilet only. There was a main bathroom that could be used for bathing and showering, if required. All bedrooms had a temporary bed for relatives to stay.

All bedrooms looked out on and had access to the garden. This meant patients could be moved out into the garden whilst still in bed, if patients wished to spend time outside but were unable to leave their beds.

The hospice was light and airy with areas which could be used as communal spaces for inpatients and families or the day hospice patients. There was also the sanctuary, a small room which was used by patients, families and staff as a place for reflection.

Clinic rooms which were used for outpatient services were bright and well maintained.

The hospice maintained a central medical equipment register. This had details of all medical equipment used in the hospice and when it required servicing and electrical testing. During the inspection, all equipment looked at



# Hospice services for adults

was stored neatly and had the required up to date checks. Staff told us they had enough equipment needed to provide safe and effective care and treatment to patients both at the hospice and in the community.

We checked a sample of consumable items for expiration dates and all were in-date. Store rooms were tidy, well organised and items stored correctly according to policies and procedures. This meant consumables were easily located for staff.

Staff carried out daily checks of emergency equipment. A defibrillator (used to treat a life-threatening abnormal heart beat) and emergency equipment trolley were situated on the inpatient ward. Records showed all checks were up-to-date and completed. This showed there was a consistent and regular approach to safety checks.

## 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 in all the hospice services completed risk assessments for each patient on admission and these were reviewed when a patient's condition changed. Risk assessments were in patient's notes. We reviewed four sets of notes on the inpatient unit and saw comprehensive risk assessments were carried out. These included risk assessments for moving and handling, falls, nutrition and hydration and pressure damage.

Recognised tools were used, such as the Waterlow (used to identify patients at risk of pressure ulcers) and the Malnutrition Universal Screening Tool, commonly referred to as 'MUST'. When a risk was identified, we saw actions were taken to minimise any potential harm to the patient, such as from falls or pressure damage. In both the inpatient unit, and out in the community, appropriate equipment was identified and ordered, such as bed rails and pressure relieving mattresses. Clinical staff we spoke with told us there was no problem obtaining equipment from the suppliers, with most equipment available on the same day.

Hospice patients were assessed daily by a member of the medical team. Patients who had deteriorated or their

symptoms had increased overnight were identified at the morning inpatient unit handover and priority was given for these patients to be reviewed by the doctor. Patients were also assessed by the nursing staff every two hours on the care round and four-hourly during the medication round, any change was reported to the doctor for review.

Shift changes and handovers included all necessary key information to keep patients safe when handing over care to others. During the inspection we observed all aspects of patient care were discussed and planned, including those with 'Do not attempt cardiopulmonary resuscitation' (DNACPR) orders in place, current patient risks and observations.

Patient records we reviewed and observations we made during the inspection demonstrated that risk assessments, action planning and reviews were developed in collaboration with the patient and their family and supported patient choice.

An initial multidisciplinary assessment was carried out when patients were identified to be within the last days or hours of life. This included consideration of advance care planning, symptom management, nutrition and hydration, as well as spiritual and psychological needs. We saw end of life care plans were individualised and developed in accordance with patient wishes, following discussion with them and those close to them. Patients with end of life care plans were reviewed a minimum of two-hourly. Staff took into account symptom and comfort measurements, including pain, elimination, mouth care, secretions, agitation and pressure care.

Staff completed intentional care rounding assessments. Intentional care rounding is a structured process where staff are required to perform regular checks of patients at set intervals. Checks carried out by staff included assessment of patient comfort, mobility, falls risk, skin condition and position. We saw there were completed in the four sets of patient records we reviewed.

The hospice had named leads for falls prevention and pressure damage prevention who were responsible for championing best practice and provided support, training and advice to staff as needed. During the inspection we spoke with the tissue viability lead who was knowledgeable and passionate about providing the best care and treatment for patient's to minimum their discomfort and the training of the hospice staff.



# Hospice services for adults

The central team for Sue Ryder instigated workforce steering groups in areas of key responsibility such as falls, and pressures ulcers which staff at the Duchess of Kent were part of. These working groups identified common themes across Sue Ryder and developed ways to work together to reduce risk and inform best practice as a unified working team approach.

Vulnerable patients or patients with complex needs would often be identified prior to admission. In these cases, senior inpatient nurses or the specialist doctor would visit the patient to make sure the hospice was well equipped to meet their needs. During the inspection we were given examples of such cases and the specialist doctor had planned a visit to a patient at home that day. This patient was due for admission to the inpatient ward and the team wanted to make sure their needs were assessed so effective care could be delivered.

## Nurse staffing

**Despite some nurse staffing vacancies, the service had enough nursing and support 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 and agency staff a full induction.**

Before permanent and bank staff could work at the hospice, pre-employment checks were carried out and relevant information required to demonstrate their suitability for the role. This included up-to-date disclosure and barring service (DBS) checks, references, full employment history, evidence of qualifications and professional registration, where applicable. As part of their continuing employment, DBS checks were repeated every three years and evidence of nurse's registration checked at their annual appraisal. Agency nursing staff provided evidence of their registration, level of safeguarding and life support training to their employment agency and where provided with a thorough induction before starting work at the hospice. Having robust employment checks meant the hospice could make safer recruitment decisions and prevent unsuitable people from working with vulnerable patients.

The nursing establishment for the inpatient unit had been reviewed two years ago over a six-month period to understand the nursing and nursing assistant needs. The current establishment was:

Ward Manager: 1.0 WTE band 8

Team Leader: 3.2 WTE band 7

Senior Staff Nurse: 3.9 WTE band 6

Staff Nurse: 8.4 WTE band 5

Senior Nursing Assistant 3.0 WTE band 3

Nursing Assistant 12.0 WTE band 2

In general, the inpatient unit had three registered nurses during day shifts with four nursing assistants and two registered nurses during night shifts with one nursing assistant plus a nursing assistant working a twilight shift. However, we were told there was a flexible approach to nurse staffing as it could be dependent on the complexity of patients admitted to the unit. In addition, the ward manager would work Monday to Friday 9am to 5pm in a supernumerary role.

At the time of the inspection the clinical team had a vacancy rate of 5.5 WTE registered nurses and 2.0 WTE nursing assistants. The clinical team were using overtime, bank and agency staff to fill gaps. In addition, the ward manager and other nursing staff who were not patient facing were working clinical shifts to fill the gaps.

When we spoke to the nursing team they told us they were feeling the impact of having reduced nursing and nursing assistant staff numbers. For example, lack of time for non-patient tasks such as attending meetings, training, personal development and general oversight and support of staff on the inpatient unit. Staff we spoke with said presently there was no impact on the patient care given but were worried that present staff levels could start to affect standard of care given or the number of patients they could admit to the unit. We observed the inpatient unit had enough staff of an appropriate skill mix, to keep patients safe and provide effective care and treatment, on the days of our inspection.

The senior management team were aware of the nursing staffing issues, were actively recruiting and looking for ways to support staff. They were also looking at patient outcome and audit data to make sure there was no



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impact on the care and treatment patients and their families received. Nursing vacancy rates was on the Duchess of Kent risk register and was discussed at the monthly quality improvement meetings.

The inpatient unit operated an on-call system for providing out of hours support for nursing staff. This nurse could be called upon for advice or support or would come to the unit if an additional registered nurse was required.

The community clinical nurse specialist (CNS) had caseloads of appropriately 30 patients per 1 WTE CNS. We were told there was some flexibility in this number depending the level of support required by the patient. Caseloads were monitored at the quality improvement meeting. The CNSs we spoke with during the inspection felt their caseload was appropriate.

At the time of the inspection the establishment was:

In Reading 5.0 WTE CNSs

In Newbury 3.35 WTE CNSs

In Wokingham 2.8 WTE CNSs

The day services supported a caseload of patients and there was an agreed maximum number of patients in each of the sites on any given day:

In Reading the day hospice ran three days a week covered by three registered nurses and one nursing assistant. They were supported by a diversional therapist, physiotherapist, occupational therapist and volunteers.

In Wokingham the day hospice ran three days a week covered by three registered nurses and one nursing assistant. They were supported by a diversional therapist, physiotherapist, occupational therapist and volunteers.

In Newbury the day hospice ran two days a week covered by three registered nurses and one nursing assistant. They were supported by a diversional therapist, physiotherapist, occupational therapist and volunteers.

Caseload and capacity were monitored on a monthly basis and discussed at the monthly quality improvement meetings. The clinical team we spoke with during the inspection felt their caseload was appropriate.

## Medical staffing

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

The hospice had their own medical team which was led by a consultant in palliative medicine. As of July 2019, the hospice employed one doctor full-time and eight on a part-time basis. There was always a consultant or speciality doctor on the inpatient unit Monday to Friday 9am to 5pm. They were supported by GP trainee and/or foundation doctors. There was a member of the medical team present on the inpatient unit Saturday and Sunday 9am to 5pm.

Out of hours and overnight there was no doctor present on the unit but they were available on-call and would attend the unit if required. There was also a second doctor on call, either a consultant or specialist doctor, who could be contacted to provide advice and support, as needed. Nursing staff we spoke with on the inpatient unit told us medical staff were easy to get hold of out-of-hours and would always come into the unit when needed.

There were daily handover and ward rounds on the inpatient unit and a multidisciplinary team meeting once a week to discuss patients care and treatment.

Every Thursday there was a Sue Ryders live stream doctors' presentation, where all doctors working for Sue Ryder had the opportunity to attend an hour training session on areas relating to palliative care.

The medical team were actively encouraged to attend the hospice journal club and the mortality and morbidity meetings to increase their knowledge and share learning.

The day hospice's at Reading, Wokingham and Newbury had their own palliative care doctors who were involved in the patients care and treatment. There was a daily handover between the doctor and the hospice team, nurses and therapists before the start of each day hospice. This meant the team were up-to-date with their patients and could work in a safe and effective way.

## Records



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## **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.**

The hospice had been using an electronic patient record system since June 2019, with templates designed specifically for the hospice. These included a range of risk assessments as well as individualised care plans. Some paper records were also used, such as intentional rounding forms and assessment of symptoms and comfort measurements for patients with end of life care plans. We reviewed four sets of patient notes and found them to be completed in full and were up to date. They contained details of patients emotional, social and spiritual needs, alongside their physical health needs. Patients mental health, dementia, learning disability and behavioural needs were evident, where appropriate. Patient records also reflected their protected characteristics, where relevant.

The Duchess of Kent hospice were using the Recommended Summary Plan for Emergency Treatment and Care (ReSPECT) process and advance care planning to document patient's wishes in emergency situations and for end of life care. Using the ReSPECT process meant patients were involved in decisions about their care and they were empowered to make choices, know what questions to ask their doctor and feel able to make informed decisions. We reviewed four ReSPECT forms; all were filled out comprehensively and showed discussions with the patient and families. They were completed by the registrar and countersigned by a consultant.

Team leaders audited patient records against best practice and identified areas for improvement where needed. We reviewed the documentation audit from March 2019 to September 2019. Prior to the hospice changing over to the electronic patient record overall compliance was consistently above the hospice's target of 90%. Since changing over to the new system compliance rate had dropped to 77% in June 2019 and 79% in September 2019. Team leaders were aware of the drop-in compliance and were working with their teams to improve completion and knowledge on the computer system. We reviewed the action plans team leaders had put in place to improve the standard of record keeping.

The electronic patient record system was the same as that used by local GPs and the district nurses. This meant

staff could share details of hospice care with other professionals and agencies and had had immediate access to up-to-date patient information. The system was not used by the local NHS trust but the hospital palliative care team did have access to the system. This meant patient details could be shared and helped with consistency of care. Hospice staff who cared for patients in the community had access to the same electronic system via laptops. This meant they could up-date patient records at each visit.

During the inspection records were stored securely. Staff used key cards to access the electronic patient record system. These were password protected. Therefore, the risk of unauthorised persons accessing patient records was minimal. Paper records were stored securely in the nurse's office. Consent to storing and sharing patient information was obtained.

## **Medicines**

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

Staff followed Sue Ryder policies and procedures when prescribing, administering, recording and storing medicines. As of June 2018, the hospice commissioned pharmaceutical products and clinical pharmacy services from an external provider through a service level agreement. Under the agreement the hospice had access to a pharmacist on call seven days a week 9am to 10pm and a pharmacist would visit the hospice weekly to monitor stock, storage, review patient prescription records and facilitate staff training. They produced a weekly report which highlighted any prescribing errors and attended the monthly hospice medicines management meeting where issues were discussed, and action plans put in place.

During the inspection we found medicines were stored appropriately in locked cupboards. We checked a selection of medications in the inpatient unit and found all were in date and kept in line with manufacturers advice. Fridges temperatures were recorded daily, and staff sought advice from the pharmacist when temperatures were found to be outside recommended ranges

Controlled drugs (CDs), medicines that are controlled under the Misuse of Drugs legislation (and subsequent amendments), were stored in separate locked cupboards.



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We checked the CD register and found entries were completed in line with best practice. Controlled drugs brought in by patients were stored securely and there were adequate controls in place to prevent misuse. The hospice had a controlled drugs accountable office as required by legislation.

Controlled drugs were frequently used to manage patient's pain. The hospice permitted single nurse administered controlled drugs (SNAD) to ensure patients received them promptly when needed.

Blank prescription pads (FP10 prescriptions) were stored securely and monitoring systems were in place to ensure all prescriptions were accounted for. The hospice completed a basic audit of FP10 prescriptions.

We reviewed two patient prescription records and found they were signed, dated, timed and legible. Patient allergies were documented, and medicines were given as prescribed. We saw patient medicines were regularly reviewed, including the use of 'as needed' medicines.

Patients being cared for at home administered their own medicines. Anticipatory medicines and controlled drugs for pain relief were managed by the district nurse service. The community clinical nurse specialists worked closely with district nurses and GPs to make sure patients had the appropriate medicine management to manage their pain and/or symptoms. Each of the community teams (Reading, Wokingham and Newbury) had two non-medical prescribers, a health professional who is not a doctor. This meant patients in the community could be prescribed medication to help relieve their symptoms without needing to see their GP. The Duchess of Kent non-medical prescribers received regular supervision and peer review of prescribing habits.

Medicines were disposed of safely and records of destruction were maintained. Unwanted or expired[MS2] medicines were kept separate from other medicines and were disposed of correctly. However, the temporary storage of pharmaceutical waste before collection was not always secure as it was kept in an area where other items were stored and collected from. This meant pharmaceutical waste could have been accessed and removed for inappropriate usage.

There was a medicines management group and a designated medicines lead. This team met monthly to review policies and procedures, address medicine related

alerts and looked at medicine incidents. If trends were identified, for example an increase in prescription errors, then the medicine management group would investigate and make sure action was taken to minimise recurrence. The information from this meeting fed into the Duchess of Kent quality improvement meeting. We reviewed minutes from the medicine's management group and the quality improvement meetings and saw the hospice had good oversight in their medicine management.

## Incidents

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

The Duchess of Kent hospice took incidents very seriously as they were passionate in ensuring patients and their families have the best experience possible when using the hospice services which were often at a period of emotional distress.

The hospice followed the Sue Ryder Central accident, incident and near miss reporting policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken. Also included was an incident reporting flowchart to follow to make sure all steps were completed within the correct timeframe. There were also Sue Ryder Central policies on serious incident management and critical incident for staff to follow.

The hospice used an electronic reporting system for reporting incidents. All grades of staff could access the incident reporting system and those who worked remotely could access the system through their laptops. Staff said they knew what constituted as an incident, were encouraged to report incidents in a no-blame culture and felt confident in doing so.

From November 2018 to October 2019 there had been 225 incidents reported. 49.8% of incidents were rated as no harm, 49.8% rated at low harm (minimal harm –



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patient required extra observation or minor treatment) and 0.4% rated as moderate harm (moderate harm: short term harm - patient required further treatment, or procedure).

From November 2018 to October 2019, the hospice reported one serious incident, which was being investigated at the time of the inspection and zero never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

All incidents were reviewed and investigated following Sue Ryder procedures and policies. Incidents were discussed at the monthly quality improvement meeting, common themes identified and action plans put in place to minimise recurrence. We reviewed the minutes from three of the quality improvement meeting and saw incidents, their root cause analysis and resulting actions were a set item on the agenda.

Themes of incidents from the Duchess of Kent hospice and other Sue Ryder hospices were discussed at the quarterly Sue Ryder Central performance and quality meeting. This meant the central quality team and chief executive for Sue Ryder had oversight of all incidents reported.

Staff we spoke with confirmed they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospice. This promoted shared learning from incidents throughout the hospice. Staff said learning from incidents would be communicated to them mainly at handovers, team meetings, emails and notice boards. Staff confirmed managers supported them when they were involved in incidents. Staff could give us examples of when procedures had changed or additional training had occurred due to an incident. All staff we spoke with during the inspection were committed to providing an excellent service to their patients. Staff told us they saw learning from incidents as a vital tool to help them achieve this.

Sue Ryder Central had cross hospice work streams. This meant staff from other Sue Ryder centres could get together to discuss certain topics, for example, there were

falls, pressure ulcers, safeguarding and medicines management work streams. Information on incidents relating to the work stream was talked about in these meetings. This was a good way to share experiences and learning from incidents. The Duchess of Kent tissue viability lead told us she found these meetings extremely useful and valued the input from other Sue Ryder clinical teams.

The hospice held mortality and morbidity meetings to discuss patient deaths or adverse incidents affecting patients. These meetings gave an opportunity for the clinical team to review deaths as part of their professional learning and reflective practice in a safe space. By talking through patient case studies was seen as a way to improve quality of care given to patients and their families at the hospice.

Sue Ryder Central had a duty of candour procedure which contained a set process that would be followed in the event of an incident occurring that would trigger after a notifiable safety incident. The hospice was committed to being open, honest and transparent in all instances and their practice was to inform patients and/or their relatives whenever an error had occurred and not just in cases that were considered reportable.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Clinical staff were aware of the duty of candour and all staff we spoke with were aware of the importance of being open and honest with patients and families when something went wrong and the need to offer an appropriate remedy or support to put matters right. From November 2018 to October 2019, the hospice had one incident which required the duty of candour to be instigated. All Sue Ryder procedures and policies were followed.



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Patient safety alerts were a set agenda at the quality improvement meetings. Team leaders for services ensured actions from patient safety alerts were acted upon where needed and information shared with staff.

## Safety Thermometer (or equivalent)

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.**

Staff monitored safety performance to indicate how safe the service was in providing harm free care. The prevalence of patient harm because of falls, pressure damage and healthcare associated infections was monitored and reported monthly.

From September 2018 to August 2019, the service reported 29 hospice acquired pressure damage, 57 falls and zero healthcare associated infections (MRSA and C. Diff).

Prevalence of patient falls had started increasing during the three months from May - July 2019 (May 2019 – 10 falls, June 2019 – 7 falls, July 2019 – 11 falls). This trend was identified in the quality improvement meetings. The clinical team had investigated why this had happened and had put actions in place. For example, there had been additional staff training and new guidance on the use of bed rails. Actions the hospice had taken saw patient falls reduced to two for August 2019.

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

Good



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

## Evidence-based care and treatment

**The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**

Patients' needs were assessed and care and treatment was delivered in line with legislation, standards and national best practice clinical guidance. Policies and procedures seen were up-to-date and referenced

national guidelines and legislation. These included the National Institute for Health and Care Excellence (NICE) guidelines. For example, care of patients in the last days and hours of life was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014) and NICE guidance 'care of dying adults in the last few days of life' quality standard [QS144] March 2017.

The NICE guidelines and other legislation were reviewed by Sue Ryder central, cascaded to the individual hospices and shared with staff. At a local level the practice educator, head of clinical services and senior members of staff would be responsible for reviewing information sources and updates in guidelines. It was their responsibility to ensure these changes were incorporated into the working practices of the hospice and its staff. This would be discussed at the monthly quality improvement meeting.

## Nutrition and hydration

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

Staff completed assessments in nutrition and hydration. Staff used the Malnutrition Universal Scoring Tool (MUST) on admission to assess patients at risk of malnutrition and dehydration. This was reviewed weekly or when there was any change in the patients' condition and recorded in the patient records.

Individual patient care plans were established from the assessment and in consultation with the patient. If required, the patient would be referred to the on-site dietician for advice on their dietary needs. Patients who needed assistance to eat and drink were identified through the initial and ongoing assessments. The dietician was also trained to help with any social or emotional difficulties patients might be experiencing relating to food during these times.

The catering department prepared freshly made meals on-site. Hot and cold food options were available for each meal and patients could specify meal size. The service catered for all types of needs including vegetarian, soft, dairy and gluten free and any religious or cultural





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requirements. Meals could be fortified with full fat milk or cream if required. The chef spoke with each patient on a regular basis and provided individualised menus when needed.

Food and drinks were available outside of mealtimes. The inpatient unit had a tea bar where patients and those close to them could help themselves to hot and cold drinks. Families and carers could also bring in their own food or order takeaways to be delivered to the hospice, if they wished. There were also vending machine in reception where snacks could be purchased.

The inpatient unit completed two hourly care rounding during the day, where food and drinks were offered and documented on the chart that it had been offered. Nutritional intake was also monitored and recorded on the care rounding chart. We observed water jugs in inpatient's rooms and were told ice was available, if wanted by the patients.

Staff provided support and advice to families of patients nearing the end of life with limited or no oral intake, this included giving mouth care to patients to maintain their comfort. For patients that could not maintain their own hydration subcutaneous or intravenous fluids could be offered depending on the patient's requirements.

The catering service at the hospice had been brought in house to provide a high-quality service for their patients. The hospice had been working on improvements to the catering services and had reinstated catering meetings. This was chaired by the head of support services and had input from the hospice dietician and representatives from the inpatient unit and day hospice. Feedback was also gathered from the service user group who had an interest and could give insight into the catering needs of patients especially around menu choice.

## 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.**

Clinical staff discussed pain and pain relief with patients during admission. This was documented in the patient's care record. Patient pain levels were then regularly reviewed using recognised tools and staff gave pain relief

in line with individual needs and best practice. Other recognised tools were used to help identify distress cues in patients who because of cognitive impairment or physical illness, had limited communication. Staff also regularly assessed patient's ability to tolerate oral medicines with alternative administration routes prescribed if necessary, such as intravenous infusion or pain relief patches.

Patient's pain levels were regularly reviewed and discussed at the daily handovers, during drug rounds. In addition, pain and pain management would be discussed during ward rounds and at the weekly multidisciplinary team meeting.

Patient records we reviewed showed care plans included an appropriate pain assessment and management plan. Anticipatory medicines with individualised indications for use, dosage and route of administration were prescribed for patients identified as being in the last days of life. These included medicines for pain, agitation, respiratory tract secretions, nausea/vomiting and dyspnoea (difficult or laboured breathing). Prescribing medicines in anticipation can prevent a lapse in symptom control, which could cause distress for the person who is dying and those close to them.

The hospice permitted single nurse administered controlled drugs to ensure patients received pain relief promptly when needed.

We observed a patient's initial assessment when attending the day hospice when the patient's pain and pain management was discussed. We were told by the clinical staff that it was important to manage and get patient's pain under control as this helped improve patient's quality of life.

The palliative community clinical nurse specialists monitored patients' comfort levels during their visits and would escalate to the district nurse service or their GP for review when needed. Nursing staff were trained on the use of syringe drivers which were used to administer a continuous subcutaneous infusion of drugs which helped to control pain.

## Patient outcomes



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

There was a clear approach to monitoring, auditing and benchmarking the quality of the services and outcomes for patients receiving care and treatment.

Information on clinical quality outcomes for example, healthcare associated infections and acquired pressure damage, were monitored and tracked over time. These were reviewed and discussed at the monthly integrated quality and performance meetings. There was evidence of action taken in response to any areas of concern.

The Duchess of Kent hospice took part in the Sue Ryder Central audit programme. This was a rolling programme of audits and included audits of documentation, management of falls, medication management and safeguarding. Outcomes were collated and used to benchmark against the other Sue Ryder hospices. There was also an internal audit programme, which including audits on hand hygiene and waste management.

Results from the central and local audits were monitored and discussed at the hospice's integrated quality and performance meetings. If actions were required this would be fed back to the departments, actions taken and the area re-audited. Assessing, evaluating and improving care via an audit programme meant the hospice was committed to providing and maintaining a high quality of clinical care for their patients.

The hospice used patient and relatives feedback tools to measure patient outcomes. This included inpatient unit survey results, patients in the community and anonymous real-time feed-back. Information was sought on a range of quality indicators and the findings were used to make improvements to services were needed.

Staff used the Integrated Palliative care Outcome Scale (IPOS) to capture patients most important concerns, both in relation to physical symptoms, but also extending to information needs, practical concerns, anxiety or low mood, family and friends' anxieties and overall feeling of being at peace.

The Duchess of Kent hospice were introducing the Outcome Assessment and Complexity Collaborative (OACC) tool to measure patient outcome. The OACC is a

suite of measures used to assess the care that matters most to people and their families at the end of life, such as control of their pain, breathlessness and fatigue, the opportunity to discuss worries, or to achieve one more personal goal before they die. By collecting this data the multidisciplinary team caring for patients would be able to plan care, treatment and support to best meet the needs of each individual patient. At the time of our inspection, staff were waiting to be trained on the OACC before its implication.

## **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.**

When starting work at the hospice, there was a two-week mandatory induction programme for new members of staff, including the bank staff. This induction included training on safeguarding, health and safety, infection, prevention and control, moving and handling and basis life support. Nurses and nursing assistants worked in a supernumerary capacity alongside an experienced staff member until they were competent to work alone. Staff we spoke with spoke highly of the induction programme and said it was relevant, useful and met their needs in the new workplace.

Mandatory training was not offered to nursing agency staff as this was the responsibility of the agency to provide. However, the hospice ran checks to make sure agency staff had completed the correct mandatory training before they started work. Before being allowed to work with patients, agency staff were orientated to the hospice environment and, before being allocated patients to care for, needed to have completed medicines training.

Clinical staff had to complete competency training on specific areas to ensure they had the appropriate skills and knowledge to manage patients safely and effectively. Sue Ryder Central were currently working on a competency framework for staff which would detail the competences required for each grade of staff, for example senior staff nurse, staff nurse and nursing assistants. Completed competencies would be recorded on a central computer rather than in individual's workbooks.



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Clinical supervision was provided to staff. This was provided on a one-to-one or group basis. Clinical supervision was a safe and confidential environment for staff to reflect on, discuss their work and their personal and professional responses to their work. The focus was on supporting staff in their personal and professional development and in reflecting on their practice. Ad hoc supervision sessions were arranged to support staff following any significant events or incidents.

The Duchess of Kent had an education team, with a practice educator and a clinical educator. The team played an active role by providing support, educational input, development activities and internal training days for staff working in the hospice. Staff we spoke with talked highly of the team and the educational support they provided to the them. The clinical educator worked clinically one day a week on the inpatient unit to provide supernumerary support to the team.

Staff could attend external training courses if they added value for the individual attending and benefit to the hospice. Staff we spoke with said managers were supportive if they asked to go on training courses and could give us examples of courses they had been on. Staff also told us it was expected of them to disseminate their learnings to their colleagues when they returned from training courses, which they were happy to do so.

Trainee doctors had a clinical supervisor who they worked with regularly during their placement. Medical staff we spoke with told us they felt supported from senior medical staff and could approach them for advice at any time.

Volunteers were used throughout the hospice and were trained and supported for the roles they undertook. There was a volunteer's coordinator who made sure volunteers had the required DBS checks and mandatory training before they started volunteering at the hospice. Volunteers were also invited to attend training course offered to the permanent and bank staff. Volunteers we spoke with said if they were available and training was relevant they attended as it increased their knowledge which helped when caring for the patients. Volunteers who worked in more specialist areas, such as the befriending service and the bereavement team, had additional training, including counselling, safeguarding and lone-working, to make sure they were competent for the roles they undertook.

Managers supported staff to develop through regular development meetings and yearly, constructive appraisals of their work. As of July 2019, 98% of staff had completed an annual appraisal (Source: Provider Information Request). At the beginning of each appraisal year, managers met with staff to agree their performance and development objectives for the coming year. These were linked to the service's strategic objectives and priorities and the Sue Ryder behavioural standards. Staff had regular one-to-one meetings with their manager to monitor their performance. They had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake.

## Multidisciplinary working

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

We observed excellent multidisciplinary team (MDT) working throughout the hospice. MDT working was a fully embedded practice which helped delivered a joined-up approach to delivering care and treatment to the patient. This facilitated better communication between healthcare professionals, patients and relatives and positively impacted on the care and treatment patients received.

Staff held regular and effective MDT meetings to plan and deliver holistic patient care. We observed the weekly MDT handover on the inpatient unit. This was attended by the medical team, nursing team, physiotherapist, occupational therapist, admission/discharge coordinator, and the patient and family support team leader. We also observed the day hospice morning meeting which was attended by day hospice doctor, nursing staff, the diversional therapist and the befriending coordinator. At both meetings, each patient was discussed in detail, with care and treatment planned in accordance with their physical, psychological, emotional, spiritual and social needs, as well as their wishes. The well-being of patient's family was also discussed and plans put in place to make sure they were also supported.

The community clinical nurse specialist (CNS) teams had good working relationships with the GPs, surgery's and



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district nursing teams they worked with. CNS attended Gold Standard Framework (GSF) meetings with local GPs where they discussed each patient on the end of life register and how they could best support them. The GSF is a framework which promotes best-practice in end of life care. It is used by many GPs, hospices and hospitals to enable earlier recognition of patients with life-limiting conditions, helping them to plan ahead to live as well as possible.

The hospice had good links with the local NHS trusts and local authorities, information and support was shared to offer joined up services, care and treatment for patients.

We observed positive interactions between staff and volunteers. Staff and volunteers we spoke with told us they worked together to provide the best care and support they could for patients and their families or carers. The volunteer coordinator had developed a role description so staff and volunteers understood the role of the volunteer. This meant there were clear guidelines as to what a volunteer could and could not do. This safeguarded both the patients and volunteer. Clinical staff on the day hospice always made sure there was a handover with the volunteers before patients arrived. This meant volunteers could give the appropriate support to patients.

## Seven-day services

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

The inpatient unit was operational 24 hours a day, seven days a week to provide timely patient care when needed. The hospice had an open visiting policy. Family, friends and carers were welcome to visit their loved one any time of the day or night.

A consultant or specialty doctor was present on the inpatient unit Monday to Friday 9am to 5pm, with a ward round daily. On Saturday and Sunday the on-call doctor was present between 9am and 5pm and conducted the daily ward round. Out of hours there was a doctor on call, supported by a second on call consultant for advice and support.

The community clinical nurse specialists working in the community operated an out of hours service and were available to provide support and advice over the phone 24 hours a day, seven days a week.

The chaplaincy services were multi-faith and provided 24 hours a day, seven days a week service.

## Health promotion

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

Staff assessed each patient's health and well-being when they were admitted. The specialist teams at the hospice worked together to give personal co-ordinated care to patients. Services offered by the hospice supported patients physical, psychological, spiritual and social needs.

The day hospice teams provided a six to twelve-week programme aimed at empowering patients to live well by supporting them to manage their condition, maintain independence and make new friendships. The programme was provided by a multidisciplinary team, including clinical staff, palliative social worker, complementary and diversional therapists, physiotherapist and occupational therapists.

The team told us they offered palliative care to patients with a life-limiting illness, that treatments could still be offered but were aimed at improving quality of life rather than a cure. This could include both physical and psychological solutions.

Therapy programmes were tailored to individual needs and goals. A variety of methods were used to help patients, such as mindfulness and relaxation techniques, exercise sessions and complementary therapies, such as massage. We were told by staff they had recently had a gong therapy session for patients. This was a form of sound therapy where a gong was played softly for the purposes of relaxation.

All the patients we spoke with during the inspection, told us how attending the day hospice had had a huge impact on their health and well-being and had improved their quality of life.

The inpatient unit offered a service where patients could be referred to for symptom management such as pain or breathlessness or respite care.

## Consent and Mental Capacity Act and Deprivation of Liberty Safeguard



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## **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the hospice's policy and procedures when a patient could not give consent.**

The service had up-to-date policies and procedures regarding consent and the Mental Capacity Act 2005. These included the Mental Capacity Act documentation, deprivation of liberty procedure, consent procedure and lack of capacity procedure.

Staff we spoke with understood the importance of consent when delivering care and treatment to patients. We observed staff seeking consent from patients prior to examination, observations and delivery of care. In most cases this was implied consent and not documented. However, when an intervention was required, formal written consent was sought.

Staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and the procedures and documentation used by Sue Ryder Central to assess a patient's capacity. Staff were aware when patients lacked the mental capacity to make a decision, best interest decisions were made in accordance with legislation and took into account patients' wishes, culture and traditions. Information was documented in the patient's records.

Eligible staff completed training on the MCA and DoLS. As of October 2019, 95% of staff had completed MCA and DoLS training, which exceeded the hospice target of 90%.

The Duchess of Kent hospice were using the ReSPECT (recommended summary plan for emergency treatment and care) process and advance care planning to document patient's wishes in emergency situations and for end of life care. By using the ReSPECT process meant patients were involved in decisions about their care and they were empowered to make choices, know what questions to ask their doctor and feel able to make informed decisions.

We reviewed four ReSPECT forms and all were filled out comprehensively, showing discussions with the patient and families. They were completed by the registrar and countersigned by a consultant. Staff were knowledgeable about the ReSPECT process, the completing of documentation and the importance it played in carrying out patient's wishes. However, currently the hospice did

not audit ReSPECT forms for compliance with completion[MS1]. This meant there was no process in place to make sure standards were maintained and the forms continued to be completed correctly and in full.

Most staff we spoke with had received training to make them aware of the needs of people with mental health conditions and dementia. Sue Ryder had recognised it needed to be more effective at equipping staff with tools to manage mental health. This need was being addressed and in October 2019, an e-learning module on mental health was launched. The hospice practice educator had a special interest in people leaving with dementia, learning disabilities and autism and was currently putting on training sessions for hospice staff and volunteers. They had forged links with external networks in the Thames Valley region and hoped to bring learning back to the hospice. Staff we spoke with told us they had limited knowledge in dementia, learning disabilities and autism but if a patient with these conditions was admitted to the unit they would take advice from others, risk assessment the patient and make sure they had a personalised care-plan that was appropriate for their care and treatment.

## Are hospice services for adults caring?

Outstanding



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

### **Compassionate care**

**Staff treated patients and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond expectations to meet their individual needs and wishes. Patients and their families were truly respected and valued as individuals by an exceptional service.**

Staff were passionate and committed to providing compassionate care for patients and those close to them. Staff were aware of the importance of providing compassionate care and the impact their actions had on the patient and their families at this time of their lives. Staff fostered and promoted an atmosphere of calm and tranquillity throughout the services at all three sites.



# Hospice services for adults

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interact and how they treated patients and their families in a friendly, warm, caring and compassionate manner. Patient-centred care was embedded in all staff working at the hospice and the other services we inspected. We could see staff had built strong and trusted relationships with patients and those close to them. We observed staff displayed an understanding and non-judgmental attitude when caring for, or talking about, vulnerable patients.

Staff told us how much of a privilege it was and how it humbled them to work with patients at the most difficult time of their lives. By listening to their patients and those important to them, staff got to know their patients and were aware of the things that mattered to them. We observed this whenever staff spoke about their patients, for example, during handovers, MDT meetings and in clinics. We were told how staff and volunteers spent time getting to know patients and what was important to them, their interests and what lifted their spirits. For example, staff and volunteers would find books on subjects that interested their patients. They would look at the photos together and talk about the subject. During the inspection we observed patients receiving highly personalised care with patient's wishes being creativity fulfilled by staff. We said examples of this in the day hospice where patients were helped and encouraged to create very tailored lasting memories for loved ones.

We were given many examples where staff had gone above and beyond for their patients. For example, arranging a drive in a sports car, arranging for pets to be brought in to say a final farewell, arranging for certain menu requests, arranging special family get togethers and making sure a patient could be at a loved one's wedding via a skype link. The hospice had facilitated weddings and blessings for patients and those close to them, often at very short notice and moved Christmas forward. We were given examples when staff continued to think about their patients outside of the working hours. The patient's needs were continuously thought of and staff had innovative ways to meet them. For example, staff would see things and ideas when not at work and bring them back to the hospice to support or enhance a patients well-being under their care.

Staff understood and respected the personal, cultural, social, religious needs and protected characteristics of patients and how they may relate to care needs. Patient records we reviewed and observations we made demonstrated the totality of people's needs were recognised and respected, including spiritual, religious and cultural needs. We were given examples when the chaplain had been with patients at the end of life, at any time of the day or night, when family members were unable to be there. This had given comfort to both the patient and relatives to know that they were not alone.

Patients and relatives we spoke with told us their privacy and dignity were always respected and protected. We saw 'Please do not enter' signs used on the inpatient unit when patients and those close to them did not want to be disturbed. We observed these were respected by staff. Feedback from relatives who's loved ones had been patients on the inpatient unit between July and September 2019 showed that 18 out of the 22 relatives felt their loved one had been completely treated with respect, with three feeling their loved one had been mostly treated with respect and one relative answering did not know.

All patients and relatives we spoke with at the hospice and at other services we inspected told us they were extremely happy with the care and treatment they had been provided with. We looked at thank you cards and feedback received via patient and relative surveys. Words frequently used to describe the service provided were; 'compassion', 'kindness', 'dedication', 'supportive'. Patients and relatives described staff as 'angels' and the service they provided as 'a lifeline' and 'helped to get things into perspective'. Patients told us 'they were amongst friends'.

## Emotional support

**Staff were devoted to doing all they could to support the emotional support to patients, families and carers to minimise their distress. People's emotional and social needs were seen as being as important as their physical needs.**

All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and their relatives and consistently took account of this when providing care and treatment.



# Hospice services for adults

During the inspection we were told emotional support came in different forms depending what was required by the patient and those close to them. The services at the Duchess of Kent hospice worked together as a multidisciplinary team to support the emotional needs of the patient and their families.

We spent time with the clinical teams, in the inpatient unit, day hospice, community services and the lymphoedema service and were told about and observed how patients and their loved ones were given emotional support to limit their distress. Staff listened to patient's stories and addressed their concerns.

The patient and family support team offered emotional support to the individual and families who may be struggling with how to cope with the challenges of serious illness and the changes it brought. Support was offered on a one-to-one basis, with family or in groups. They undertook anticipatory grief work and looked for coping strategies, which included working with patients and their wider families. The hospice social worker worked closely with the patient and family support team. Their role was multifaceted and included advising on benefits and advocacy services and supported patients and their families with accessing these as required. Through their experience and training they were skilled at recognising families in distress and facilitating difficult conversations. Patients and their families spoke highly of the support offered and how it had elevated stresses at an extremely difficult time in their lives.

The Duchess of Kent hospice offered a befriending service. Trained volunteers would be matched with patients in the community who were in need of support. Their role included companionship to the patient, run small errands, accompany patients to appointments and be with the patient so relatives/carer could have a few hours respite. This service had been shown, through patient user feedback, to provide a real difference to the emotional well-being of the patient, with 100% of patients saying they were happy with the service, it made a positive difference to them and they would recommend the service to others.

The hospice had a chaplain who offered emotional, spiritual, religious or pastoral support to patients,

relatives and staff of all, any or no faith. Staff and patient's relatives gave excellent feedback for the support offered by the in-house chaplain and the comfort it had given them and the patient when needed.

The hospice had a Bereavement Care Team, which included 10 trained bereavement volunteers, offered trained counsellors and therapists to talk with patients about their situation, offer advice, practical help and understanding. The team offered support to bereaved relatives and friends before and after the death of their loved ones. This included one-to-one counselling, informal drop in sessions and bereavement groups. We saw positive feedback from service users for the support that was provided which included the comments 'very thoughtful, respectful, insightful, comforting' and 'I thought it would be a waste of time but am now thankful I used this service'.

Patients were supported to make memory boxes for their loved ones. The box could contain special things to help and give comfort to those left behind. We were told many stories by the diversional therapist of memory boxes made in the day hospice, each special and individual to the patient making the box. We were told how it gave comfort to know that they could continue bonds with loved ones after they had died.

## **Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and ensure they were active partners in their care and treatment. Staff helped patients live every day to the fullest.**

Staff were fully committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

We observed staff explaining to patients and their relatives the care and treatment that was being provided. Medical ward rounds were conducted not just in front of patients and relatives but involving them, making all information and decisions transparent and inclusive. Handovers we observed referenced conversations with patients and relatives and their views were very much taken into account when discussing and planning care and treatment.



# Hospice services for adults

Staff discussed advance care planning, including preferred plan of death, with patients and this information was included in the ReSPECT forms. By completing advance care plans patients were making a plan for future health and personal care if they should lose their decision-making capacity. It captured their values and wishes and enabled them to continue to influence treatment decisions even when they could no longer actively participate. The advance care plans we reviewed during the inspection were filled in comprehensively and documented discussions with the patient and their family.

Relatives of patient's we spoke with felt they and their loved ones had received the information they needed to understand about and make informed decisions about their care. Information was explained gently and with sensitivity, questions were never ignored or remained unanswered. We were told they were kept fully informed, staff had time to answer questions and would answer in a way they could understand.

Families were invited to use the communal areas, quiet room and gardens. Which gave patients and their families areas away from patient's bedrooms to be together. Family pets were welcome to visit the hospice and the hospice regular had a visit from a registered pet as therapy (PAT) dog. A PAT dog has been shown to brought joy, comfort and companionship to many patients who appreciated being able to touch and stroke a friendly animal.

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

Good



Our rating of responsive stayed the same. 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.**

The services provided by the Duchess of Kent hospice reflected the needs of the population and promoted flexibility, choice and continuity of care. The specialist palliative care services provided aimed to ensure local people were cared for in their preferred place of care and death. This was not limited in terms of diversity, ethnicity, culture or aimed at any particular community group. It was available to all people requiring specialist palliative care, symptom management or end of life care. The hospice provided inpatient services, day services and 'at home' palliative and end of life care services to support the local community with individualised person-centred palliative care.

The day therapy services offered in Reading, Newbury or Wokingham aimed to help with specialist palliative care needs so patients could continue living at home safely and in comfort. Patients under the care of the day services had access to treatments which otherwise they would have had to attend the local hospital. For example, lymphoedema clinics, physiotherapy and occupational therapy, blood transfusions and variable infusions. Complementary therapies were also offered such as massage and art therapy.

The community nurse specialists worked collaboratively with others in the wider system to design and plan palliative and end of care services for patients in the local community. This included local GP surgeries, care homes and district nurses from the local trusts.

The inpatient hospice located in Reading had facilities available for family and friends. There was a free on-site car park. The inpatient unit had an open visiting policy. Family, friends and carers were welcome to visit their loved one any time of the day or night. This meant there were no limitations on visiting loved ones. All bedrooms were large and had facilities for visitors to stay overnight if they and the patient wished. All patients and visitors could use the hospice's free Wi-Fi. This meant they could easily keep in touch with people. There was a kitchen area for relatives to use for drinks or prepare food. Visitors could order food from the on-site kitchen, there was a vending machine in reception and a public house and local shops a short distance away from the hospice. These details and transport links were in a folder in each of the inpatient bedrooms. The hospice had thought of the practicalities for visiting family and friends, which reduced the burden on them at a difficult time.





# Hospice services for adults

Sue Ryder had an on-line community service. This was available to anyone. It provided information and advice about a range of topics, such as going on holiday, making a will and what to expect when someone is dying. It also provided an opportunity for people to chat on-line with people in similar circumstances, so they could share and help each other with valuable emotional support.

## 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 told us they treated every patient as an individual. Staff strove to provide care that was not limited in terms of diversity, ethnicity, culture or aimed at any particular community group. They demonstrated a holistic, patient-centred approach to care planning and delivery of care. Patients' spiritual, religious, psychological, emotional and social needs were taken into account. Care plans we reviewed demonstrated that people's individual needs were taken into consideration, this included personal, cultural, social and religious needs.

Staff spoke sensitively and confidently about the differing needs of patients with learning disabilities, mental health concerns and dementia. Clinical staff told us they would liaise with and involve relatives, specialist practitioners in the community and from the local trust who were already involved in the patient's care. By working in partnership would aid continuity of care and enabled the hospice to use and increase their knowledge and skill base.

Sue Ryder had introduced 'What Matters to Me' training for staff. This training workshop had been developed with the British Institute of Human Rights. It was designed to help practitioners use human rights as a practical framework for ethical decision-making and for ensuring compassion and dignity in end of life care. As of October 2019, 81% of eligible staff had completed this training.

Staff told us they had rarely needed to use interpreters, but they could access translation services for patients for whom English was not their first language or would find a sign language interpreter, when needed.

Patients on the inpatient unit were encouraged to bring personal belongings to make them feel more at home, for example bedding, pillows and photographs.

Inpatients could reach call bells and staff responded quickly when called. We observed call bells being answered promptly during the inspection.

The hospice used volunteers. Some of the volunteers were drivers who picked people up and took patients home from the day hospice, which made the day hospice accessible to them, others tended the hospice garden, which provided patients with a safe, wheelchair friendly tranquil outdoor space. The garden included raised beds which could be accessed and tended by patients in wheelchairs. A garden shelter had recently been added meaning the garden could still be enjoyed by patients and their families in inclement weather.

The family support service provided support to children within a patient's family. They could do this directly or by referral to other agencies, for example Daisy's Dream, a charity which supported children and their family who had been affected by life threatening illness or bereavement of someone close to them.

The hospice had a chaplain who offered emotional, spiritual, religious or pastoral support to patients, relatives and staff of all, any or no faiths. There was a sanctuary where patients, families and staff could use as a place for reflection. In the room was a tree statue lit with fairy lights where messages had been tied to its branches. This gave people a place to pay tribute to a loved one at a difficult time. The chaplain had establishing links with different faiths to help support patients and at the time of our inspection, was completing flowcharts for different faiths for staff to use. The flowcharts would be a reference for all staff to know how a patient's faith could influence their decisions before, during and after death.

## 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.**

The hospice had effective processes to manage admission to the services. Referrals came into the service mainly from GPs, district nurses, the local hospital



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specialist palliative team and the hospice's own community and day hospice services. Each specialist team, for example the inpatient unit, day hospice and lymphoedema were responsible for managing and reviewing their referrals.

Referrals to the inpatient unit were through a single point of access and were assessed at the daily referral meeting each morning, where patients were triaged and admitted according to the capacity and occupancy on the inpatient unit and the needs of the patient. Any referrals requesting 'same day admission' or 'urgent' were reviewed by the inpatient unit ward manager and the lead doctor for the shift as soon as they arrived. A decision again was made on patient need and capacity. We attended the daily referral meeting during the inspection, and observed the process for managing admissions, which included an urgent referral. Staff discussed the patient's need, capacity in the unit and safe staffing. Once the decision had been decided to admit, the information was taken to the daily handover to organise and prepare for the patient's arrival.

In August 2019, data supplied by the hospice showed the inpatient bed occupancy was 80%. This was above the hospice target of 75%. Data collected September 2018 to August 2019 showed the inpatient bed occupancy operated around the 80% for most months. The hospice operated a waiting list. We were told during the inspection there were patients on the waiting list to be admitted to the unit for symptom management and respite. These patients had been assessed and were known to be in a place of safety and receiving care from the local hospital or the local community teams. In addition, these patients and their families would be supported by the Duchess of Kent hospice community clinical nurse specialists.

Most admissions occurred during the day, but the service would admit out of hours and at weekends, when necessary, to meet patients care needs and preferences. During the inspection we observed the clinical team discussing arrangements for a weekend admission.

The service has seen referrals for the inpatient unit increasing with some referrals not always appropriate and this was impacting on the number of referrals received. The Duchess of Kent team were currently

undertaking a piece of work to look at referrals and admission criteria to streamline the procedure and make sure care and treatment was available to the appropriate patients.

The hospice followed the Sue Ryder Central transfer and discharge policy. Inpatients were reviewed regularly, and the hospice would discharge patients if they could, so they could return home. The hospice had a dedicated discharge coordinator to facilitate fast track discharges for patients to their preferred place of death.

The hospice did not have a mortuary. Cold blankets were used to cover the deceased patient until the funeral director of the family's choice collected the body. The Duchess of Kent had an arrangement with a local funeral director to collect the body within 24 hours including on a bank holiday, if required. Once the body was transferred to the funeral director's care, relatives of the deceased could arrange for transfer to a funeral director of their choice, if required.

Nurses and medical staff could verify death, with the medical team completing the certificate. Families were invited to attend collection of the certificate and to discuss other arrangements. If death was expected families were supported by the team at the Duchess of Kent hospice. Families would be given information and told what would happen. Leaflets with the same information would also be given to the family. It was recognised it was a difficult and confusing time families and providing information in different ways helped the families understand what was happening. We saw feedback from families thanking staff for the support and help shown to them after their relatives had passed.

Day hospices operated from Reading, three days a week; Newbury, two days a week; and Wokingham, three days a week. With 10 spaces each day. The percentage uptake for the day hospice service was appropriately 60% from September 2018 to August 2019. Patients were not always able to attend due to feeling unwell or other health issues. Patients usually attended the day hospice for a six or 12-week programme. Patients attending the day hospice, stayed under the care of their GP's, with the day hospice team contacting the GP, if required, regarding changes in medication or care and treatment recommended.



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There was coordinated care between the hospice services and good links with the local hospital palliative care team, GPs and the local district nurses. This meant everyone involved in the patients care were informed of the person's changing health and social care needs. This benefited patient's by providing coordinated care, treatment and well-being at a distressing time.

At the Duchess of Kent Quality Improvement Group monthly meeting data was reviewed for all services offered. Data included, occupancy rate, length of stay, non-acceptance of referrals in the inpatient unit and patient uptake at the day hospice. By reviewing this data the hospice could look at demand, capacity and make plans for the services.

## 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.**

The Duchess of Kent hospice took concerns and complaints very seriously as they were passionate in ensuring patients and their families have the best experience possible when using the hospice services which were often at a period of emotional distress.

The hospice followed the Sue Ryder Central complaints policy. The policy included a complaints flowchart to follow to make sure all steps were completed within the correct timeframe. The complaints policy stated that complaints would be acknowledged within three working days, and routine complaints investigated and responded to within 20 working days. Where the complaint investigation took longer than 20 working days, a holding letter was sent to the patient, explaining why the response was delayed.

The hospice director had overall responsibility for the management of complaints. Complaints were logged on the electronic reporting system. Complainants were offered a face-to-face meeting or a telephone call with the hospice director and appropriate staff such as the head of clinical services. At the end of the process a formal letter would be sent to the complainant which had

to include how the complaint had been investigated, conclusions drawn, what action was to be taken following the complaint and next steps the complainant could take if they were not happy with the outcome.

All staff we spoke with were aware of the complaint's procedure. Staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge or a team leader in the first instance. Emphasis was placed on listening to the patient or relative to identify their needs and to address their concerns in a manner that improved outcomes for them, wherever possible. If concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint.

The hospice clearly displayed information about how to raise a complaint. We saw 'How to raise a concern or make a complaint' leaflets throughout the hospice. The Sue Ryder website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email. In addition, patients could raise concerns using the hospice's feedback opportunities such as, real time feedback, 'we're listening, please let us know how we can improve' cards and patient and relatives' surveys.

Complaints were discussed at the monthly quality improvement meeting, common themes identified, and action plans put in place to minimise recurrence. We reviewed the minutes from three of the quality improvement meeting and saw complaints and resulting actions were a set item on the agenda.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings, emails and notice boards. The hospice used 'you said, we did' boards to show how they had made improvements in response to patient and relative's feedback.

All staff we spoke with during the inspection were committed to providing an excellent service to their patients. Staff told us they saw learning from complaints and concerns as a vital tool to help them achieve this.

From July 2018 to June 2019 there had been one complaint received and five informal concerns raised. All



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complaints and concerns were responded to according to the Sue Ryder policy and reviewed at the quality improvement group meeting to identify any themes or trends and if any changes in practice are required.

In the same reporting period the hospice had received 107 formal compliments. However, we saw many more expressions of gratitude during the inspection. Since April 2019 compliments were logged on the hospice's reporting system. This meant the hospice could breakdown compliments by service, examine what was making the biggest impact on people using the service and feedback people's thanks to the staff. Compliments were discussed at the monthly quality improvement meeting and common themes identified. These included the whole family feeling cared for not just the patient, care was focussed and individual and how caring the staff were and how patients and their families were treated with dignity and compassion.

## Are hospice services for adults well-led?

Outstanding



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

### Leadership

**Leaders at all levels had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and had successful leadership strategies in place to ensure sustainability in the desired culture. They were highly visible and approachable in the service for patients and staff. They supported staff to develop their skills, including management and leadership skills and take on more senior roles.**

The hospice had a clear management structure in place with defined lines of responsibility and accountability. The senior leadership team were a stable team, with a wealth of experience and expertise developed from working in the palliative care sector and different areas of the health service. The hospice was led by a hospice director, who had overall responsibility for the hospice. They were supported by the medical lead; the head of clinical services who was responsible for the clinical teams at Reading, Wokingham and Newbury, the family

support team and befriending service; the head of support services was responsible for the administration staff, catering and the domestic teams and the head of hospice fundraising. The hospice, had in the last month, recruited a deputy hospice director to help support the hospice director, as the hospice director also managed another Sue Ryder hospice in the local area. The senior leadership team was accountable to the Sue Ryder executive leadership team, who in turn were responsible to the council of trustees.

Local leadership was strong. Each level of leadership worked in accordance with the hospice vision and created a positive culture. Each service, for example the inpatient unit, day hospices and lymphoedema had a team leader who was responsible for the day to day running of their service. These team leaders were supported to lead and develop their service by the executive team. The inpatient unit had a medical lead who was responsible for the medical team working in the service. There was a volunteer coordinator responsible for the volunteers at Reading, Wokingham and Newbury.

The senior management team and team leaders understood the issues, challenges and priorities in their service, and beyond, and proactively sought to address them. A culture of continuous improvement and service development was a common thread throughout all areas of the hospice. They worked collaboratively with partner organisations, stakeholders and other agencies to deliver high-quality, patient and family-centred palliative and end of life care services.

Staff we spoke with were positive about their leaders. They told us they were very visible, approachable and they felt well supported. We observed this during the inspection. Staff working at the centre at Wokingham said they had close working relationships with the senior management team and team leaders at the Duchess of Kent hospice and the team leaders at Newbury. Although not on the same site they did not feel isolated or that they were working in a silo.

The service provided good development opportunities for staff by supporting them to develop leadership and management skills though both formal and informal learning. Staff were encouraged to learn and build on



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their prior knowledge. The hospice had promoted from within as well as recruiting from outside. This meant there was a good balance of experience and new ideas in the leadership roles at the hospice.

## Vision and strategy

**The service had a clear vision for what it wanted to achieve and a detailed 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 and national plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The Duchess of Kent hospice's vision, mission and values were those of Sue Ryder, and were focused on providing high-quality palliative care for patients and those close to them living with life-limiting conditions. The Sue Ryder vision was, "We see a future where our palliative and neurological care reaches more communities; where we can help more people begin to cope with bereavement; and where everyone can access the quality of care they deserve." The mission was, "Sue Ryder supports people through the most difficult times of their lives. Whether that's a terminal illness, the loss of a loved one or a neurological condition – we're there when it matters. Our doctors, nurses and carers give people the compassion and expert care they need to help them live the best life they possibly can."

There was an established set of values, which were:

- Make the future together – sharing our knowledge with each other and collaborating with our volunteers, supporters and people who use our services to deliver positive outcomes.
- Do the right thing – working with honesty and integrity, having courage and resilience to face the challenges in delivering our goals.
- Push the boundaries – constantly looking at ways to improve what we do and how we do it, with creativity and innovation.

The values were underpinned by Sue Ryder 'behaviours' which staff were expected to demonstrate at all times. These included emotional awareness, honesty and integrity, resilience, delivering

outcomes and working together. We observed that staff worked in a way that demonstrated they upheld the values in practice and kept exceptional patient care as the basis for all they did. The appraisal process incorporated the Sue Ryder values and behaviours, whereby staff had to evidence how they demonstrated them at work. We saw the Sue Ryder vision, mission and values were publicly displayed throughout the hospice. Most staff we spoke with could articulate the Sue Ryder vision and mission.

Sue Ryder had developed a five-year strategy for 2018 to 2023. This had been developed in collaboration with staff, service users and external partners, and was aligned to national recommendations for palliative and end of life care. The strategy recognised the challenges presented by a growing and ageing population, with more people being diagnosed with complex conditions, and outlined how the organisation planned to deliver services which met the needs of more people and enabled them to access personalised, life-enhancing care. There were two strategic aims: provide care and support for more people; influence new models of care across the UK. In partnership with relevant stakeholders, the hospice had developed services in line with the strategy.

The Duchess of Kent hospice had a local business development plan 2019/2020 which outlined four key areas it was focusing on; 'ensure we demonstrate and deliver excellent quality driven care within all our clinical services and departments'; 'to develop our people to ensure everyone undertakes their roles with professionalism and skill, working as proud ambassadors for Sue Ryder'; 'to grow income, making sure Sue Ryder Duchess of Kent is sustainable now and for the future'; and 'to review and develop all aspects of our core business practices and stakeholder management'. There were actions associated with each of the four key areas, who was leading the actions, the timescale for delivery and review of progress. Progress against delivering the strategy and plans were monitored and reviewed. The senior manager team spoke to us in detail and with knowledge about their strategy, their progress, the challenges they faced, and how they were working to sustain and develop the Duchess of Kent hospice services for the local community for the future.



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## Culture

**Staff felt respected, supported and valued with an emphasis on strong collaboration and team-working. Staff were very proud to work for the hospice and could articulate why. There was a common focus on providing the best possible care to patients and continually improving the quality of care and people's experiences. 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 and were confident to do so. The service used these as an opportunity to learn and improve the service.**

Staff felt respected, supported and valued by patients and their families, their peers and their managers. Staff told us there was good team work and very good working relationships throughout the hospice. Staff were proud to work for the hospice, they were enthusiastic and passionate about the care and services they provided for patients. They enjoyed coming to work, with many staff having worked at the hospice for many years. Staff told us they were committed to providing the best possible care for patients and those close to them. They felt it was a privilege to care for people at the most difficult time of their lives.

Throughout the inspection we saw pleasant, respectful and non-judgmental interactions between staff, patients and their relatives. There was an inclusive culture with the service centred on the needs of the patients and those close to them.

There was a culture of honesty, openness and transparency. Staff were encouraged to report incidents and raise concerns or issues, so they could be learnt from and the service offered to patients improved. The senior management team promoted an 'open door' culture and it was evident staff felt confident to voice any concerns or issues they had. None of the staff we spoke with raised any concerns about bullying or inappropriate behaviours from

colleagues. Arrangements were in place to ensure staff could raise concerns safely and without fear of reprisal, including a Sue Ryder Central whistleblowing policy.

Success was celebrated by staff, we were told how positive feedback received was shared with staff by the senior management team. Sue Ryder held an annual 'Incredible Colleagues Awards' event which recognised staff and volunteers who had gone the extra mile. The hospice in 2019 had two winners, with the hospice director winning the leadership award for great people management category and a member of the lymphoedema team winning the unsung hero award category.

There was a supportive network for staff. The hospice had two Schwartz round facilitators. Schwartz Rounds were evidence-based forums for staff to come together to talk about the emotional and social challenges of caring for patients. Schwartz rounds were available to all staff, including volunteers and domestic staff. Debrief sessions were organised for staff after difficult or upsetting patients. Staff told us clinical supervision was available to them and staff could access the chaplaincy service for support. Every member of staff we spoke with during the inspection said they felt supported and their well-being was looked after.

Staff spoke positively about development and training opportunities. Staff felt able to discuss personal development with their line managers and one-to-one meetings and the annual appraisals were seen as constructive and a time to identify and agree objectives as well as training needs.

## Governance

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

The Duchess of Kent hospice had a governance framework in place through which the hospital were accountable for continuously improving their clinical, corporate, staff, and financial performance.



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Patient outcomes, the audit program and hospital meetings fed into the governance framework. Each month a hospice integrated quality and performance report would be produced which was discussed at the monthly quality improvement meetings. These meetings followed a set agenda which was aligned to the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well-led. We reviewed three sets of meeting minutes which showed governance matters, such as, incidents, audit findings, complaints, activity trends and quality improvement were discussed. Actions arising were monitored, completed and updated at each meeting.

The governance and risk structure for Sue Ryder showed information discussed at quality improvement group meetings fed into relevant Sue Ryder Central groups, such as the research governance group and medical devices group. These groups fed into the Sue Ryder Central health governance committee, which fed into the Sue Ryder Central health and social care sub-committee, which fed into the council of trustees (board) meetings. This meant there was oversight of the service at hospice to board level.

Relevant information from the quality improvement meetings was reviewed by team leaders to understand how their services were performing. It was up to the team leaders to disseminate this to their teams and to act on any issues arising. We were told by staff working in the inpatient unit that information would be shared with in various ways including, handovers, meetings and via emails. They were committed to improving the quality of services for people who used the service.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

## **Managing risks, issues and performance**

**Leaders and teams used systems to manage performance effectively. They proactively identified and escalated relevant risks and issues and identified actions to reduce their impact. They had clear and tested plans to cope with**

**unexpected events, which were understood by staff at all levels. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

There was a Sue Ryder Central risk management in health and social care procedure and risk policy which explained the aim of risk management, explained what risk was and how to identify, record, review and mitigate risk.

There was a Sue Ryder health and social care risk register which was a high-level risk register that identified key risks to the operation of the Sue Ryder charity within the context of health and social care services.

The Duchess of Kent had its own local risk register. The register included a description of each risk, the potential impact of the risk and the risk owner, alongside mitigating actions and controls in place to minimise the risk. Each risk was scored according to the likelihood of the risk occurring and its potential impact.

At the time of our inspection, six risks were detailed on the risk register; We saw the risk register had been recently reviewed and action had been taken to minimise each risk. Risks were reviewed regularly at the monthly governance meeting. There was alignment between the recorded risks and what staff identified as risks within the service, such as staffing.

From speaking with staff and reviewing documentation we were assured the service were able to recognise, rate and monitor risk. This meant the service could identify issues that could cause harm to patients or staff and threaten the achievement of their services.

There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes in Sue Ryder hospices. During our inspection we could see from speaking with staff and reviewing documentation that the services was carrying out these audits and identifying and taking action where required.

The service had an up-to-date business continuity plan which was accessible to staff and detailed what action should be taken and by who, in the event of a



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critical incident involving loss of building, information technology or staff. Emergency contact numbers for managers and services, such as electricity, gas and water providers, was included. We were told by the head of support services that the hospice ran desk top scenarios a few times a year to test out their critical incident plan to practice what was required in a real emergency and to see if the plan needed improving.

Staff confirmed they received feedback on risks, issues and performance in a variety of ways, such as team meetings, noticeboards, newsletters and email.

## Managing information

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

The hospice had clear service performance measures, which were recorded and reported and monitored by the hospice, Sue Ryder Central organisation and the local commissioners. Information was recorded in the monthly integrated quality and performance report. We saw these reports were detailed and included data on a range of performance and quality indicators, such as incidents, staffing, service user feedback, complaints and activity. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements, where indicated. Statistical process control (SPC) charts were used to track performance over a period of time, where relevant, and to highlight unexpected variations in performance which warranted investigation. This meant staff could identify at a glance, performance trends and areas that required investigation and improvement.

There were systems in place to ensure that data and notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC).

The hospice employed a data analyst and together with the senior manager team reviewed all data collected to make sure it was accurate, valid, reliable, timely and relevant.

Information technology (IT) systems were used effectively to monitor and improve the quality of care. For example, there was a computer system where incidents, near misses and complaints were recorded.

Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system. Staff also told us IT systems were used to access the e-learning modules required for mandatory training.

Staff had access to up-to-date and comprehensive information regarding patients' care and treatment. The hospice had updated to using an electronic patient record system which was the same as that used by local GPs and district nurses. There were arrangements to ensure confidentiality of patient information held electronically and staff were aware of how to use and store confidential information. Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information.

Sue Ryder Central had policies and processes in place governing Information Governance, Security and Personal Data Protection. All data controller registrations for the processing of personal data were maintained in accordance with the requirements of the UK Information Commissioners Office and information security and governance policies were compliant with ISO/IEC27002 the Code of Practice for Information Security Management.

## Engagement

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

The hospice actively encouraged patients to give feedback through patient satisfaction questionnaires, real-time feedback, suggestion cards and via the hospital's complaint process to help improve services.





# Hospice services for adults

Feedback was reviewed by staff and used to inform improvements and learning, where possible. Since April 2019, feedback from all the various mediums was logged on the hospice's IT system and analysed. This information was then shared at the monthly quality improvement group meeting where trends and themes in feedback could be discussed, improvement of services implemented, and success celebrated.

Volunteers on the inpatient unit collected anonymous real-time feedback from patients and their relatives. By asking for feedback in this way, staff hoped issues would be raised soon after they arose and meant they could be acted upon quickly.

Patients who were discharged for a hospice service were sent a survey to fill out on the care they had received. The hospice undertook a survey of bereaved relatives. This was sent out six months after the patient had died. Relatives were asked to rate and comment on their experience of their loved one's care and treatment. From July to September 2019, the feedback showed respondents rated the service highly.

Other services who carried a caseload of patients for a significant time, such as the lymphoedema and community clinical nurse specialists sent out six monthly surveys to their patient groups to gather feedback to gain an insight on the care and service being provided.

The hospice had a service user group which had been running for seven years. The group met every six weeks and helped the hospice see things from a patient or relatives' point of view. They had helped review leaflets and information given to patients and relatives, monitors service user feedback and make suggestions, for example suggesting the garden needed a shelter so it could be enjoyed by patients even in bad weather. A member of the service user group attended the monthly quality improvement group meeting, so the voice of the patients and their relatives could be heard at a senior level.

There were high levels of engagement with patients, families and carers, partner organisations and the public. For example, the hospice held many fundraising events across the local community to raise public awareness and support for the hospice.

Families and carers were invited to attend the hospice for an annual day of remembrance where people could come together to reflect and remember their loved ones. Four times a year the family support and bereavement services ran a family and friends meet up, where people could come and talk, share memories and find support in each other's company.

The views of staff were sought and acted on. Staff were invited to participate in the annual Sue Ryder staff survey. In the 2019 survey, the hospice scored 6.8 (out of 10) for an overall indicator of staff engagement. This was lower (worse) than the national Sue Ryder average of 7.5, and indicated staff were reasonably well engaged but this could be improved. 47% of staff completed the survey which was lower than the Sue Ryder average of 66.4%. There was no reference in the quality improvement group meeting minutes we reviewed, regarding discussion of these results and therefore it was unclear how the senior management team planned to address staff engagement. Staff scored highest on the survey question 'I would be happy for a member of my family or a close friend to be cared for in one of the Sue Ryder care centres'.

## Learning, continuous improvement and innovation

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

The Duchess of Kent hospice was committed to improve the quality of services offered to patients and their relatives. The hospice had a quality improvement plan which was a live document which brought together feedback from service users, incident reporting, concerns, complaints, audit findings. It was reviewed at the monthly quality improvement group and actions put in plan to address any issues occurring.

Team leaders of the services were actively encouraged to think of ways to improve their service. During the inspection we had told of many ways improvement had been made,



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- The lymphoedema team were piloting an 'education session' for new patients who had been referred to the service. This was a group session where patients would come together to learn about lymphoedema, how to manage it and be with others who were in similar situations and help reduce the feeling of dealing with the condition in isolation. Also, by running group sessions new patients could be seen quicker after referral.
- The lymphoedema team had also written a new leaflet 'managing oedema (swelling)'. This leaflet was now being used by all the Sue Ryder units nationally.
- The practice educator had been running sessions for staff to raise awareness of the needs of people living with dementia, learning disability and autism in the end of life care setting.
- The practice educator had obtained funding to train four members of staff to deliver sage and thyme. This was a foundation level workshop that teaches clinical and non-clinical staff evidence-based communication skills to provide person-centred support to someone with emotional concerns.
- The hospice social worker had introduced monthly carers drop-in sessions, which offered practical and emotional support to carers.
- The befriending volunteer co-ordinator had made improvements in lone working for their team of

volunteers and staff. A call in/out system had been introduced in September 2018 and had recently been updated to include guidance and clear instructions what to do if the befriender should find themselves in an urgent situation, such as if the patient had fallen. Volunteers and staff welcomed this guidance and gave them more confidence in their role.

The hospice ran a 'journal club' which was open to all staff. At this meeting staff were encouraged to present topics of interest to them relating to end of life care, or share information gained from attending conferences and training courses. We were told they had recently been a presentation on the issue of hard to reach groups such as the homeless to raise awareness within the hospice.

Sue Ryder as a group championed the use of 'hangouts' for staff to have meetings with other Sue Ryder staff in similar roles at other hospices. 'Hangouts' were video communications via computer links. Senior staff, team leaders and staff in specialist roles, such as the tissue viability and infection prevention and control lead found these meetings an excellent way to improve their services through shared learning and group discussion talking through issues and incidents that had happened in their service. Staff told us they found the meetings supportive and a good way to make contacts in other Sue Ryder organisations.

# Outstanding practice and areas for improvement

## Outstanding practice

There was a strong commitment from all staff to provide truly person-centred, compassionate care and support people's holistic needs. Staff were highly motivated and inspired to offer innovative ways to support patients with their end of life care which included outreaching into the community.

The Duchess of Kent leadership team understood and proactively mitigated risks within their own services, so it was safe, responsive and meets the needs of individual patients.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The provider should make sure clinical and pharmaceutical waste was stored securely.
- The provider should consider auditing ReSPECT forms.