

Leicestershire & Rutland Organisation for the
Relief of Suffering Limited

LOROS The Leicestershire & Rutland Hospice

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 24 and 25 February 2016 and was announced.

Leicestershire & Rutland Organisation for the Relief of Suffering Limited (LOROS) is registered to provide care and support to people in relation to symptom control, pain relief, assessment and end of life care

LOROS in-patient facility caters for up to 31 people, accommodated within four bedded bays or an individual room. The hospice service provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver physical, psychological, social and spiritual care through teams of nurses, doctors, counsellors, chaplains and other professionals including therapists and social workers. The service has a team of community specialist palliative care nurses who care for people and their families within the community providing specialist advice as regards symptom control and psychological support along with other health care professionals.

The services provided include counselling and bereavement support, home visiting, chaplaincy, out-patient clinics, occupational therapy, physiotherapy, dietetics, and complementary therapies.

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

People told us that they felt safe at the service. The service was committed to promoting people's safety across all levels of staff within the organisation and included advising the Board of Trustees of safeguarding concerns and ensuring staff at all levels, including volunteers received training on protecting people from potential abuse or avoidable harm.

Risks to people were assessed and where potential risks had been identified these were minimised in consultation with the person. Where accidents or incidents occurred there was a no blame culture within the service. This ensured staff reported any concerns so that they could be reviewed and discussed to identify if lessons could be learnt to reduce the likelihood of reoccurrence.

People's physical, psychological, emotional and spiritual needs were met as the service employed sufficient staff from a range of disciplines to provide holistic care. People's needs were regularly reviewed by staff from a range of health and social care disciplines and included staff that provided spiritual support and complementary therapies.

The service supported people within the community providing psychological and practical support. People in some instances accessed the day therapy facility, which offered clinics where people could review their health, which included symptom and pain management along with complementary therapies, creative

therapies and social activities. People told us that the day therapy facility enabled them to meet with people in similar circumstances and was a welcome part of the community support.

People told us that staff understood their individual care needs and were compassionate and understanding and that their cheerful and friendly approach created a welcoming and relaxed atmosphere. Staff told us that they undertook training which enabled them to provide good quality care, which supported a holistic approach to care. Reflective practice sessions were used to enable staff to discuss issues associated with their work and their welfare was supported by the chaplaincy team who provided one to one and group support.

People's medication needs both within the hospice and the community were discussed by health professionals to manage and support people's symptoms and pain management. Medicines were regularly reviewed and audited to ensure they met people's needs. A pharmacy team including a specialist pharmacist and pharmacy technicians from a local hospital provided a clinical, and medicines supply, service to the hospice to ensure people received their medicines in a safe and timely manner.

The registered manager and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were dedicated in their approach to supporting people to make informed decisions about their care.

All of the food was freshly prepared and the meals provided catered for a range of specialist diets. People were supported to eat and drink when required. People could ask for what they wanted to eat at any time. Dieticians were involved in people's nutritional welfare and had worked collaboratively with the chef to develop a range of milkshakes and other drinks to encourage those with a poor or low appetite to eat.

People, friends and relatives were consistently very positive about the caring and compassionate attitude of the staff. They told us they were completely satisfied with their care. They spoke of excellent relationships with staff who understood their needs and preferences. Staff were very motivated and demonstrated a commitment to providing the best quality end of life care in a compassionate way. People's wishes for their final days were respected.

People and the service were supported by volunteers who played an important part in the day to day running of the service.

Staff respected people's cultural and spiritual needs and people told us they received the religious and spiritual support they wanted and needed. Relatives told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member. Bereavement support was available to people and their families and friends. This provided emotional and practical support to those who required it.

People were fully involved in assessing their care and treatment needs and their wishes and preferences were incorporated in planning how those needs were to be met. Regular reviews of people's care were held and people were involved in discussions about their health to ensure their wishes were known. Community services and the lymphoedema clinic worked with health care professionals within the wider health community to promote good practice to improve the care and treatment available to people.

The management structure showed clear lines of responsibility and authority for decision making and leadership in the operation and direction of the hospice and its services. The Board of Trustees and the management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards. The service actively encouraged and

provided a range of differing methods and opportunities for people who used the service and their relatives to provide feedback and comment about the service in order that they could influence the service and continue to drive improvement. The service has plans to improve the range of services it provides within the community and their accessibility to those living within rural locations.

The service is open and transparent providing a range of information within the service and on its website, which includes the outcome of surveys and audits undertaken and their response to improving the service. There are systems in place to enable people to make comments and ask questions about LOROS, which include completing comment cards and the use of social media.

Staff worked closely and in partnership with external health and social care professionals and other national organisations to improve the service within the hospice and health provision in the local community and nationally. Staff were encouraged and supported to undertake research and act as education facilitators to share best practice and ensure the best possible outcomes for people with life-limiting conditions and those closest to them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff had been trained to recognise and respond to any actual or potential abuse. The service had developed systems for reporting and monitoring allegations of abuse and worked with health and social care professionals.

Potential risks to people were assessed and measures put into place to reduce risks. Where incidents occur these were analysed and used as a learning tool to reduce future risks.

People's needs were met and they were supported and cared for by staff from a range of disciplines that had the appropriate skills and knowledge.

People were supported by staff in all aspects related to their medicine, which included the use of equipment where required to ensure people received their medicines.

There were thorough procedures in place to minimise the risk of infection and the risk of pressure ulcers.

Is the service effective?

Good ●

The service was effective.

People received support and care from a staff team who were trained to meet their needs. Training was well managed by a dedicated team within the service. We found staff were encouraged to develop their knowledge and skills.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making decisions about all aspects of their treatment and care.

People were supported to eat and drink and maintain a balanced diet. People were able to choose from a varied menu, which included a range of specialist drinks for those with a reduced appetite.

People's health needs were carefully monitored and appropriate

referrals made to other professionals, where required.

Is the service caring?

Good ●

The service was caring.

People and their relatives told us that staff treated them with exceptional kindness, care, dignity and respect at all times. Staff were highly pro-active in their approach to care. They demonstrated compassion in every aspect of their work to make people feel valued and supported.

People's spiritual needs were recognised and if appropriate met by a chaplaincy team who had links with external religious groups who represented a range of religious beliefs and cultures.

Staff supported the emotional wellbeing of people and their relatives with end of life care being provided with sensitivity, this included arrangements for the body of a person who had died to be cared for in a dignified way.

Is the service responsive?

Good ●

The service was responsive.

The staff responded to people's physical, psychological, social and spiritual needs. People and their families were fully involved in assessing their needs and planning how their care should be provided, which included their wishes regarding their end of life care.

The provider had a positive approach to using complaints and concerns to improve the quality of the service and was monitored by The Board of Trustees and the management team.

Is the service well-led?

Good ●

The service was well-led.

The service promoted a positive and open culture and provided a range of opportunities for people who used the service and their relatives to comment and influence the quality of the service provided.

The Board of Trustees and managerial teams provided strong, effective leadership and provided a clear strategy for the long term development of the service.

The management team was pro-active in introducing new ways

to meet the needs of people in the wider community and promote good practice.

The provider worked with other healthcare professionals and national organisations and participated in research projects to develop and influence care for people.

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Detailed findings

Background to this inspection

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

This inspection took place on 24 and 25 February 2016 and was announced.

The provider was given 24 hours' notice to provide an opportunity for the provider to help facilitate the inspection process.

The inspection was carried out by two inspectors, a pharmacy inspector and a specialist advisor. The specialist advisor had the experience working as a nurse within the community and within the field of palliative care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned to the Care Quality Commission. We found the information in the PIR was an accurate assessment of how the service operated.

We also reviewed the information that the provider had sent to us which included notifications of significant events that affect the health and safety of people who used the service.

We spoke with five people who used the service and four relatives who were visiting.

We spoke with the registered manager, the Chief Executive, managers with differing responsibility for areas within the service, which included staff training, risk management and quality monitoring. We spoke with a

Reverend and with clinical staff, which included, nurses, health care assistants, a pharmacist, a dietician, the safeguarding lead, infection prevention lead nurse and patient experience lead and the tissue viability lead nurse.

We reviewed three people's care plans to see how their support was planned and delivered. We looked at a selection of medication records to check medicines were managed safely. We spent time observing staff interacting with people and their relatives.

We also looked at the recruitment files of four members of staff, a range of policies and procedures, maintenance records of equipment and the building, quality assurance and clinical audits and the minutes of meetings.

Is the service safe?

Our findings

People we spoke with told us they felt safe, one person told us, "You can't help but feel safe here. The staff know what they are doing and so I trust them completely."

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse and were able to describe experiences where there was a risk of someone being abused and the steps they had taken to protect the person. They described how they would refer people to the appropriate organisation should they have concerns to protect people if they were concerned about potential abuse.

We found the service was committed to supporting people who were at risk of abuse or harm. A safeguarding lead had been appointed to further develop their policies and to support staff that had any safeguarding concerns. The safeguarding lead described how they were raising staff awareness about safeguarding risks. They told us healthcare assistants in particular were keen to understand more about safeguarding. We saw the strategy they had developed which included plans for developing safeguarding champions. Volunteers also received awareness training as part of their induction. Safeguarding was included as an agenda item for multi-disciplinary team (MDT - a group of professionals from a range of specialist areas) meetings to remind staff to discuss any concerns. Trustees of the Board were completing safeguarding training to help them carry out their role effectively in the monitoring of safeguarding to ensure the service was meeting its obligations.

We found the Chief Executive and the registered manager had a pro-active approach to promoting people's safety which was discussed and shared and used to ensure the service was safe for people to use. Regular meetings were held to review the practices of the service in maintaining people's safety and reducing risk.

We spoke with three staff who told us they were encouraged to report any incidents or near misses which occurred. They said they completed an incident form currently but they were aware plans to implement a computer based reporting system. Staff said incident reporting was covered as part of their mandatory training. Staff told us they received safety alerts and offered examples of equipment which had been checked or withdrawn after they had received an alert. The ward Sister said safety issues were discussed at team leader meetings to check that the correct action had been taken. Staff said they felt encouraged to report and learn from incidents and staff did not feel blamed if they reported something, this open and inclusive approach to responding to risk promoted the safety and welfare of people who use the service.

We saw examples of serious incident reports which had been submitted to the local Clinical Commissioning Group (CCG) following an investigation within the service. The CCG has responsibility for ensuring services take action to address any learning identified as a result of the investigation. The board of trustees were regularly informed of progress to ensure any agreed actions had been implemented. LOROS adheres to the Duty of Candour obligations and is transparent with people using the service and/or relatives following a serious incident. Once an investigation is completed a letter is sent to the next of kin inviting them to attend a meeting to discuss the outcomes and any recommended changes to practice that the service will be implementing following the incident.

We found the service had reviewed their falls policy following two serious incidents where people had fallen. Staff we spoke with were aware of the actions taken by the service to reduce the risk of similar incidents occurring in future. They told us they had received additional training in falls prevention and had discussed the lessons learned from the incidents at an away day. They had introduced anti-slip socks for people as a result and tried to ensure people most at risk were accommodated in areas where staff could more easily see them and therefore monitor them.

Risk assessments were carried out prior to admission to identify those with the greatest risk to enable the service to minimise risk and therefore promote their safety. Staff also told us they could speak to the physiotherapist or occupational therapist who would review a person's needs for supervision and any specialist equipment they might need.

Nursing staff used a recognised tool for checking the condition of people's skin; this consisted of a number of checks staff carried out regularly when a person was at risk of developing a pressure ulcer due to deterioration in their health. The tissue viability lead nurse told us if someone's skin condition deteriorated that this was reviewed and the results of the review were reported, as required, to the (CCG) and the local Health Community Pressure Ulcer Group to promote good practice and to promote an open culture of sharing risk. The tissue viability nurse undertook audits and looked at the care plans for people who had pressure ulcers, and completed pressure ulcer incident forms. All beds could be operated by controls, which enabled people to find a comfortable position for themselves and beds had a memory foam mattresses to reduce the risk of people developing pressure area ulcers.

A medical devices group had been established to review technical guidance on the use of equipment and had developed a policy on equipment maintenance. The group reviewed and approved all requests for new equipment. The service had procedures in place for servicing medical equipment and had developed a disaster recovery plan, should an untoward event occur, such as a flood. We saw the fire risk assessments carried out in August 2015. Additional fire training had been provided for staff and a new fire policy had been developed which was due to be approved by the board. These policies and systems to maintain the building promoted people's safety.

Staff we spoke with told us they felt there were sufficient staff on duty to enable them to care for patients. A nurse told us, "Each shift we look at the dependency of patients, generally for ten patients there are two nurses and two health care assistants." People we spoke with told us staff were always available if you needed them. One person said, "Staff seem to know you want them before you do." Our observations found that there were sufficient staff to enable them to meet people's needs and that staff were available to offer assistance in a timely manner, with call bells being answered promptly

The ward Sister and manager described the system for ensuring the ward had adequate staffing levels to meet people's needs. This was based on assessing the level of support individuals needed to assist them with the tasks of daily living and the level of assistance people required with their medicines for example, such as the use of equipment which required the oversight of a nurse. Staff rotated through days and night shifts so they had experience of working in the service during the day and at night, which enabled staff to better understand and care for people as they were aware of the person's health care needs and its impact on them.

People told us they received their medicines as prescribed and on time, they had ample opportunity to ask questions about their medicines and were able to identify specific members of staff, including the pharmacy staff, who would be able to answer medicine related questions.

A pharmacy team including a specialist pharmacist and pharmacy technicians from a local hospital provided a clinical, and medicines supply, service to the hospice to ensure people received their medicines in a safe and timely manner. The pharmacist visited the service four days each week and took part in MDT meetings, to discuss people's individual medicine requirements and ensure good clinical practice was followed. We observed the nurses and doctors seeking medicines advice from the pharmacist and the appropriate use of a range of medicines reference sources to answer queries. Medicines were obtained, stored and administered safely to people. We observed a drug round where medicines were given to people in a caring, dignified manner, accurate records were made on dedicated charts and there were sufficient staff to ensure people were given enough time to make an informed decision about the medicines they required.

Medicine refrigerator temperatures were electronically logged and these confirmed that medicines were stored within the recommended temperature ranges to ensure their safety and effectiveness. Staff were able to describe the action they would take in the event of refrigerator failure which was in accordance with the medicines policy for the service. All medicines were held securely and appropriate records were kept. We saw evidence of regular audits relating to the security and storage as well as the prescribing of medicine.

Arrangements were in place to enable people to take their own medicines although this was not used frequently due to the condition of most people being dependent on nursing staff administering their medicine. The service was undergoing refurbishment to include increased provision for people's own medication to be located close to their beds which will make this easier in the future.

Medicine incidents were recorded and reported within the service and investigated, appropriately by the service and overseen by the Therapeutics Committee with outcomes that were formally disseminated to staff at established monthly team meetings. This enabled staff to learn from events and to introduce measures to reduce the likelihood of a similar event occurring and promoting people's safety.

The head of in-patient services showed us that they were reviewing the medicine charts in response to feedback from staff to make these easier to use and to include greater detail, for example recording situations where a person may be receiving medication away from the ward to ensure people's medicine were managed safely.

There were suitable measures in place to lessen the risks of infection and ensure the hospice was clean. The service employed an infection prevention lead nurse to provide advice to staff on minimising infection risks. We found the service and staff followed procedures to promote people's safety by reducing the likelihood of infections being spread within the service. The ward area was clean and equipment which was clean and ready for use had 'I am clean' stickers which showed when the item had last been cleaned. We saw staff followed hand hygiene procedures, washing their hands between caring for people and used protective clothing when providing care.

The ward Sister described how they cared for people with an infectious condition by providing them with a single room if possible and following the service's infection control procedures. They said when it was not possible to provide a single room they would care for the person within one of the bays of the ward ensuring they followed rigorous infections control procedures. They also screened people admitted from hospital or care homes for infections, which could impact on their health, that of others using the service and staff.

Is the service effective?

Our findings

Staff were appropriately supported in their work. We spoke with staff about the support that was available to them, they told us about 'soul space', which provides a weekly opportunity for them to attend the Chapel and reflect and relax. Staff told us they found this a comfort to them when they had dealt with the death of people, who they had cared for, providing time for them to gather their thoughts and enabling them to refocus so that they could continue to support and care for people. A Reverend we spoke with told us this was protected time for staff that provided an opportunity to take time away from their working environment.

Nursing staff told us they received regular supervision meetings with their manager where they discussed their training needs and performance. Staff said they met their manager often, usually monthly and felt their managers listened to their views. This enabled the service to be confident that the care being given, was being provided by staff who were supported and valued and had the opportunity to reflect on their work and practices to drive improvement.

Staff development and learning had a proactive approach which meant people using the service received care based on up to date practices and knowledge. Staff we spoke with told us that they undertook training relevant to their role to ensure people received the care they needed. A nurse told us, "Mandatory training is sufficient, there is also additional training." They told us about the specific training they undertook with regards to nursing procedures and tasks. A second nurse we spoke with told us they liaised with the tissue viability lead nurse (TVN) and we asked them what this entailed; "We have regular meetings with the TVN and cascade the information to each team. We are told of new changes."

The service was committed to develop staff knowledge and training. They employed specific practice educators in post to support both qualified nurses and healthcare assistants who reviewed and supported staffs education and training needs. The manager told us all new staff's skills were assessed when they joined the hospice. One member of staff told us their medicines competencies were assessed when they took up their post. However, they also told us their competency in the use of syringe drivers had not been assessed. We explored this matter and were assured. We spoke with another member of staff who told us they had worked alongside another nurse for several months before they could manage people's syringe drivers. The manager told us they were developing a medical devices competency framework for staff. We observed that people's syringe drivers were checked on each drug round against a comprehensive checklist, which was completed to promote people's safety. A nurse told us when we asked them about training, "We have started working with reflective tools and the training department are supporting us."

Training staff used were knowledgeable about current guidance and practice. The TVN told us that part of their role was to provide training and education for the staff, which included updating staff on recent changes to policy. They told us they attended conferences and training to ensure they were up to date with current good practice.

We spoke with health care assistants who told us that as part of their induction and training had included completing the Care Certificate. The Care Certificate is a set of standards for care workers that upon

completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. We asked them whether in their opinion they were supported to access training, they told us, "My mentor was brilliant, very, very supportive." And "My mentor was fantastic, and so were other colleagues."

New staff completed an induction programme which lasted for three days and included topics related to safety and infection control. Staff were also required to read the services policies. Staff could access other training, for example in catheter care. Staff told us there were regular team meetings and away days where they had the opportunity to explore training topics in more depth, for example falls prevention. All nursing staff had completed advanced communications skills training and said they found this really helpful when they spoke to people and relatives on sensitive subjects surrounding death.

We found staff were encouraged to undertake additional training for their personal and professional development, to promote good practice. Three staff had completed a master's degree in palliative care and three staff had applied to train as mentors. Healthcare assistants had attained a Diploma in Health and Social Care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in hospices are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found one person had a DoLS authorisation in place; the DoLS did not have any conditions. Records showed that there had been consultation with the person's family and health care professionals.

Nursing staff understood the role of the MCA and the need to act in a person's best interests if a mental health condition meant the person had difficulty making a decision for example about their treatment of their wishes as they approached the end of life. Staff described how medical staff would assess the person's mental capacity and they would discuss whether the service needed to make decisions in the person's best interest or whether they should apply for a deprivation of liberty authorisation (DoLS) from the local authority.

People we spoke with commended the food. One person told us, "Why the food is lovely, there is always a good choice and you can change your mind if you want to." A second person told us, "They come round and ask you what you would like from the menu, it's always appetising." And, "The food, you can eat when and what you want", they went onto tell us how they had requested something that was not readily available which was provided. Menus were distributed by the housekeepers in the morning. Staff helped complete the form for the housekeepers. This highlighted which people required assistance/special dietary requirements/feeding aids. When the food was given out if there was a person who required assistance the housekeeper would inform the staff.

Each person who uses the inpatient facilities were provided with a booklet 'Welcome to the Inpatient Ward'.

Within the booklet information is provided as to meals, which includes specialist diets, vegetarian, diabetic, and gluten free, dairy free, culturally appropriate and pureed. Where people require a high calorie or high protein diet, then the service made a range of smoothies and milkshakes, presented as a cocktail, and included a 'supper berry smoothie' and 'desert island drifter'.

Staff told us it was important that they offered people choices if their appetite had reduced. They said they could offer people smoothies with a high calorie count or snacks if the person felt unable to eat a meal. They said they were also able to offer a range of choices which met with people's cultural traditions. People were able to ask for snacks at any time.

We spoke with the dietician who told us they received referrals from staff and reviewed people's needs. They told us they had liaised with the chef with regards to homemade specialist drinks to encourage and improve the food experience for people with a poor appetite. They told us that part of their role was to provide training on nutrition for volunteers. They advised us they were part of the Nutrition and Hydration steering group, which included the cultural support worker, occupational therapists, physiotherapists, volunteers and carers whose role was to develop the quality of meals available to people. This showed that the service had considered and kept under review the needs of people with regards to their nutrition and had worked with staff from a number of departments within the service to develop a system for monitoring the effectiveness of nutrition for people.

Care plans provided information for staff where people's dietary needs, were provided via a PEG or RIG (which is a system by which people who are unable to take food or fluid by mouth receive supplements via a tube directly into their stomach).

People could access on-going healthcare support. The community nurse specialist told us that they were attached to doctors' practices and provided people and their families with psychological support and support with their medicines within their own homes. A key aspect of the community nurse specialist was to liaise with other health and social care providers, which included palliative services within the community. The service has an enablement team, which comprises of occupational and physio therapists, discharge liaison nurses and social workers whose role is to promote people's independence and where appropriate to support people to return to their home.

The service has clinics which operate within the day therapy facility, the role of the clinics is to provide support to people with regards to symptom and pain management and is an important aspect of supporting people to maintain their health and receive on-going care and support.

Is the service caring?

Our findings

People we spoke with and their relatives were very positive when we asked them whether they were treated with compassion and kindness. They told us how the staff listened and talked to them to ensure their preferences and views were considered when planning their care and treatment. People's comments included, "The most caring and inclusive environment, it's solely about the patient. They [staff] have the time, and do a brilliant job." And "I didn't know care existed like this, individualised." One person told us, "I was upset the other day and five staff approached me to see if I was ok, so caring."

People accessing LOROS have access to services which provide support and counselling with regards to their emotional, spiritual and religious needs, which includes bereavement support before, during and after death. The Chaplaincy is made up of two Reverends who are employed by the service, who are supported by volunteer Chaplain's, which are representative of a range of faiths and include Hindu, Muslim, Buddhist and Greek Orthodox. The Reverend we spoke with told us that the strong links the Chaplaincy had within the wider community with representatives of different faiths meant that people within the hospice received the support they needed. They told us how they had met with relatives of people from different faiths, who had commented on the openness and how welcoming staff had been.

LOROS provides a counselling and bereavement service and part of their role is to contact relatives following a person's death, the service is available for as long as people feel it is necessary for them. Following a person's death on the ward, the next of kin receive a follow up phone call and a letter inviting them to the next 'Thanks Giving and Remembrance service'. These services are held three times a year at LOROS. They are also invited to the annual 'Light up a Life service', which takes place every year in December. Both these events provide the opportunity for the family to remember the person who has died.

The Reverend told us of the Services held at the hospice that took place to remember those that had died to provide support to bereaved families and friends. The Chapel has a Book of Remembrance and within the Chapel is a 'memory tree', made from carved wood and is used by bereaved families and friends to write a message on 'a leaf' which is hung from the tree. Part of the Reverends role in supporting people with their spiritual welfare had included celebrating life events such as performing wedding and baptisms.

A person we spoke with told us how they had been visited by the Chaplain, they told us, "I'm not particularly religious, however it was good to be able to talk about things and to understand why I was feeling as I did. It's having time to process information, without people telling you to 'keep your chin up' when it is sometimes the last thing you want to do."

Staff we spoke with told us they were able to provide care and support to people in a way they preferred as staff saw a significant part of their role was to get to know people, so that they could support them in a friendly and reassuring way. We asked staff how they recognised when people needed support. A member of staff told us, "Sometimes people are really chatty and you can see from their body language that they want your company and for you to spend time with them. Whilst on another day, when you approach the same person, they may just shake their head; we quickly learn through observation when people want time to

themselves."

Staff told us about the study day on spirituality they had attended, saying that it had helped them with their confidence and understanding of what spirituality was and how they provided this through their everyday interactions with people in their care. Staff said it was about understanding that, "We can't fix things, but we can be with them [people]."

People we spoke with told us that they had made decisions about their future treatment, which included an advanced decision with regards to the withdrawal of treatment. A person we spoke with told us, "The staff helped me and my family understand my options and decided that I would prefer to die at home. I've found it a relief to have those decisions made; now I can focus on other things." Staff we spoke with told us that people and their families were supported to talk about their wishes and that these were regularly reviewed as part of their care and treatment.

People's care plans were regularly reviewed and when treatment was withdrawn this was managed openly, with open discussions between the person, their family and the staff of the hospice. All aspects of people's treatment were reviewed by clinical staff and a care plan put into place that supported the person to promote a comfortable and dignified death. There was evidence of preparing for end of life care. We observed the MDT meeting which discussed the person's place of death and if the person was currently at their preferred place and if not what the service would do to achieve this.

We spoke with two people who received support from the community nurse specialist team, they told us that the staff had provided advice to them and part of their support was to access the day therapy facility, based at the hospice, which is where we met and spoke with them. They told us they used the services of the complementary therapy staff, which provided reflexology, they told us that spending time with others in a similar situation gave them 'permission' to be themselves, and not have to hide how they were feeling.

People have access to information about the services provided by LOROS, which are readily available throughout the service. The information provided covered a range of topics, which included practical support with finances, along with information about advocacy services, the services provided by LOROS and information of other organisations that provide support. The service in addition provides information booklets about specific health related conditions, which are used by the specialist services within LOROS, and are given to people as part of their consultation with health care professional to help them understand their health and its management. The hospice has produced leaflets relating to its Duty of Candour and how to raise a concern or complaint about the service.

The inpatient service has a ward which is made up of bays that accommodate up to four people; in addition there are individual rooms, which provide en-suite facilities. To promote people's privacy and dignity within the ward, each bed has a curtain screen which is pulled around when people are receiving care and treatment.

Visitors are encouraged to visit without restriction and the service provides information on its website about visiting, which includes the need to sign in at reception to ensure that the person wishes to be visited, before people are taken through to the ward.

We spoke with staff to find out what arrangements were in place which made sure that the body of a person who had died was cared for in a dignified way. We were told that when someone is dying or has died then relatives and friends are encouraged to spend time at the person's bedside. Where cultural and religious needs had been identified by the person, then this is supported, which included the caring of the deceased,

in preparing the body. Staff told us that they had a good working relationship with the coroner, which when necessary, enabled them to certify a person's death in a timely manner so that families could register their relative's deaths and make the appropriate arrange

Is the service responsive?

Our findings

People told us that staff were available when they needed them, people's comments included, "Yes buzzers are answered quickly" And "My pain is dealt with, and sickness is dealt with in minutes."

A person told us, "The doctors are incredible." Whilst another person told us, "The doctor's spend so much time with you, one day they were in here over an hour explaining things; they got right down to the floor and sat and explained."

We were present for the MDT meeting as part of our inspection. The team discussed 12 people who were in-patient at the service along with discussions about people discharged home and those who had recently died.

The meeting discussed all aspects of people's needs, the physical, psychological, social, financial and spiritual needs of the people. Members present knew the people well and it was apparent they were a close working team, working for the good of the person at its heart. Staff were mindful of the families' needs and considered alternative therapies for a couple of the partners of the people within the hospice. Family support was discussed and social needs, the social worker discussed extra benefits that may be available. Sensitive scenarios were discussed; which included one person with complex family dynamics.

The service's doctors operated an on-call service 24 hours a day to ensure staff had access to advice at all times, this also included offering advice to community colleagues including GPs and care home staff. This enabled the service to promote people's welfare by responding to people's changing needs and provide support in the management of their symptom's and pain.

We were present at the staff handover, where people's care and support was discussed between staff. We found each person was discussed, which included reporting on those people who had died. People whose condition had deteriorated were also discussed to ensure people's preferred place of death was ensured, where possible. We found staff to have great empathy for people and families and knew them well.

There were care plans for each person, which focused on all aspects of their care and support. All were detailed care plans and reviewed regularly. There were options for staff to make comments when acknowledging each care need. There was a range of additional care plans that could be adapted for each person to ensure each person received personalised care.

When a person's condition deteriorated then all care plans were reviewed and the focus of care was on supporting the person to have a dignified and pain free death with a focus on managing people's symptoms. Care plans were reviewed by a doctor and nurse, to ensure that staff were able to respond as the person's needs changed.

The service had identified planned improvements over the next 12 months within the PIR, which would enable the service to improve its services to people within the community. The PIR referred to one project

the hospice was piloting called VALE (Volunteer support At Life's End). The project had recruited and trained a number of volunteers to support people in their own homes during the last hours or day of life, supporting other staff to enable the person to remain within their own home if they wish.

Complaints were managed effectively and used to improve the service for people. A complaints policy was in place and there were leaflets and information displayed to inform people using the service and their families how to raise a concern or make a complaint if they wish to. One staff member we spoke with told us, "We don't receive many complaints; most concerns are dealt with immediately when brought to our attention." Records of complaints we looked at showed the service responded quickly to complaints raised. People told us they were aware of how to make a complaint and who to raise their concerns with. They said that they felt their concerns would be taken seriously and acted upon. Where a complaint was raised, this was passed to the registered manager and thoroughly investigated. A response letter was sent and a meeting was offered to discuss the concern and its outcome. The Board of Trustees were provided with information about all written complaints. A register of all complaints/concerns received is discussed at the bi-monthly Clinical Governance Meetings, which membership includes members of the Board and CCG quality leads. Any learning points or recommended changes to practice are agreed and cascaded to the appropriate staff members for implementation.

Is the service well-led?

Our findings

People and their families were all very positive about the care provided and the management of the hospice services. "Everyone here is so very welcoming, it's a first rate service that enables people to talk about what is important to them.", They went onto say, "We have been asked for our views about the service and are confident that comments are used to develop the service. We have seen information about other people's views which are on display and how LOROS has responded."

People who used the service told us that all staff, regardless of their role were friendly, kind and supportive and gave a sense of calmness to the service. Our observations demonstrated that staff across all areas within the service were motivated and enthusiastic and committed to providing a high quality service to people and their families.

A health care assistant told us that they had been encouraged by a member of the senior management team to apply for different roles within the organisation, which had resulted in them taking on the role of health care assistant and working to attain a Diploma in Health and Social Care, they told us, "I feel my voice is valued." They went onto say that they found the doctors to be approachable and that they felt part of a team.

Staff were aware of the visions and values of the service, one person told us. "We care for patients and provide what the patient wants and if we can do it, we will." Whilst a nurse told us, "LOROS is aimed at giving good quality care in collaboration with other agencies." And when we asked if they believed they achieved this, they went onto say, "You only have to look at the compliments, legacies, cards and volunteers. People want to give something back."

Volunteers were an important part of the service and provided support in a variety of ways. Volunteers who were trained provided group support for bereaved people and visited people within their own home as part of the home visiting service. Volunteers were also used to support fundraising events and activities as well as supporting in welcoming services by working on the reception desk, the snack bar and shop.

There was a clear management structure with senior staff allocated lead roles, which included a registered manager for the service. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards.

The service is timely in sharing information with external organisations, including the CQC to ensure transparency. The PIR provided information about the service and its plans for improvement over the next 12 months. Since the submission of the PIR planned improvements are underway and the registered manager provided us with an update. Improvements have included developing the role of housekeeping and volunteer staff within the service, to improve people's care and develop opportunities for staff to develop their skills through new opportunities and a revised induction and training programme.

LOROS actively seeks to promote a positive culture that is open and inclusive to people who use the service and their relatives, the staff who work at the service and the wider community. The service provides a 24 hour advice telephone line, which is accessible to everyone, including health care professionals. In addition the service has developed links with health and social care providers and professionals to promote good practice through training and learning events. This enables the service to continually review the quality of the service it provides and to bring about improvements. The provider also promoted learning and development within the wider health and social care community. The hospice offered placements for trainee doctors, nurses, occupational and physio therapists students and trainee social workers. LOROS has plans to extend the service, which will include a new building to increase its day therapy facility, out patient service and will provide a professional development centre. The centre will be used by staff within LOROS and within the wider health and social care community.

The service is committed to the providing and sharing of information about the services it offers and does this in a variety of ways to reach as many as people as possible. Information is provided within its magazine, which is available at the service and via its website. Information about LOROS is also available through social media and advertisements within the local press about fund raising events and open days. The 'Care We Provide leaflet' has been used externally to raise awareness of the services provided within GP's, hospitals and organisations whose focus is on providing care to people within specific groups such as those living with cancer.

The service team had strong links to the local community. A person who accessed the community service told us how they had taken part in the 'reaching out programme', where children from a local school had visited the service over several weeks, spending time with people using the service. The purpose of the project was to raise awareness of the work within hospices and to raise awareness within children of death and dying. The project had included staff from the service visiting the school to raise awareness. A participant in the project told us, "It was lovely to spend time with the children, children always make me smile. The children were able to see us as people and learned to understand how our health affected our ability to carry out day to day tasks. It also taught them that we all can have a laugh and smile." The project had been initiated by the hospice and had plans to continue, involving other schools to further promote children's understanding of the role of hospice services.

The service provided extensive opportunities for families and staff to shape the services, which included the Patient and Carer Participation Group (PCPG) whose role is to share views and experiences to help improve LOROS care services. One aspect of the PCPG is to influence the service through the carrying out of surveys, known as the 'five senses'. Representatives from PCPG gathered information from around the hospice using sight, sound, smell, touch and taste and included observations of areas within the hospice. The group taking part in the five senses survey provided feedback as to their observations, which are used to develop an action plan where improvements had been identified. A survey carried out in the main ward found many positive aspects with regards to the attitude and friendliness of staff and the welcoming environment. Observations were noted where action could be taken to bring about improvements. It had been noticed that cooking smells travelled from the kitchen onto the ward, this was rectified by ensuring doors to the main ward were closed during the morning, until lunch was served. This was in part to support people who were experienced nausea.

The PCPG in addition were involved in the development of new literature and revised existing LOROS information leaflets, to ensure the information is targeted and relevant to people who use the service and their relatives. One person we spoke with told us, "I have looked at the leaflets and it's a good starter point for information".

People's views are sought annually about the service, which included a patient satisfaction questionnaire along with a survey which seeks the views of bereaved families. Results from the patient satisfaction questionnaires were analysed and used to develop the service with an action plan which is monitored by The Board of Trustees and senior management. The results of the questionnaires showed that people were given information about LOROS and that they had found the information easy to understand and had been helpful. There was a high level of satisfaction in the services received. The action plan had identified areas for improvement, which included the need to further promote information as to how people could raise concerns about the service. The initial response was to identify whether this applied to specific areas of the service. As a result the response was targeted, a laminated sign by the complementary therapy room was displayed and a more proactive approach by staff in raising people's awareness was discussed with staff.

A leaflet entitled 'tell us what you think' provides people with an opportunity to provide feedback on hospice services and the community nurse specialist team. The results of these were published monthly and displayed within the hospice, and include additional comments and the action being taken to address people's comments so that people using the service and visitors had up to date information about how the service was developing. The comments written by people for January 2016 included, 'A wonderful environment matched by the caring, understanding and knowledgeable help from the lymphoedema nurse [nurse's name]. I cannot praise her enough.' 'Everyone has been so caring to my whole family, we are going through an awful experience, your staff are making it easier and helping us cope.' One person commented that 'I realise there is a funding problem, but more appointments for the lymphoedema service would be useful.' The service had responded by providing a response detailing that the service was currently working with external health care providers to further develop the service. The aims and objectives outlining what people using the service and families should expect from the service and the day therapy and inpatient ward area along with posters outlining the different uniforms worn by each member of the nursing team.

We spoke with the manager of the Lymphoedema (a condition where fluid builds up and causes swelling) service who told us how they had undertaken a pilot project with a local CCG. The project had identified how the service provided to people with the condition could be improved so that people could access the specialist treatment they need more quickly. They told us how they supported colleagues within health centres to identify and treat people with oedema by providing training. This collaboration with external services evidences the commitment of the service to promote good practice and share knowledge to improve services within the wider community for people.

The service has introduced 'cards' which are called 'small things make a big difference', which are being used as a tool to gather people's views. We looked at some of the cards which had been completed, which identified where people had felt staff had made a difference. The comments written by people in the month prior to our inspection included, 'The staff were fantastic, but the food was cracking! Good selection, well cooked, always hot, well done team.' 'Very friendly greeting and could not do enough to make me feel at ease, genuinely thoughtful and kind in a professional way.' 'Being involved with the decisions about my care and treatment really helped me to understand what was likely to be happy to me.'

The Chief Executive spoke with us about the governance of the hospice and the role of The Board of Trustees, whose members have specific areas of responsibility for which they oversee. They spoke of their development plans which had a focus on raising the presence and awareness of LOROS within the community, through the provision of a mobile resource. That can be used to deliver aspects of care and also provide information and support to people across all areas of the local community along with the development of volunteer led, well-being centres attached to LOROS retail premises to improve the accessibility of services.

The Board of Trustees has an active role in the leadership of the service and meets six times a year, providing clear directives to enable the service to work well. The LOROS website provides information about members of The Board of Trustees, and their role within the service. Senior management have the responsibility for running the service, under the direction of The Board of Trustees. The Chief Executive, Director of Care Services [registered manager] and the Lead Clinician attend all board meetings; this promotes good governance as there is an open and transparent system in place which reviews all aspects of the service provided.

LOROS produces an annual quality account, which provides information as to the services priorities for the next twelve months, along with a progress report on the previous year's priorities. The report includes information provided by people who have used the service, which have been gathered through questionnaires, the involvement of people who use the service and their relatives in the services development along with information gathered from complaints and compliments. Clinical audits are monitored by the services clinical governance group and the Board, and are accessible to external agencies, which include the CCG and the public through its website.

The service had an annual clinical audit programme for the period 2014-2015, 122 clinical audits were completed during this period covering medicines management, pain management, dignity and respect, end of life care, nutrition and hydration, consent, chaplaincy, resuscitation decisions, pressure ulcer management and safeguarding. Bi-monthly audit presentations took place for all staff and a quarterly clinical audit newsletter was produced and distributed to hospice staff. An example as to how audits influenced and developed the service could be evidenced with regards to safeguarding. A person had been employed for the purpose of leading on safeguarding and to further develop policies and procedure and staff awareness. With regards to pressure ulcer management, LOROS has been involved, along with other health organisations within Leicester, Leicestershire and Rutland to develop a consistent approach to the management and recording of pressure ulcers, with a view to effective management and the reduction in the number of pressure ulcers in different care settings.

We found the Chief Executive and the Registered manager had a pro-active approach to promoting people's safety which was discussed and shared and used to ensure the service was safe for people to use. A clinical governance group met every eight weeks which was chaired by the lead clinician or director of care services, to ensure that potential risks and the safety of people was openly discussed and shared to develop the service and improve the outcome of people's care. The group discussed audit results, safeguarding issues including deprivation of liberty authorisations (DoLS), mandatory training, medical devices alerts, serious incidents, pressure ulcers, infection prevention, nutrition and hydration needs and complaints. Clinical policies and guidelines were also discussed for example standing operating procedures of the management of controlled drugs, this showed that the service and its staff took people's safety seriously and systems were in place which monitored its effectiveness.

The service carried out a range of audits chaired the Lead by their clinical governance lead. A clinical audit newsletter had been developed which was sent out to all staff. These contained information about audit findings. The service is transparent, sharing the outcome of its audits on the LOROS website which is accessible to the public. The infection prevention lead nurse told us they visited the ward regularly and undertook infection control audits. The audits included hand hygiene practice and ensuring patient equipment was cleaned and labelled. An annual infection prevention and control programme had been developed for 2015-2016, to enable the service to comply with the Health and Social Care Act 2008 Code of Practice on infection control. An infection control group met bi-annually and reported to the clinical governance steering group.

The service works in partnerships with other organisation to make sure they are following current practice and are providing a high quality service. LOROS is using a nationally recognised outcome tool for hospice and palliative care services to find out from people using the service and their families how they rate their physical and psychological symptoms as well as family concerns. The idea is to use the information gathered to see what support is needed and whether the help provided is effective.

The provider strives for excellence through consultation, research and reflective practice as part of its commitment to improving end of life and palliative care. Staff were encouraged to take part in research projects to support and inform improvements in the care people received when living with life-limiting conditions. The provider also contributed to university based research. Information was available so people were aware they may be invited to take part in research projects. One person we spoke with told us, "They have spoken to me about research and we want to take part, it's good to know that your experiences can influence the care of others."