# St Rocco's Hospice

## Quality Report

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Date of inspection visit: 19 November to 20 November 2019
Date of publication: 28/02/2020

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 | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

## Overall summary

St Rocco's Hospice is operated by St Rocco's Hospice, a registered charity. Staff provided care to adults 18 years and upwards from across the Warrington area. It has one inpatient ward with 10 single bedrooms.

The hospice offers 30-day therapy places at its Vitality Centre which is located within the hospice. The centre offers care, support and activities on an outpatient basis. Therapies include complementary therapies, alongside physiotherapy and occupational therapy services. Craft sessions and social activities are also available.

In addition, other services provided are:

# Summary of findings

The Hospice at Home team who provide a dedicated home-based sitting service to enable patients to get home from hospital or to enable and support death at home.

The hospice operates a telephone advice line 24 hours a day, seven days a week for hospice patients and a designated telephone support line for GPs Monday-Friday.

A counselling and emotional care service provides bereavement, counselling and spiritual support to patients and their families.

We inspected this service using our comprehensive inspection methodology. We carried out a short-announced inspection on 19 and 20 November 2019.

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

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

**Services we rate**

**Our rating of this service stayed the same. We rated it as Good overall.**

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

We found areas of outstanding practice:

- The service had direct access to electronic information held by community services, including GPs. This meant that hospice staff could access up-to-date information about patients, for example, details of their current medicines.

We found areas of practice that require improvement:

- Risk assessments were not always updated every 72 hours in line with the hospice's procedure

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

# Summary of findings

**Ann Ford** **Deputy Chief Inspector of Hospitals (North West)**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Hospice services for adults** | Good  | The hospice provided care to adults requiring specialist palliative and end of life care following a diagnosis of a life limiting condition. The hospice has 10 inpatient beds, a dedicated day centre service and provides outpatient appointments.<br>We rated this service as good overall with all key questions rated as good. |

# Summary of findings

## Contents

Good

**Services we looked at**
Hospice services for adults.

# Summary of this inspection

## Background to St Rocco's Hospice

St Rocco's Hospice is operated by St Rocco's Hospice, a registered charity. The hospice opened in 1985 in a former location and moved to this location in Bewsey, Warrington in 1999. The hospice primarily serves the communities of Warrington.

The hospice has one inpatient ward with 10 single bedrooms. In addition, the service offers 30 day therapy places at its Vitality Centre which is located within the hospice. The centre offers care, support and activities on an outpatient basis.

The hospice is funded by income generated through its fundraising and voluntary donations, and through some additional NHS funding. The hospice works collaboratively with the local clinical commissioning group to develop integrated specialist palliative care services.

The hospice previously had two registered managers, who shared the role, one was the hospice clinical outreach manager and the other the inpatient manager. Both managers had been in post since March 2019.

At the time of our inspection the Clinical Lead for Outreach Services had just taken on the sole role as the registered manager and was registered with the CQC in March 2019. The former In Patient Unit manager had de-registered.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, a pharmacy inspector and a specialist advisor with expertise in hospice care. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

## Information about St Rocco's Hospice

The hospice is registered to provide the following regulated activities:

- Personal care
- Treatment of disease, disorder and injury
- Diagnostic and screening procedures

During the inspection, we visited the inpatient ward, the Vitality centre/day services and we spoke with staff from the Hospice at Home service. We spoke with 40 staff, including a consultant in palliative medicine, registered nurses, health care assistants, reception staff, medical staff, trustees, and senior managers. We spoke with six patients and five relatives. During our inspection, we reviewed six patient records and four prescription charts.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in November 2016, when we found that the service was meeting all standards of quality and safety it was inspected against and was rated as good.

The hospice provides several services including:

Inpatient service

St Rocco's had one inpatient ward providing 10 inpatient beds. The inpatient facilities were available 24 hours a day, seven days a week. Staff provided care to adults 18 years and upwards requiring access to supportive specialist palliative care following a diagnosis of a life limiting condition with a cancer and/or non-cancer diagnosis.

Day services

# Summary of this inspection

The Vitality Centre which is registered for up to 30 day patients at any one time and includes access to:

Out-patient clinics led by a team of doctors

Physiotherapy/Occupational therapy (including sessional based programmes to support management of breathlessness, anxiety, fatigue)

Complementary therapies (aromatherapy, reflexology, acupuncture, massage)

Diversional therapies (relaxation, yoga, art therapies).

Counselling and emotional care services (bereavement/ counselling/spiritual support).

Social worker for practical advice/assistance with arrangements for managing care at home and Hospice at Home services.

Weekly drop in sessions for information and signposting (coffee mornings/ bereavement café)

Community Engagement Projects (Choir/Gardening)

The Hospice at Home team provide a dedicated home-based sitting service to enable patients to get home from hospital or to enable and support death at home. The team work closely with the local Continuing Health Care Services to finance night/day sits via personal health care budgets. The home team received referrals from district nurses or other healthcare professionals and worked closely with community nurses and GPs to support people in their own homes. In addition, the team manages a volunteer visiting service in the community.

Rocco's 'on your doorstep'- a volunteer befriending service where volunteers were matched to people and that people living in the community were supported to have a chat with a befriender, be accompanied to appointments and volunteers could do errands or go shopping for the person.

RocON -an innovative project working with schools from across Warrington to help children to learn more about St Rocco's, whilst helping them to explore issues around loss and dying. This was led by an employed staff member and supported by a team of volunteers including patients.

Activity (August 2018 to July 2019)

- In the reporting period August 2018 to July 2019 there were 1009 inpatient episodes of care recorded at the hospice.
- In the reporting period August 2018 to July 2019 the hospice had 120 patients who died in their care.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

No never events

No serious injuries

One incidence of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

One incidence of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

Two complaints

Services provided at the hospital under service level agreement:

- Maintenance of medical equipment
- Provision of medicines and drugs
- Pharmacy time and haematology
- Medical staffing
- Medical professionals-a GP advice line

The hospice also has a service level agreement with the local Clinical Commissioning Group for provision of specialist palliative care services.

# 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?

Good

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

- 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 managed clinical waste well.
- 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.
- 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.
- Staff kept detailed records of patients' care and treatment. Records were clear, legible, 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 and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient's safety alerts were implemented and monitored.

However;

# Summary of this inspection

- Risk assessments were not always updated every 72 hours in line with the hospice's own procedure.

## Are services effective?

Good

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

- The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service 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.
- 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.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Key services were available seven days per week to support timely patient care.
- Staff gave patients practical support to help them live well until they died.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

## Are services caring?

Good

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

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

# Summary of this inspection

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

## Are services responsive?

Good 

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 specialist palliative care service when they needed it.
- 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.

## Are services well-led?

Good 

Our rating of well-led stayed the same. We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

# Summary of this inspection

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

# 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 | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

Good

# Hospice services for adults

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

## Are hospice services for adults safe?

Good

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

**Mandatory training**

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

The mandatory training was comprehensive and met the needs of patients and staff. All staff completed annual mandatory training by eLearning and attended annual mandatory dedicated in-house or external training programmes as required by their specific roles. Staff received and kept up-to-date with their mandatory and statutory training. The mandatory training programme for staff ensured relevant knowledge and competence was maintained and updated throughout their employment within the organisation.

Mandatory training for all staff included, equality and diversity, health and safety at work, conflict resolution, infection prevention and control, manual handling, basic life support and intermediate life support for adults.

Statutory eLearning training for all staff was regularly monitored for compliance. The mandatory training compliance in November 2019 was 89.5%. The hospice e-learning target was 90%, however we were told by the manager that 85% was acceptable compliance.

There was a structured induction programme for staff to ensure they had the skills needed for their roles.

Managers monitored mandatory training and alerted staff when they needed to update their training.

**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.**

Staff received training specific for their role, both face-to-face and online, on how to recognise and report abuse. Data for September 2019 showed that 88% of staff requiring adult safeguarding level one training were up to date and 80% of staff requiring level two training were up to date. We were told a plan was in place to address the level two training for those staff who had not yet completed this. Staff told us that in addition to the training, if they were concerned about anything they could refer to the safeguarding policy on the hospice company IT drive and they could always approach one of the two safeguarding leads for guidance and support."

Staff were aware of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The service had nursed patients from different race and religious backgrounds, they had facilitated a same sex marriage and developed relationships with local charitable organisations, for example a homelessness charity.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could explain the

safeguarding referral process and were able to give examples of when they had made safeguarding referrals. A flowchart and contact numbers were displayed for staff on how to raise a safeguarding concern.

Staff followed hospice guidance for safe procedures for children visiting the ward.

We saw evidence of the Disclosure and Barring Service (DBS) checks that had been made on staff and volunteers.

**Cleanliness, infection control and hygiene**

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Nursing and care staff said the cleaning team kept the premises clean and responded promptly when extra cleaning was needed for example, to deal with liquid spills. Staff and patients said the hospice was always clean and tidy.

Staff followed infection control principles, including the use of personal protective equipment. We observed staff in clinical areas were 'bare arms below the elbow'.

The hospice had monthly infection prevention and control surveillance audits which were submitted to a local trust who carried out annual infection control audits. The data was also reported to a clinical commissioning group at three monthly meetings.

In the previous 12 months the hospice had reported the following healthcare acquired infections; seven urinary tract infections, two chest infections, one Meticillin-resistant Staphylococcus aureus (MRSA), and one incidence of Clostridium difficile (c.diff). The report had not identified any specific issues.

Staff told us they cleaned equipment after patient contact and labelled equipment to show when it was last cleaned; however, we observed some equipment without stickers. We raised this with management, who ensured that staff put stickers on cleaned equipment. The "I am clean" labels on the ward and throughout the hospice were dated and signed to enable staff to identify when the equipment had last been cleaned and if it required another clean before use.

Clinical areas had hand washing facilities, and staff carried hand sanitiser with them as we noted there was not access to hand sanitiser in patients' rooms.The hospice infection prevention and control policy stated, that 'all staff have access to suitable gel available at the point of care'.

Staff told us that patients with active infections were nursed in isolation and warning signs were used to inform staff and carers of the potential infection risk.

The service generally performed well for cleanliness. The hospice scored 97% in an infection control audit carried out in May 2019 by a local trust. The action plan had been addressed at the time of this inspection. We saw the hand hygiene observational audit from November 2019 where the staff scored 100%. All eight staff observed were compliant with 'bare arms below the elbow' during this audit. Staff told us they always had enough supplies of personal protective equipment.

The hospice completed regular water testing for legionella and bacteriological infections. There was a policy in place to action any positive results that may occur. This policy included notifying external agencies.

At the time of the inspection, the hospice did not participate in the Patient-Led Assessments of the Care Environment (PLACE) programme. The manager acknowledged they would address learning or actions that the hospice needed to take.The aim of the PLACE programme is to allow healthcare providers to undertake an assessment to a standard national format of a variety of non-clinical aspects of the care they provide.

**Environment and equipment**

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

The hospice had committees that reviewed the environment and equipment used across the service.

The service had suitable facilities to meet the needs of patients' families. Facilities included a relatives' room where they could stay over. In addition, there was a quiet room for patients and relatives for difficult conversations.

Visitors to the in patient unit could access drinks and snacks in the unit's lounge area and could make a donation via an honesty box.

Patients were provided with call bells so that they could summon assistance from staff. Monthly checks by zones of nurse call equipment were maintained. The service used portable oxygen cylinders. Oxygen cylinders were stored and managed safely. Syringe pumps used to continuously administer pain relief were serviced and maintained. The service had enough suitable equipment to help them to safely care for patients, such as bariatric equipment.

Staff carried out daily safety checks of specialist equipment, including resuscitation equipment. A defibrillator was centrally accessible if needed for all areas. Equipment required in the event of a clinical emergency for example, suction machines, adrenaline and anaphylaxis kit, pulse oximetry and blood glucose monitoring machines were kept in clinical rooms on both the inpatient unit and Vitality Centre for staff to access.

Staff disposed of clinical waste safely. Clinical waste was appropriately segregated. Sharps boxes were appropriately stored, and we saw staff following good practice when disposing of sharps. For example, they ensured the date of opening was recorded and sharps bins were disposed of before they became too full. Clinical waste outside the building was securely stored while awaiting collection by a clinical waste collection service. There were contracts for the disposal and removal of clinical and non-clinical waste.

We spoke with the facilities manager who confirmed the hospice had a maintenance system to log all jobs which required action and to plan routine servicing and maintenance. A health and safety audit in July 2019 showed the planned preventative maintenance regime was well managed. Equipment, including housekeeping, catering, medical appliances and the premises showed the condition, date of last and next service and its location. These were all being monitored, and service dates were met for both major and minor equipment. The legal compliance items; the boilers, gas appliances, electrical devices, hoists and slings, lift, generator and fire safety equipment had service dates which were met.

The audit showed that fire safety checks had a good history recorded and a fire service familiarisation visit had not raised any issues. The lighting protection system was serviced, and fire detectors were being changed in rotation and according to priority. We saw the documentation to show that tests of the fire alarm were completed on a regular basis to ensure it was in safe working order.

The hospice had access to the community loans department to arrange the supply of equipment in patients' own homes.

**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 completed risk assessments for each patient on admission / arrival and updated them when necessary if a patient was deteriorating or in the last days or hours of their life and used recognised tools. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This early warning score for inpatients assessed patients' observations and identified early signs of deterioration to enable timely treatment for a medical review or active treatment.

We saw staff completed comprehensive risk assessments for patients and these were documented in the patient records as part of the personalised care plans. These risk assessments included falls risk, skin integrity and wound assessments, moving and handling needs, nutrition, swallow, pain assessments and any risks specific to the individual patients' condition. Additional risks included the patient's resuscitation status and whether they were to be resuscitated in the event of a cardiac arrest and patients discharge arrangements.

Staff were meant to update risk assessments for patients every 72 hours; however, in three of the six patient records we reviewed, the risk assessments had not been

updated but the care plans had been reviewed so that the care provided covered all aspects required. We raised this with the manager at the time, who assured us that action would be taken to make sure that risk assessment records were updated when they should be.

At multidisciplinary meetings we heard risks being discussed before staff visited people's homes. This meant plans to mitigate these risks were discussed prior to staff going out and the staff member was aware of any concerns before entering the patient's home. An example included staff acting in a timely way where a risk to the patient's skin integrity was high and they required a pressure relieving mattress.

When patients were discharged from the inpatient unit we saw discharge plans were completed and shared, with the patient's permission, with other care agencies, such as a care home or the patient's GP or district nurse. This reduced the risks of any gaps in care provided.

If a patient was identified as being at risk of falls, the staff described appropriate action they could take to reduce the risk of falls for example; footwear, bed rails, additional monitoring and access to the local hospital falls team to see if additional equipment may be appropriate.

Staff knew about and dealt with any specific risk issues. Nursing and medical staff understood their responsibilities around sepsis identification and sepsis care. Sepsis awareness was included during mandatory training and clinical staff had completed this training.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We attended a shift handover from night staff to day staff and noted information about the patients' medical, social and psychological needs were shared, ensuring a holistic approach to care. Staff demonstrated clear knowledge of patients' care needs and any specific risks facing them. The handover included any updates about family support that would be important to a patient.

In the event of a patient requiring transfer to an acute setting for appropriate management, the nursing or medical staff would arrange this by contacting the emergency services.

Each patient had a personal emergency evacuation plan to ensure up to date information was readily available in the event of emergency services being required.

**Staffing**

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

The care team included experienced registered nurses, a social worker, medical staff, physiotherapist, occupational therapist, counselling staff, heath care workers, with previous relevant experience, and volunteers.

From a review of the duty rotas and conversations with staff, the ward always had two registered nurses on duty. The manager told us, and staff confirmed that the manager assessed patient dependency to adjust staffing as necessary.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. A dependency assessment was carried out for each patient on admission to the inpatient unit and reviewed when there was a change in their condition.

The ward manager could adjust staffing levels daily, according to the needs of patients. Daily clinical meetings were held to review patient dependency for the Vitality Centre patient attendances and the inpatient unit admissions to ensure correct number and skill mix of staff were available. Safe staffing was on the agenda for the Quality and Safety Group and the Health and Safety Subgroup, where staffing was escalated and presented to the trustees.

Analysis of duty rotas and interviews with staff assured us that the number of nurses and healthcare assistants matched the planned numbers. The number of allied health professionals was calculated to enable specialist support when needed on the ward. We were told by members of the allied health professional team that their workload was manageable.

At the time of our inspection, the inpatient service was 54 hours a week short of registered nurses despite efforts to fill these posts. The service was covering the shortfall with current staff carrying out additional shifts, and additional health care support worker hours.

The service had a low number of bank staff available and was trying to recruit more. Despite needing agency staff at the time of the inspection, we were told that the service had not used agency staff for several months. Managers told us that agency staff were rarely used for the inpatient unit. Extra shifts were usually offered to part-time staff to maintain staffing levels, or staff from the Vitality Centre worked additional shifts on the ward, to provide some consistency.

Staff worked well to support each other and to ensure that they had time to give compassionate care. There was an on-call manager out of hours to escalate any staffing concerns that arose.

Managers made sure all bank, agency and volunteer staff had a full induction and understood the service. Some volunteers provided support for clinical services. On appointment all volunteers received a generic induction followed by face to face and/or on the job training specific to their role profile.

**Medical staffing**

The hospice had access to advice and support from one of four contracted doctors, including two specialist consultants, who provided 24-hour medical advice cover for staff by on call rotas, 365 days per year.

As part of their responsibilities, there were regular consultant ward rounds on the ward. Staff confirmed they could always access the medical support they required, including during the night. Two of the medical staff were employed by the hospice while the other four medical staff were on contracts from the NHS.

A professional advice line was available for GP's for an hour a day. Outside of this, GP's contacted the inpatient unit or Vitality Centre to access nursing and medical advice and support.

**Records**

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

Patient records were comprehensive, and all staff could access them easily. The service used electronic patient records, however some paper records were still used. Paper records kept at the patients' bedside included; medication charts, the early warning score chart to monitor a deteriorating patient, and a care chart. We reviewed six patient records, and each contained all the appropriate information. Records could only be accessed by those who had authority to do so.

The hospice used a computerised patient database. Information sharing agreements were in place. We saw evidence of clear record keeping of the weekly multi-disciplinary meetings, daily single point of access meetings and three discharge letters which all provided patient information. Consent was gained before any sharing of patient information on the electronic record.

Electronic records were stored securely. We observed staff locking or logging off computers when not in use. This protected patient's privacy and was in line with the Data Protection Act 2018 and the General Data Protection Regulations 2018.

**Medicines**

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The hospice used bespoke paper medicines administration records for inpatients.

Records demonstrated that medicines were prescribed and administered safely. Prescribing followed national palliative care guidance, patients' allergies were recorded and there were no administration gaps for regular medicines.

Times were recorded for 'when required' medicines to ensure a safe gap between doses. We noted that as there were only a small number of medicine spaces on each page, this meant some patients had two or three current medication records. Due to frequent rewrites because of

changes in prescribing there was the potential risk of transcribing errors. The hospice was monitoring electronic prescribing which another hospice had recently introduced to think about for the future.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients' medicines were recorded and reviewed on admission by clinical staff. There was evidence that a pharmacist provided advice and guidance to patients and staff to keep patients safe.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The dedicated medicines room was secure, and access was restricted to appropriate staff. The environment was monitored, and controlled drugs were checked daily in line with the provider's policy. Syringe driver charts we reviewed followed the prescription and all rates we checked, showed administration was as prescribed.

Outpatient prescription stationery was stored securely, and use was monitored.

Staff followed current national practice to check patients had the correct medicines. Staff followed national and local prescribing formularies and charts were checked to ensure compliance. Non-medical prescribers received regular training and supervision. The hospice provided expert advice to staff providing care in the community. Advice was documented and checked by senior staff. Training was planned in response to any emerging themes.

Nursing staff received medicines training and competency checks and regular medicine administration record audits were undertaken to ensure patients received their medicines safely.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Information about medicines and safety alerts were shared with staff via notices, communication book entries and at handover to ensure all were up to date. Senior staff attended local intelligence network meetings in the region regarding controlled drugs 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.

Staff knew what incidents to report and how to report them. All incidents were reviewed, addressed, collated and reported to the bi-monthly Quality and Safety subcommittee meeting.

Staff told us they would write a reflection on any incident and describe the incident. One example given was the late administration of a controlled drug. This was shared with all staff via an email for learning.

The service monitored clinical incidents and rated the level of harm accordingly. Staff reported serious incidents clearly and in line with the provider's policy. The service had an incident reporting policy which was in date and was not due for review until 2022. The policy clearly set

out the roles and responsibilities of staff and included clear guidance on compliance with statutory requirements, including when duty of candour was applicable.

In 2018 and 2019 the service had reported no never events on the ward or in the community care setting for end of life care. 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 have happened for an incident to be a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We saw evidence that duty of candour had been completed accordingly. Staff had evidenced duty of candour on completed incident forms, and in patients' electronic records highlighting when and who was spoken with and which staff member spoke with them. Letters were sent out as per hospice policy.

Good

# Hospice services for adults

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Staff told us managers debriefed them after any serious incident and that they felt supported. Staff reported serious incidents clearly and in line with policy. There had been one serious incident reported since August 2019. We reviewed the incident and found that the manager had investigated it thoroughly, had involved the patient's family in the investigation, and that appropriate actions had been taken to reduce the risk of subsequent similar incidents. The clinical lead told us they had improved their links with the equipment stores at the local hospital following a review of improving patient care in relation to patient falls.

Staff told us they met to discuss feedback from investigation of incidents and to look at improvements to patient care. Changes had been made because of feedback. A notable change which had improved patient care was the single nurse administration of oral opiates, which had saved nurses time. Additional staff were now undertaking training for this.

## 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. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care and treatment were evidence-based and staff managed end of life care in accordance with the National Institute of Health and Care Excellence guidelines and standards, NG31 care of dying adults in the last days of life.

St Rocco's worked closely with local trusts and other local services, including, a palliative care network, ensuring the needs of the local community were met, working on an integrated model, "Transforming Palliative and End of Life Services" with other health and social care providers.

There was clear guidance for staff to follow. We reviewed six policies and found they were current and in date.

In 2014, the Department of Health launched a new approach to the care of people who were dying, based on the needs and wishes of the person and those close to them. The Five New Priorities for Care replaced the Liverpool Care Pathway, creating the basis for caring for someone at the end of their life. During the inspection, the six patient records we reviewed included the five priorities for care. We found that all five priorities (recognition of dying, sensitive and effective communication, involvement in decisions, emotional needs being met and individualised care plans) had been met. Patients had clear, personalised care plans that reflected their current health care needs. The care plans were evaluated and reviewed regularly by the nursing team and further reviewed at daily clinical meetings and weekly multi-disciplinary team meetings.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed patients', relatives' and carers' holistic needs being discussed at ward rounds. Emphasis was placed on the spiritual wellbeing of patients and the staff arranged for religious leaders to attend the hospice if this was the patient's choice.

The hospice participated in a range of audits; including audits of medicines management, patient safety, infection prevention control, National Institute for Health and Care Excellence guidance and symptom control. Action plans and updates were fed back to the clinical governance meeting. Audit results were shared with staff. Recommendations from the audits were incorporated into the action plan and were monitored at bi-monthly clinical governance meetings.

In the Vitality Centre, St Rocco's used various tools to support patient-centred care, for example; individual

patient outcome scores (IPOS) which were used to guide patients to assess their own priorities. In addition, goals were set to sustain the individual's optimum quality of life. We reviewed six sets of patient care records and we found these to be individualised and contemporaneous. In the last days of life patients had an Individual Plan of Care (IPOC) which linked to the "Five Priorities of Care for the Dying Person". We saw that medical and pharmacy staff had contributed to the records as necessary.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The hospice catering team provided nutritious, homemade meals, taking into account the cultural and religious needs of patients as required.

Any allergies and/or dietary requirements were discussed with the patient and the catering team to ensure their nutrition and hydration needs were met. To ensure transfer of information, a whiteboard in the kitchen department highlighted patients' special arrangements.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patients had water in reach and we observed staff assisting people to eat and drink.

Staff used an internal nutrition and hydration form as a screening tool to monitor patients at risk of malnutrition. We saw six completed nutritional assessments with evidence of daily reviews.

Specialist support from staff, such as community dieticians was available for patients who needed it.

Ward staff told us they maintained good mouth care for patients at the end of life and records we reviewed reflected mouth care was given.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. For patients living with dementia, the Abbey Pain Score Tool was available.

Registered nurses told us there was an individualised approach to pain relief at the hospice that was patient-driven. We saw evidence that staff took account of pain and acted upon this in the six patients' records we checked. Staff prescribed, administered and recorded pain relief accurately and the records we looked at showed this.

Staff took account of patient's preferences in relation to pain relief methods. There were different methods and approaches to pain relief which were available to all patients, for example patches, liquids and via syringe pumps. We saw in one record where alternative pain relief was prescribed and administered for a patient. Staff told us they always prioritised patients 'pain relief if they requested it.

**Patient outcomes**

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

The service participated in several audits and had an audit plan for clinical services which was reviewed at the clinical governance meeting. Examples of audits included medicines management, patient safety, infection prevention control and indwelling catheters.

St Rocco's participated in an annual FAMCARE audit, a bereaved relatives satisfaction survey with specialist palliative care services which benchmarks services against regional and national standards. The hospice used the integrated palliative care outcome score (IPOS) to assess their effectiveness for individual patients. All the audits and outcomes were fed back to the bi-monthly Quality and Safety Sub Committee meetings. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers and staff used information from the audits to improve patients' outcomes. We saw anticipatory medicines for pain management, breathlessness, nausea, distress and agitation were prescribed. The hospice audited the use of these anticipatory medicines to ensure patients were benefitting from them.

Audit results were shared with staff by email and at team meetings and managers made sure staff understood information from the audits.

The service reviewed the governing policies and procedures and monitored and evaluated new services, those reviewed this year included; providing training sessions to support the introduction of new clinical policies, for example slips, trips and falls, pressure ulcers and the verification of expected adult death. The hospice had designated staff who were responsible for ensuring hospice policies and procedures followed the national guidance.

**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.**

The hospice had a structured competency and training programme for all levels of staff. New staff completed a comprehensive induction and then started the training programme. Staff were suitably experienced, qualified and had the right skills and knowledge to meet the needs of patients.

The hospice had two staff who were non-medical prescribers. Non-medical prescribers are health professionals who are not doctors. They have undergone appropriate and ongoing training and would be as competent to prescribe as a non-medical prescriber. There was a governing non-medical prescribing policy, further supported by transcribing of medicines standard operating procedures. The non-medical prescribers had regular support meetings with the clinical lead doctor.

All staff responsible for administering medicines completed a specific induction training and received competency checks which were reviewed three-yearly for nurses. In addition, staff were trained in controlled drugs, syringe driver and intravenous drug administration. Single nurse administration for oral controlled drugs had recently been introduced. At the time of our inspection nine staff were trained and assessed as competent to administer oral controlled drugs without a second checker."

We looked at a staff competency self-assessment for the use of a syringe driver. The training for use of the syringe drivers was carried out by the company who provided the syringe drivers. The form showed if someone assessed themselves as being a level one they should be re-reviewed to become level four competent. The audit trail to demonstrate that the staff member was now competent was unclear. The manager told us this would be acted on immediately. We discussed this with the registered manager and action was taken to review the syringe driver policy in January 2020 to ensure this included the training and competency assessments.

Managers gave all new staff a full induction tailored to their role before they started work. We saw the completed records from recruitment, through to the induction and orientation process. This also included a probation review, the new starter and clinical induction checklist, and the training programme for both qualified staff and volunteers. The human resource lead monitored when dates for probation reviews and training should be completed by. Email reminders were sent out to managers to complete these. One nurse told us about their thorough induction plan, which was completed and monitored by the manager in a timely way and a volunteer/hospice helper told us how well supported they felt to be able to carry out their duties on the inpatient ward.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers supported staff to develop through yearly, constructive appraisals of their work. The service provided data which showed in November 2019, 117 out of 127 staff had completed an appraisal in the last year: 87% clinical staff and 97% of non-clinical staff. Nurses' and health care assistants' competency and training was also monitored via their appraisal. Three nurses and two health care assistants told us this was a good opportunity to look at development needs for the following year. All staff were supported to improve performance in line with the performance appraisal policy.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Health care assistants received education and training to develop and advance in their role by completing medicine competencies for example, so they were able to support the registered nurses. There were also opportunities available via the apprenticeship route for health care assistants to train as associate nurses.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Nurses were supported regarding revalidation and there was a system in place to support staff to complete this process. We saw the records which showed that regular checks had been made of clinical staff registration with professional bodies.

The clinical educators supported the learning and development needs of staff. The hospice had its own practice development centre that provided training to staff, volunteers and other healthcare professionals. All nurses were encouraged to complete further competency assessments and training in advanced subjects and to attend an in-house palliative care skills course. The senior clinical leads were qualified to academic degree level in palliative care. Staff we spoke with told us they felt well supported with their personal and professional development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The team meetings, reflections, debriefs and patient centred meetings also supported the continual assessment of staff competencies and effectiveness.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the hospice. The volunteer training was provided dependent upon their role. Volunteers provided support for clinical services. We spoke with the voluntary services manager who managed the recruitment, training and support of volunteers in the hospice. On appointment all volunteers received a generic induction followed by face to face and/or on the job training specific to their role profile. The team supported a number of volunteers, 620 active volunteers and 250 occasional volunteers. The service kept databases to ensure they held the correct training for each role.

**Multidisciplinary working**

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The multidisciplinary team working included the involvement of palliative care doctors, palliative care nurses, physiotherapists, occupational therapists, creative and complementary therapists, counselling therapist, social worker and a spiritual leader.

We attended a multidisciplinary team weekly meeting, this included full multidisciplinary and multi-professional representation with 17 members present. The meeting gave a full interactive review and overview of inpatients, the acute setting, Hospice at Home and the Vitality Centre. In addition, waiting list patients, discharges and patient deaths were reviewed. We observed that patients who were awaiting admission were clearly supported by the community team.

Staff worked across health care disciplines and with other agencies when required to care for patients. The multi-disciplinary teams of staff worked across both the Vitality Centre and the inpatient unit. The physiotherapist spoke positively of the teamwork.

Patients could flow seamlessly between the various services provided. The hospice worked collaboratively with community nursing services, specialist Macmillan services, Warrington Hospital, Warrington Continuing Health Care Team and other agencies.

**Seven-day services**

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

The inpatient unit was open 24 hours a day, seven-days a week to support patients who required inpatient care. Nursing and other healthcare staff provided care to patients 24 hours a day.

Staff could access support from doctors and other disciplines, 24 hours a day, seven days a week.

The hospice is moving to a single point of contact telephone service 24 hours, seven days a week for patients, relatives and other care agencies to call if they are concerned about a patient's condition or care needs. This will be covered by registered nurses on a rota. A medical GP advice/professional support line is available one hour each day, Monday to Friday.

Consultants attended ward rounds twice weekly. Medical on call was available out of hours weekdays and at weekends if more support is needed for hospice in patients. This could be escalated to a consultant if needed. At the daily ward round patients who required more consultant input were identified and were reviewed by consultants if the care pathway required it.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

Staff gave patients practical support to help them lead healthier lifestyles to maximise their independence or to live well until they died. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The hospice followed a rehabilitative palliative care ethos, meaning they aimed to keep patients living the most normal life as possible for as long as possible.

The Vitality Centre was located within the hospice and provided a sessional rolling programme of both individual and group sessions, for example mindfulness, acupuncture cancer rehabilitation session, creative therapies, breathlessness management, medical and non-medical outpatients clinics, physiotherapy and occupational therapy. The service aimed to provide care that enabled patients, as far as possible, to lead their lives in the way that they would wish.

The hospice promoted and provided services to support the mental wellbeing of patients and their relatives. The counselling and emotional support service was offered to patients and waiting times and caseloads were regularly reviewed. However, at the time of the inspection, skill mix and resource were under review.

St Rocco's counselling and emotional care team and hospice volunteers ran a bereavement café, which provided a drop-in service for people who had been bereaved, to chat and receive support information. Patients could be referred to counsellors who worked for the hospice, to work through various problems such as heightened anxiety.

There were rooms in the hospice that were dedicated to complementary therapies, for example a massage room.

The service had relevant information promoting healthy lifestyles and support within the hospice.

**Consent and Mental Capacity Act**

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

The hospice consent policy included the patient consent form. The consent to share patient information was within the electronic records system. At the time of the inspection a new consent form was due to be ratified at the governance meeting to simplify the consent process for care examination or treatment.

Staff clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with demonstrated a good understanding of when a person might lack capacity to consent to care or make significant decisions about their treatment. Where patients lacked capacity to make decisions regarding their care and treatment we found that discussions with patients' relatives or those close to them were recorded within the patient records. The opinions and wishes of patients' relatives were considered when making decisions.

When patients could not give consent, staff made decisions in their best interest, taking into account

patients' wishes, culture and traditions. In the records we reviewed, mental capacity assessments had been completed where patients had been identified as lacking capacity.

The patient records we reviewed included 'do not attempt cardiopulmonary resuscitation' forms. In all cases the decisions were dated and approved by the lead clinician in consultation with the patient. There was a clearly documented reason for the decision recorded on the form with clinical information included. All do not attempt cardiopulmonary resuscitation forms included a review having taken place when the patient was admitted to the hospice.

Staff training records showed that staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Our interviews with staff demonstrated they could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards

## Are hospice services for adults caring?

Good

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

**Compassionate care**

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

Throughout our inspection it was evident that patients and families were at the heart of everything staff did. Staff were compassionate when patients or their relatives and loved ones needed help and this culture was evident in the service. On arrival at the hospice all staff/volunteers were encouraged to provide a friendly and compassionate welcome to all patients/visitors and signpost them to the correct department. Staff were expected to display the organisation's values and behaviours, which were incorporated into staff annual appraisals. This was seen throughout our inspection.

Support was always given by caring staff, to meet the needs of the patients and their families. Feedback from people who used the service was continually positive about the way staff treated them. Patients and relatives, we spoke with told us the staff treated them well and with kindness and compassion. Numerous thank you cards were displayed reflecting the positive comments patients' loved ones had made.

The hospice had a respect and dignity policy. Staff showed their respect to patients, for example, by asking how they wished to be addressed and by knocking on bedroom doors before entering and introducing themselves. We observed staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The hospice was in the process of introducing the 'hello my name is' campaign, which focuses on reminding staff to introduce themselves to patients properly as it is the first step to providing compassionate care.

There were several quiet areas situated around the hospice, where patients and relatives could be spoken with privately, as well as each bedroom having doors and blinds in place to be used if necessary. We spoke with a patient and their loved one who had received further sad news. They were sitting quietly, gathering their strength, which a staff member had encouraged them to do. They told us, "No one could have put into words in a better way than we have been told today. This place has given us such comfort already from amazingly kind and understanding staff, despite our sadness".

Staff said patients could request special foods to meet their individual tastes. One patient had asked for (and been given) a jam sandwich battered and deep fried. The catering staff was able to respond to individual requests, they had worked with a patient who was able to tell them what they wanted in their clear fluids, for example which flavours and stocks to make it to their personal taste. To make the presentation of pureed foods look more appealing for patients, the kitchen used moulds or ramekins.

Staff followed policy to keep patient care and treatment confidential. All staff and volunteers agreed and signed confidentiality agreements. At all times, these were given the utmost consideration, and all staff and volunteers are made aware of the strict rules surrounding confidentiality of all patients. All staff were required to complete an

eLearning module on customer care and the General Data Protection Regulation (GDPR). Additional communications training was provided to staff/ volunteers' dependent on their role.

The managers told us they believed they were empowering patients by taking a patient-centred approach to care planning. Patients had individualised care plans and documentation to support their wishes and hopes. From the electronic care plan records we looked at, we saw that patients' emotional and psychological needs were discussed. Staff told us that care plans, and any changes made to them, were explained to patients. If the patient indicated their consent, carers/families were also given the opportunity to participate in the care planning process. Patient stories were submitted to the Board of Trustees as part of patient feedback. Two trustees we spoke with confirmed this.

All patients, carers and families were signposted to other services as needed and where appropriate leaflets/ written information were provided.

The hospice had an interpretation and translation policy framework to provide help for patients as needed.

Spiritual and psychological support was available for patients, carers and families with after care available to those bereaved. Clinical staff were mandated to attend 'Opening the Spiritual Gate' training, subject to availability, arranged by the trained hospice facilitator. The training was optional for other staff members.

Every three months the hospice held a service of remembrance for bereaved carers/families, which, we were told, were always well attended.

The hospice had its own non-denominational chapel and a multi-faith prayer room, available 24 hours a day, for all patients and relatives who might find comfort in using it and there was an Islamic centre close by. The hospice had its own chaplain and a full contact list of other faith providers was available.

Staff told us the hospice conducted weddings for patients, allowing patients to celebrate special occasions with loved ones and that they did whatever they could to make these events special for them. When a patient could not attend a wedding overseas, the staff enabled the patient to 'attend' the wedding via a 'skype' call to the wedding, they decorated their bedroom and the patient wore their wedding outfit and virtually attended the wedding.

Staff were passionate about creating positive memories for patients and families during their time as an inpatient. There was one double bedroom and a relative room for overnight stays. We were told the staff made an 'amazing' dining experience event and allowed a patient and their partner to enjoy a special meal together. Families were supported to eat together by staff, depending on the patient's condition. This demonstrated the lengths staff were willing to go to ensure patients' wishes were met.

Deceased patients received religious rites for the dying from the clinical staff and were treated with respect until taken to the chapel of rest by the undertaker chosen by the family. A dedicated bedroom was used for patients who had died to lay in rest until they left the hospice.

**Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. People's emotional and social needs were seen as being as important as their physical needs.

We observed that all staff were attentive to and prioritised the needs of patients at the hospice. The hospice had a chaplain, counselling and emotional care team, allied health professionals, social workers, and a complementary therapy team who worked with clinical staff to ensure patients' and relatives' emotional needs were catered for. Members from these teams attended ward rounds and multidisciplinary meetings and were regularly consulted to ensure staff had a full understanding of all the needs of the families cared for.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. On the ward, all patients were cared for in single rooms so their need for privacy could be respected. Staff told us how they provided emotional support to patients' loved ones who wanted to provide as much care as possible themselves.

Good

# Hospice services for adults

Staff undertook training on being open and on communication and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients' records we reviewed showed that staff gathered information about the individual, their life stories, personal views and choices, which enabled them to support patients in a way that met their wishes, beliefs and personal preferences. Conversations with staff and managers demonstrated how passionate and dedicated to their work the staff team were.

The chapel contained memory books where families and loved ones could come together to reflect upon their loss to support their spiritual and emotional needs.

The Vitality Centre/day therapy service included the option to take part in wellbeing crafts and various therapies to ensure that both patients and their carers received support. One patient told us, 'I didn't know for a while until someone signposted me to this place, the support I have received has made an unbearable situation, bearable'. Staff told us how they could signpost patients to the bereavement or counselling services or advise patients to be referred via their GP.

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

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

Staff made sure patients and those close to them understood their care and treatment. In the six care plans we looked at we saw evidence of family involvement in the care planning records. Patients and relatives told us they valued the relationships they established with staff and the support, kindness and compassion the staff provided to their loved one.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make advanced decisions about their care. Staff recognised that people need to have access to, and links with, their advocacy and support networks and they supported people to do this, for example with bereavement support.

We saw evidence in the records we reviewed of discussions between patients and their families, including discussions around 'do not attempt cardiopulmonary resuscitation' decisions, and decisions about patients' preferred places of care.

## 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.**

Managers planned and organised services, so they met the changing needs of the local population. The hospice worked well with other services, specialist Macmillan services, local hospital and continuing health care team and other agencies to provide integrated end of life care services that embedded best practice, to provide choice for patients in a variety of settings.

The service had implemented a single point of access process, whereby a formal meeting was held each day to review all referrals and decide who and which department would contact the patient and discuss the offer of services. Patients who were referred as an urgent inpatient unit admission were dealt with immediately, especially if a bed was available.

Senior managers told us that they were looking at extending the use of the single point of access meeting to other organisations to improve response and waiting times to ensure patients could receive and access the most appropriate service at any time.

Good

# Hospice services for adults

The hospice had been part of a project to develop integrated palliative and end of life care services in the Warrington area. As part of this project, the hospice had worked with the local clinical commissioning group and other agencies to collect information from patients and carers to influence new care models and to identify how hospice care could be improved.

A "palliative hub" was due to commence in February 2020 and the new model was to be rolled out in April 2020. The hospice would be the base for the "palliative hub". There would be a designated telephone number and email for all palliative referrals and contact. This would enable a single point of contact for healthcare professionals and patients to access services, information, support and guidance. The hub would work collaboratively with other providers and services in the area to ensure patients received appropriate and timely interventions, avoiding duplication and confusion for patients and carers. The hub would also support people to be cared for in their own homes, avoiding inappropriate hospital admissions and enable smooth discharges from hospital.

Since our last inspection the service had supported the frailty service by providing a staff member to sit with patients discharged from the local acute hospital emergency department in their own homes at night temporarily until a long-term package of care was arranged. The Hospice at Home organised packages of care for palliative patients to support rapid discharge from hospital.

To alleviate patients' anxieties about hospices, St Rocco's offered a drop-in session each Friday where prospective patients could discuss the services available. Tours of the hospice were available, these could be attended by anyone with prior arrangement to provide an introduction and an overview of services.

Discharge planning was discussed with the staff team. Discussions and assessments took place with the physiotherapist, occupational therapist for any equipment required, liaison with other agencies such as the local authority, the Hospice at Home service and Macmillan nurses if required. The service had systems to help care for patients in need of additional support or specialist intervention. The Hospice at Home service offered patient support and choice at end of life.

In line with its business plan the hospice aimed to continue developing services, for example: strategy and anxiety management services, counselling and emotional care services via bereavement outreach hubs, frailty services and night sits. In addition, the service was due to be involved in the implementation of the electronic palliative care coordination system across the local primary and acute care trusts, including out of hours. This dataset would allow those involved in the delivery of palliative care services to view important information about the patient and their care, to help shape multidisciplinary team meetings and encourage information sharing across the wider system.

Facilities and premises were spacious and met the needs of a range of people who used the service. The building's design and layout were fully accessible for people living with a disability or limited mobility. The inpatient area was built around an internal courtyard with a pond and seating area. All 10 bedrooms had en-suite facilities, with each bedroom looking out over the hospice gardens. Patients were able to go out into the communal spaces, including the garden area, on their bed if they were unable to transfer to a chair.

The Vitality Centre was designed to provide multifunctional spaces to meet the needs of patients, carers and families, for example a craft room for diversional therapies, relaxation rooms, single rooms for one to one discussion, a bedroom for day treatments, surrounding peaceful grounds and quiet areas. The centre also provided an information point, which was supported with leaflets.

**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.**

The service was flexible and responsive to people's individual needs and preferences, finding ways to enable people to live as full a life as possible. A range of activities was provided in both the Vitality Centre and on the inpatient ward. One patient told us; "the day services are amazing, the therapy unit comes to me, here I am enjoying a wonderful foot massage and reflexology before I go back home".

The service had a homecare service to meet patients' changing care needs and to provide advice, care and support.

Since our last inspection when the electronic care planning record system was in development we saw how this was now firmly embedded within the hospice. The clinicians were able to access a single source of information which detailed the patient's contact with the NHS and their GP records. We observed in a care record where for religious reasons, a patient had chosen to not have routine bloods taken, this was respected as it was the patient's choice and would not change the clinical management of this patient.

The Individual Plan of Care (IPOC) for end of life care sets out how care needs were reviewed and met for patients who were dying and what is taken into account. The manager told us this was used across Warrington services and only available as a paper record currently. The one we reviewed was detailed and appropriately completed.

Care plans were person-centred and included evidence of consent and discussion with the patient. We reviewed six care plans and saw that services were coordinated with other agencies to provide care to patients with complex needs.

We attended a weekly multi-disciplinary team meeting which reviewed all new and existing hospice patients for a re-assessment of their needs. We found the meeting ensured that people's care was individualised, and person-centred. Arangements were made for patients celebrating significant events, for example birthdays, anniversaries; also wedding celebrations could be catered for. Yoga classes had been introduced at the request of patients.

The call bell response times were displayed in the office, during the inspection we observed these being answered within 19 seconds and patients confirmed they were not left unattended.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We consistently observed staff displaying kindness, and compassion towards patients and their relatives, which helped to reduce their anxiety. We saw that patients, family members, friends and fellow staff were treated with dignity and respect. Patients' privacy and dignity was firmly embedded in the way staff approached daily tasks. For example, we observed staff ensuring patient dignity was protected during personal care by closing doors and curtains of bedrooms and bays.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Registered 'pets as therapy' were welcomed to the hospice and at the time of our inspection the service had one pet enrolled to visit the hospice. Patients' own pets were welcomed to visit by arrangement. We met a patient's own pet who was visiting with their next of kin, they told us this had made them feel 'great'.

St Rocco's had a spiritual care policy and catered for different religious needs. There was access to a chapel and prayer room for spiritual reflection. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss and the needs of patients living with dementia.

The hospice had an interpretation and translation policy framework to provide help for patients as needed. The service had access to translation services. In the hospice, although we did not see leaflets were available for people whose first language was not English, managers and staff told us they were able to access support from telephone or face-to-face interpreters or signers when needed.

Equipment was available on the inpatient unit to help patients, for example with dementia or neurological difficulties. St Rocco's had access to specialist sensory services for use of equipment either in the hospice or at home.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The catering staff told us they were able to meet patients' preferences if they requested any food or drink they wanted even if it was not generally on the standard menu. Visitors could access fresh food from a designated fridge and make a donation via an "honesty box". Volunteers visited all patient rooms each afternoon with tea and cake and offered refreshments throughout the day.

**Access and flow**

Good

# Hospice services for adults

**People could access the service when they needed it and received the right care promptly.**

The service had referral criteria in place. Patients had to have an incurable, life limiting advanced and progressive disease where care needs were palliative. The service adhered to the referral criteria. Bed occupancy was reviewed at bi-monthly Quality and Safety Sub Committee meetings and also Trustee Board meetings plus quarterly CCG contract meetings

The hospice had not needed to close its services; however, we were told there were occasions when, due to staffing and patient dependency/complexities, it may be necessary to reduce the rate of inpatient unit admissions by 24 hours. Admissions could be influenced by patient choice and by the appropriate transport being available for the transfer of patients to the hospice.

Waiting lists for the inpatient unit were reviewed daily at clinical meetings and at weekly multi-disciplinary meetings, and a decision was made to admit those in most need clinically. In addition, for patients in the community, the Hospice at Home team could support families at home, particularly for night sitting requirements if this was their wish. The Hospice at Home team was based at the hospice and worked on a short-term intervention approach to support people at home or to enable them to get home from hospital. The home team received referrals from district nurses or other healthcare professionals and worked closely with community nurses and GPs to support people in their own homes.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex needs. Discharge planning, and identification of the preferred place of care was included as part of the individualised plan of care for the dying person.

The Hospice at Home team were working to develop a new rapid response model, whereby care will be provided for up to 72 hours to prevent admission to hospital. Currently Hospice at Home on average made contact within six hours of referral. Data was being monitored for the response times arrange care. (Figures for the month of October 2019 showed there had been three days where there had been a delay in the service provided).

Liaison with community, specialist and acute palliative care teams helped facilitate decision making and provide support for patient care.

**Learning from complaints and concerns**

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. "We Welcome your Comments" notices were displayed at various points around the hospice, as well as forming part of the patient and carer information folder. Staff understood the policy on complaints and knew how to handle them. Informal arrangements were in place to discuss any concerns.

The service had a complaints, concerns, and compliments policy which outlined the complaints process and how to manage different types of complaints. The policy was version controlled and in date.

The service received few complaints. Managers investigated complaints and identified themes. There were two complaints in the last 12 months managed under the formal complaint's procedure. One of these was non-clinical and the second complaint related to a medical outpatient appointment and took longer than 20 days to resolve due to communication delays with the patient. Of the six informal complaints logged, four related to internal communications.

The service clearly displayed information about how to raise a concern in patient areas. St Rocco's took a proactive approach to address issues and had a logging and reporting process for informal and formal complaints. The hospice encouraged concerns to be dealt with by staff directly discussing issues and to aim for timely resolution.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Good

# Hospice services for adults

Managers shared feedback from complaints with staff and learning was used to improve the service. Senior managers told us that complaints and any improvements made were also reviewed by the board of trustees to ensure they were completed in accordance with the provider's complaints procedure.

Staff could give examples of how they used patient feedback to improve daily practice. Staff gave examples of how they dealt with issues before they became official complaints in a positive way. They spoke with family members or patients to try and resolve any issues early.

People's feedback was valued, and staff told us that they felt that responses to any matters raised were dealt with in an open, transparent and honest way.

Compliments about St Rocco's services were also collected via cards, letters, verbal feedback and social media. Feedback was summarised for the quality and safety subcommittee and the board of trustees. From August 2018 to July 2019 there had been 209 written compliments. The following data categorises the compliments received: catering 3, compassion 19, dignity 5, environment 5, excellent staff 20, grateful thanks 45 and quality of care 112.

## Are hospice services for adults well-led?

Good

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

**Leadership**

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

We found an established leadership structure at the hospice with a clear management and governance structure. The senior leadership team represented medical care, finance, income generation and corporate services. The clinical leads team had responsibility for oversight of clinical care delivery.

The hospice was led by the chief executive and was clinically led by the medical director of care. The inpatient and Vitality Centre were overseen by the registered manager, who despite having recently taken on the sole role as registered manager, had a long and varied history within the hospice, and in palliative and end of life care. In addition, the clinical lead oversaw clinical care in the inpatient area.

The leadership team had a wealth of experience in delivering high quality end of life care and all staff we spoke with told us that the leaders provided clear support and direction. Leaders were visible, accessible and approachable. There were clear lines of accountability within the service. Staff knew and understood their roles and responsibilities.

St Rocco's was governed by a board of trustees, who monitored the management of the hospice, its operational and strategic objectives. As a charity, the chief executive was accountable to the board of trustees, led by the newly appointed chair. The chair recognised that the governance of the hospice required a balance of skills and types of people from a range of professional backgrounds. The service had a clear structure for the day to day management of the hospice with seniors leading teams.

The board of trustees' organisational structure incorporated four sub-committees: these were the finance, health and safety, human resources and quality and safety sub-committees. The board of trustees and its sub- committees met every three months. The trustees received a dashboard of data activity and summary of an anonymised patient journey prior to each meeting.

We spoke with the newly appointed chair to the board of trustees and two trustees. The chair's appointment was confirmed at the annual general meeting in October 2019, a review of the board of trustee's membership and skills was in progress. The chair spoke passionately about their new role and the trustees we spoke with demonstrated a good overview of the challenges facing the hospice to promote sustainability, whilst maintaining high standards of care.

Conversations with managers demonstrated that the relationship between the chief executive and trustees

was effective, productive and transparent. Both the leadership team and the trustees described an open culture that promoted information sharing, discussion and encouraged professional challenge.

In addition, various operational groups met regularly: for example, an inter departmental meeting, focus group, doctors, policy, clinical leads and senior management team.

Team, and staff meetings provided the opportunity to share information, discuss service delivery and provide support.

The structure of annual appraisals, regular newsletters, annual staff surveys and informative emails further supported the sharing of information and support mechanisms.

**Vision and strategy**

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

The organisation's vision and values were reviewed in April 2019: St Rocco's vision was: "We want everyone in our community who is diagnosed with a life limiting disease to live well and, towards the end of their life, have a dignified death in a place of their choice. We care for the whole person and those who matter to them." The service's leaders were able to describe the strategy for end of life care.

All staff we spoke with shared the values and the vision of the hospice.

The hospice had a strategy 2019 -2024, which had been developed with input from staff, volunteers and external stakeholders. The strategy offered the overall vision of what the hospice aimed to achieve for the people of Warrington in the next five years.

The overall business plan was reviewed quarterly measuring successes and reasons for not achieving outcomes.

The business plan was linked to annual budgets and NHS contract for services, which were reviewed at hospice sub committees and commissioning meetings. To help staff deliver the objectives set, the hospice had agreed a list of values and behaviours to support the delivery of services.

At the time of our inspection the organisation was in the process of restructuring its fund-raising department to facilitate income generation. Since our last inspection in 2016 we saw the service had made progress with its strategy. For example, the service had promoted itself within the local community, embedded the staff training of the electronic patient data system and further developed the Hospice at Home service.

**Culture**

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

Staff described their workplace as a place they wanted to give their best, they were dedicated, felt passionate about their roles and teamwork was effective. This appeared to be across the organisation, from ward staff, day centre staff, housekeepers, volunteers, medical staff, trustees, home support and therapy staff and local and senior leadership team members.

We observed and were told by staff they were fully committed to the vision and mission of the hospice to provide and support the best life possible for people with life limiting illnesses.

In contrast to our last inspection we found staff felt respected, supported and valued. There were no negative comments from staff about working or volunteering for the service. The staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear. All staff told us they were proud in their work to provide the best care they could for patients. Day and night staff we spoke with told us there was a strong sense of teamwork to provide high quality care, despite current staff shortages on the inpatient unit.

A culture of being open and honest was encouraged at all levels throughout the hospice including trustees, maintenance, fundraising, housekeeping and administrative staff. This culture maintained the safety at the hospice and allowed individuals and the organisation to learn from mistakes.

Staff told us they received support from management and the team. Staff were provided with de briefs and personal supervision as required. Staff told us they were proud to work at St Rocco's and staff confirmed they had the skills to be able to do their job well to provide high quality care.

The service had a whistleblowing policy which was available to all staff and information on how to raise whistleblowing concerns formed part of mandatory training. Staff we spoke with knew how to raise any concerns and felt comfortable in doing this.

Staff received annual appraisals, this assisted them with their development and career opportunities. The organisation had a culture that supported and actively encouraged staff development. The leadership team supported staff at all levels to undertake additional training and competencies, not only to support the work of the hospice, but to develop individuals. For example, the ability for healthcare assistants to undertake medication second checking training and another team member told us how they had progressed to start trainee nurse associate training.

Senior staff were knowledgeable about the duty of candour, there was a procedure in place for the duty of candour.

The senior leadership team acknowledged the impact on staff of working in the hospice environment could be emotionally stressful and staff need to be supported. The provider offered clinical debriefs after complex or difficult situations, access to an external counselling service and internal staff counselling and clinical supervision as ways to support staff.

**Governance**

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

There were clear lines of governance and accountability from the board of trustees through to the chief executive, senior managers and to all staff. Staff were clear about their roles and responsibilities. Staff knew what they were accountable for and who they reported to.

The quality and safety sub-committee monitored clinical governance, the finance sub-committee monitored compliance with the General Data Protection Regulations 2018 and the health and safety sub-committee monitored compliance with Health and Safety Executive requirements.

Groups of the sub-committees met to discuss specified areas of business including: general data protection regulations, education, medicines management, clinical audit and a user feedback group. Minutes were presented to the sub-committee meetings.

In addition, various operational groups met regularly: for example, an inter departmental meeting, focus group, doctors, policy, clinical leads and senior management team.

Patient stories were presented at each trustee meeting. The committee reviewed themes from incidents, performance against measures relating to end of life care and audit outcomes to identify any areas for improvement.

There was a range of policies and procedures available to staff. The polices were in appropriate detail and they were regularly reviewed and updated.

**Managing risks, issues and performance**

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

St Rocco's had a risk management policy governing risk register management.

Risk registers were reviewed at each sub-committee meeting. A red, amber, green rating system was in place so scores were escalated to the corporate risk register, which was reviewed at each board of trustees meeting and discussions were held regarding mitigation.

We reviewed the corporate risk register included in the trustees' annual report, which was available on the Charity Commission website. The risk register highlighted five risks, which related to staffing levels, funding streams and sustainability, data protection regulations, trustee vacancies, succession planning and training and cyber-attacks.

The risks shown on the register matched those described to us by the service leaders during the inspection.

The service's leaders knew, and were able to describe, the challenges facing the service and the plans to address these. We spoke with the finance director who was passionate about the service and the importance of all the leaders understanding the financial position of the service.

The hospice had plans in place to ensure continuity of care in the event of an emergency, where they may be unable to use the hospice building.

There was systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken.

There was ongoing monitoring of incidents and complaints to improve the service.

**Managing information**

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

The provider had a confidentiality and data protection policy. The policy covered all aspects of record and information management including accessing information, sharing of information and when and how staff should report breaches of confidentiality.

Information governance was carried out as part of the mandatory training process. All staff we spoke with were aware of their responsibilities regarding information management and the General Data Protection Regulations (GDPR) tailored by the Data Protection Act 2018.

Information was kept securely to maintain the confidentiality of patients and information was shared with relevant agencies after patient consent had been obtained.

All information technology systems were protected by security measures.

The provider submitted statutory notifications as required for specific incidents such as the death of a patient to the Care Quality Commission.

**Engagement**

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

Since our last inspection and from September 2019 staff engagement in the new vision and mission statement formed part of annual staff appraisals, where new values and behaviours had been set.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were good patient feedback channels and staff acted on any concerns, patients highlighted throughout their stay. Patients gave positive feedback about the service. Information received from the provider told us that St Rocco's had introduced a 'feedback friends' process whereby patients and/or their carers/ families were encouraged to complete a feedback questionnaire. Feedback was collated and reported back to the user feedback group and quality and safety subcommittee every three months and annually. From July to September 2019, 100% of patients said they received a clear explanation of the care they required. User feedback was shared with staff and was to be made available on a planned new hospice website.

Boards were displayed in the hospice to show user feedback, 'You said we did'. One example included the

catering staff providing more vegetarian options at mealtimes, following feedback from the Vitality Centre. The theme was analysed from 64 questionnaires returned. Feedback reports from April 2018 to 2019 indicated a significant increase in the volume of user feedback, which was overwhelmingly positive, and managers aimed to continue this trend. The service was developing drop in focus groups to further support user feedback data collection and analysis.

We saw the service was keen to engage with its local community. There was a community project called 'RocON!' facilitated by the hospice that worked with schools and young people about death and dying. Young people had visited the Vitality Centre and met with patients, joined in sessions and used equipment. We were told that RocON! had a marked impact on the psychological and emotional care of patients, as well aiming to improve access to care, assist with young people's attitudes to hospice care and enabled the hospice to engage with more potential service users.

Another scheme called 'Rocco's On Your Doorstep' had established a volunteer befriending service where volunteers were matched to people and that people living in the community were supported to have a chat with a befriender, be accompanied to appointments and volunteers could do errands or go shopping for the person. This meant people who may be lonely were supported for as long as they needed by a regular 'friend'.

New community engagement activities now included a choir, gardening group and reading group.

The provider confirmed that the hospice website was due to be reviewed and updated.

Staff self-care, wellbeing and resilience training sessions had been introduced in September 2019. An evaluation of the training session had been collated and further sessions were being arranged and made available to all hospice staff. Staff were able to access complementary therapies

Staff told us they felt listened to. Following staff engagement in the inpatient unit, the service had introduced 12-hour shifts following a 12 months' monitoring period.

Staff engagement in family support team meetings had resulted in a new departmental name and service model, for example the bereavement cafe, bereavement outreach hubs and remembrance services.

St Rocco's was currently working with the Warrington Together Partnership and clinical commissioning groups to develop new strategic directions, particularly for a new integrated model of palliative and end of life care across Warrington. This included the hospice actively piloting support for frail patients by providing night care/support.

**Learning, continuous improvement and innovation**

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

There was a focus on continuous learning and development for all staff within the hospice.

The service had plans to roll out information points in hospice shops to help share information about the hospice and the services provided. Work was currently being undertaken to review and develop the website.

There was regular review of governing policies and procedures and monitoring and evaluation of new services including: providing training sessions to support introduction of new clinical policies, for example slips, trips, falls, pressure ulcers, and the verification of expected adult death. Work was ongoing in relation to the completion of competency assessments for clinical staff, for example, the administration of intravenous therapy and the single administration of controlled drugs. Work was ongoing with the development and implementation of the carer assessment tool and the training of staff to be non-medical prescribers as part of the medical team and outpatient clinics.

There was monitoring of business plan initiatives, which included the following: the service was reviewing and continuing to develop the single point of access process. There was development of the palliative care hubs as part of the integrated palliative and end of life care model between the hospice, hospital, community services, health and social care providers, voluntary services and other charitable organisations.

Good

# Hospice services for adults

The counselling and emotional care team, formerly the family support team, was developing and expanding. The service had plans to develop bereavement care and develop another outreach service.

# Outstanding practice and areas for improvement

## Outstanding practice

- A scheme called 'Rocco's On Your Doorstep' had established a volunteer befriending service where volunteers were matched to people and supported people living in the community to have a chat with a befriender, be accompanied to appointments and volunteers could do errands or go shopping for the person. This meant people who may be lonely were supported for as long as they needed by a regular 'friend'
- There was a community project called 'RocON!' facilitated by the hospice that worked with schools and young people about death and dying. Young people had visited the Vitality Centre and met with patients, joined in sessions and used equipment. RocON! had a marked impact on the psychological and emotional care of patients, as well aiming to improve access to care, assist with young people's attitudes to hospice care and enabled the hospice to engage with more potential service users.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should consider involving patients and service users in the assessment of the care environment.
- The provider should ensure it continues to monitor written care plans including risk assessments in line with provider policy.