The Mary Stevens Hospice

Quality Report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Mary Stevens Hospice provides specialist palliative care to adults aged 18 years and older.

The inpatient unit could provide services for up to ten patients at a time, with 24 hour nursing and medical support. Patients could be referred to the inpatient facility for symptom control, terminal care, respite care and crisis intervention.

The day services unit offered a full range of care, therapy and support services for those with life-limiting illnesses which includes medical advice and support, physiotherapy and occupational therapy, complementary therapies, recreation activities and social activities. The day service unit has capacity to accommodate up to 25 patients a day, Monday to Friday.

This was the second inspection of this service. It was previously inspected in 2016 and rated Good overall. We inspected this service using our comprehensive inspection methodology. This was an unannounced inspection (they did not know that we were coming). We carried out our inspection on the 25 and 26 February 2020.

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.

Services we rate

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

- 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 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 provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patient's needs were constantly assessed and identified with treatments and opportunities aligned to their needs and wishes. Patients nearing the end of their life were encouraged to think about wish lists to allow the staff and those close to fulfil those that were possible.
- People's individual needs and preferences were central to the delivery of tailored services. The service had innovative ways to provide integrated person-centred pathways. Services were flexible to meet patient's needs.
- The service took a proactive approach in understanding the needs and preferences of different groups of people and delivered care which met these needs. Staff made reasonable adjustments to meet the needs of patients, including those with protected characteristics.
- 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 fully aligned to local plans within the wider health economy.
- 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.

Summary of findings

- 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.

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

Heidi Smoult
Deputy Chief Inspector of Hospitals (Midlands)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	Services were provided from one location. We rated the service as outstanding overall as it was rated outstanding for caring and responsive and good for safe, effective and well led.

Summary of findings

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Outstanding ☆

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Summary of this inspection

Background to The Mary Stevens Hospice

The Mary Stevens Hospice is operated by Mary Stevens Hospice (The). The service opened in 1991. It is a private hospice in Oldswinford, Stourbridge. The hospice primarily serves the communities of the Dudley Borough. It also accepts patient referrals from outside this area.

Our inspection team

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

Information about The Mary Stevens Hospice

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

During the inspection, we visited the inpatient and day services areas of the hospice. We spoke with 22 members of staff including senior managers, registered nurses, health care assistants, medical and domestic staff. We spoke with one hospice volunteer, four patients and two relatives. During our inspection, we reviewed five sets of patient records.

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 hospice was previously inspected in 2016 which found that the service was meeting all standards of quality and safety it was inspected against.

The Mary Stevens Hospice provided several services including:

- Inpatient services with 24 hour a day nursing and medical cover for up to ten patients.
- Day services unit, five days per week.
- Family support services – bereavement support responsive to the needs of carers, families and friends.
- Care at Home – in partnership with Macmillan Cancer support
- Social work support
- Spiritual care services
- Complementary therapies

Activity (October 2018 to October 2019)

- In the reporting period October 2018 to October 2019, the hospice provided care for 74 patients aged 18-65 and 229 patients aged 65 years and over. One hundred and seventeen of these patients had been diagnosed with a life limiting illness and 184 were receiving palliative care.
- Between October 2018 to October 2019 there had been 183 admissions to the inpatient unit.
- Between October 2018 and October 2019 144 patients on the hospice's case load had died , eight of these deaths had been referred to the coroner.

Track record on safety (October 2018 to October 2019)

- No never events
- No serious injuries
- Thirty-two incidents, 12 of which were near misses.
- No incidents of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidents of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Summary of this inspection

- No incidents of hospital acquired Clostridium difficile (C.diff)
- No incidents of hospital acquired E. coli
- One formal complaint

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 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, up-to-date, stored securely and easily available to all staff providing care.

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

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

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 evidence-based practice. Managers checked to make sure staff followed guidance.

Summary of this inspection

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.

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

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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

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 knew how to support patients who lacked capacity to make their own decisions.

Are services caring?

Outstanding ☆

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

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patients needs were constantly assessed and identified with treatments and opportunities aligned to their needs and wishes. Patients nearing the end of their life were encouraged to think about wish lists to allow the staff and those close to them to fulfil those that were possible.

Staff gave patients and those close to them help, emotional support and advice when they needed it to minimise their distress. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff supported patients and those close to them to be fully involved in making decisions about their care and treatment and understanding their condition.

Are services responsive?

Outstanding ☆

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

Summary of this inspection

People's individual needs and preferences were central to the delivery of tailored services. The service had innovative ways to provide integrated person-centred pathways. Services were flexible to meet patient's needs.

The service took a proactive approach in understanding the needs and preferences of different groups of people and delivered care which met these needs. Staff made reasonable adjustments to meet the needs of patients, including those with protected characteristics.

People could access the service when they needed it in a way to suit them and received the right care promptly.

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 fully aligned to local plans within the wider health economy.

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.

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.

Summary of this inspection

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.

Outstanding

Hospice services for adults

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Outstanding
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 programme was comprehensive and met the needs of patients and staff. Mandatory training for nurses and health care assistants was delivered as a one-day course which covered topics including fire training, manual handling, mental capacity, infection control and anaphylaxis. Safeguarding training, cardiopulmonary resuscitation (CPR) and food hygiene were delivered as stand-alone modules.

Nurses and health care assistants kept up to date with their mandatory training. The service told us that the overall compliance rate with the mandatory training one day course was 91%, CPR training 91% and food hygiene at 80%. We saw that six staff had courses booked to complete their food hygiene training following the inspection. A new medicines management module had been designed on the online training system and was due to be launched and included within the mandatory training cycle.

Dementia training was delivered on induction and then every three years. We saw that staff members were booked onto learning disability, autism and lesbian, gay, bisexual, transgender (LGBT+) awareness study days.

Medical staff were provided with mandatory training including fire, manual handling, health and safety and infection control through the hospice. Doctors also had to provide evidence of other mandatory training completed through their other places of work such as safeguarding training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was delivered both face to face and through an online system. Managers monitored compliance rates and staff were reminded when training was due for completion. The online mandatory training tool had recently been acquired to promote flexibility in completing mandatory training and to increase compliance.

All volunteers had mandatory training which included communication training, cultural awareness and working with interpreters.

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 on how to recognise and report abuse.

All medical staff had completed safeguarding adults' and children level three training in the year before the inspection.

Members of the family support team were trained to safeguarding adults' level three and children level two,

100% of these staff members had completed their training in the year before the inspection. Advanced nurse practitioners and nurse prescribers were trained to safeguarding adults and children level three.

The service told us that from January 2020 level two online safeguarding training had been mandated to all clinical and non-clinical staff that came into any contact with children during their work, at the time of inspection 48% of eligible clinical staff and 33% of non-clinical staff had completed this training. The service provided us with assurances that the face to face training that staff received before the online training came into place met the competency standards for both level one and two training, 96% of staff had completed this training within the last two years.

Not all staff were trained to safeguarding adults level three, as defined by the Adult Safeguarding: Roles and Competencies for healthcare staff published August 2018, providers have until August 2021 to be fully compliant with this document. At the time of inspection, 100% of healthcare assistants had received training in safeguarding adults level one, band five nurses received safeguarding adults level one and band six nurses received safeguarding adults level two training, 96% of registered nurses had completed the training assigned to them in the last two years.

The matron and social worker were the nominated safeguarding leads for the service, both were trained to level three for safeguarding adults and children. An on-call rota was in place to provide out of hours support to staff if required. All staff involved in family and child bereavement sessions were trained to safeguarding children level three. Level four advice was sought from safeguarding leads at the CCG.

Staff received safeguarding supervision appropriate to their role.

We reviewed the adults safeguarding policy, last reviewed in June 2019. The policy contained a list of different types of abuse but not information on how to recognise them, there was no mention of PREVENT or female genital mutilation within the local policy. The policy did not identify who safeguarding leads were within the service, how to contact them for out of hours support or what level staff groups should be trained to. Staff were signposted to the West Midlands Adult Safeguarding policy and procedures document however, the most recent version of this document was not referenced, therefore we could not be assured the most up to date information was accessible. No separate child safeguarding policy was in place. However, the hospice accessed the West Midlands Child Protection and safeguarding procedures to align themselves with current best practice in relation to child safeguarding.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to confirmed they had received safeguarding training. Staff were knowledgeable about different types of abuse and were able to discuss times where they had raised concerns. Staff were able to discuss the themes of safeguarding concerns that were more commonly seen at this service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would escalate their concerns to the shift lead.

The service had process in place to undertake Disclosure and Barring Service (DBS) checks on staff upon recruitment and throughout employment. We reviewed three staff files and saw all had a valid DBS check in place.

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 and communal areas were clean and had suitable furnishings which were visibly clean and well-maintained. Throughout our inspection we observed a high standard of cleanliness throughout all areas of the hospice. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, cleaning records were not always up-to-date to demonstrate that all areas were cleaned regularly.

Staff followed infection control principles including the use of Personal Protective Equipment (PPE). We observed all staff working clinically to be bare below the elbows and hand washing between patient contacts. We observed that PPE and hand sanitiser were readily available at points throughout both the inpatient and day services facility.

Hand hygiene facilities and compliance was audited quarterly. We reviewed the audit of quarter three for 2019. The audit showed 98.4% compliance however, minimal observation of handwashing technique was observed.

The quality improvement lead was responsible for completing infection prevention and control audits. A hospice wide annual infection prevention and control audit was undertaken in 2019 which recorded 88.25% compliance overall, this was a decrease from the 2018 audit which recorded a 97% compliance. The audit covered 16 key areas including policies and procedures, hand hygiene, patient rooms, clinical rooms and sharps. An action plan was developed to increase compliance where needed such as, to ensure appropriate hanging storage for mop heads and ensuring the pre-planned cleaning programme was updated to reflect the new areas of the hospice that had recently been built or expanded.

The single bedroom style allowed patients to be isolated if infection was suspected. The hospice recorded no incidences of Methicillin Resistant Staphylococcus Aureus (MRSA) and no incidents of Clostridium Difficile in the 12 months before our inspection.

An infection prevention committee was in place to identify, monitor and action risks in relation to infection prevention and cleaning. The service had recently invited a review of its cleaning policies and practices by an external contractor and was working to align itself with the policies and procedures used by the local NHS trust.

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 design of the environment followed national guidance. The inpatient area was a 10-bed facility aiming to provide a home away from home for service users. Each patient bathroom and communal bathrooms and toilets were equipped with emergency call bells for patients to alert staff if they were in difficulty.

In 2018 three million pounds had been invested into the infrastructure of the hospice to increase the capacity and capability of the day services unit. The day service area was bright and spacious with private rooms for patients and their families to speak to staff or to use privately. A physiotherapy gym was available on site, this was equipped with a range of equipment to help patients with their therapy and rehabilitation needs. The service had two fully equipped spa therapy rooms where alternative treatments could be accessed by patients and their families.

Doorways and corridors were wide to allow patients with wheelchairs or mobility aids to pass through safely. All patient facilities were located on the ground floor however, a lift was available to the second floor where offices and meeting rooms were located for staff and visitor use.

The hospice had a large patio and garden area that was maintained to a high standard. We saw in meeting minutes that grounds and estates were discussed to ensure these spaces were appropriate for those using the services and that their upkeep was in line with the standards set for the rest of the hospice.

Staff carried out daily safety checks of specialist equipment. We saw that items such as blood sugar monitors were calibrated daily before patient use.

The service had enough suitable equipment to help them to safely care for patients. We saw the service had a good stock of mobility aids which were in good condition and ready for use. Each bedroom was equipped with a ceiling hoist to aid patient mobilisation where needed. Communal bathrooms were well equipped with a variety of hoisting equipment to enable users with different mobility needs to use the facilities. We saw that equipment that needed charging was left plugged in to charge when not in use to ensure that it was ready for use when needed. We checked six pieces of electrical equipment and all had been tested and serviced within the last 12 months. We checked three different mobility hoists and all had been serviced within the last 12 months.

The areas where spare nursing consumables and equipment was stored were clean and well organised. We checked ten items of nursing consumables such as oral hygiene packs and wound dressings and found all to be in date.

Staff disposed of clinical waste safely. We saw that waste was appropriately segregated and labelled. Waste was kept in a lockable cage whilst waiting for collection, full sharps bins were stored in a lockable cupboard away from the patient area.

We saw fire exits were clearly marked and clear signage was in place to highlight the path to the nearest exit.

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.

All patients were comprehensibly assessed at home by a senior member of hospice staff before starting to access either the day service or inpatient services. This enabled an individualised care plan based on risk assessments to be put in place before the patient accessed the service.

Patients had risks assessments performed which covered nutrition, falls and pressure ulcer development. In the five sets of patient notes that we saw these were completed on admission and updated at least weekly dependant on the length of stay. We saw that patients had a full skin assessment once per day as standard, areas covered by medical devices were checked twice a day as applicable. Pressure ulcer care and avoidance was a documented part of the patient comfort round that were performed at least every two hours throughout the day.

Care plans were continually assessed to calculate the patients' phase of illness to ensure that treatment plans were appropriate to patients' needs.

Staff had the equipment it needed to safely manage the increased risks of pressure ulcers and falls for people using the service. The service had started to replace all its inpatient beds with tilt beds which have been shown to be effective in decreasing surface contact for those at risk of pressure ulcers, pressure relieving inserts for chairs were also available. The service had access to beams sensors for use with patients at high risk of falls, these alerted staff when patients had starting mobilising in their rooms without calling for assistance.

During our inspection we reviewed the notes of one patient within inpatient services and saw they had bed rails in use to promote their safety. Although we found the patient had full capacity and had given verbal consent to these being in place no risk assessment around the use of bed rails had been documented within the patients file. During the inspection the service reminded staff of the importance of documenting the reason that bed rails were in use within patient files.

At the time of inspection, the service did not have a sepsis pathway in place. Managers were in talks with the local NHS trust to develop a tool that worked for the type of patients seen within the hospice.

Patients had an Integrated Palliative care Outcome Scale (IPOS) score performed on each admission. This considered aspects of emotional wellbeing to ensure any deterioration in a patients mental or emotional state was highlighted.

Nurse staffing

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 staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. A recent staffing review had taken place using the safer nursing care tool and benchmarking against other similar services. An uplift in staffing was approved to allow adequate cover for annual leave, sickness and study leave. A nursing restructure was also implemented with three new roles being created, a ward manager and two team leaders.

The service had enough nursing and support staff to keep patients safe. The ward manager calculated a daily dependency level based upon a recognised staffing tool and staffing numbers could be increased to support patients' needs.

Inpatient staffing rotas were divided into two shifts per day covering a day and an evening shift. The day shift ran from 7am to 7.30pm and was staffed with three trained nurses and three health care assistants for up to 10 inpatients. The night shift ran from 7pm to 7.30 am and

was staffed with two trained nurses and two health care assistants. However, staffing levels could be flexed to meet patient demand such as increasing healthcare assistants to three overnight when patient acuity was higher. Shifts were scheduled to allow for an extensive staff handover of all necessary information to keep patients safe. We observed that a handover was also given to volunteers on the inpatient unit when they arrived. This was to ensure they were aware of any changes in dietary or mobilisation risk of the patients they interacted with.

The day services unit was staffed with two trained nurses, two health care assistants and one complementary therapist. Rotas were completed by ward and day unit managers up to six weeks in advance. We checked rotas for the inpatient service over the three weeks before the inspection and found shifts were fully staffed in line with planned numbers.

The day services unit had one therapist on duty per shift to ensure consistent access to complementary therapies was provided.

The service did not use agency staff and used bank staff members familiar with the service when needed. The service used a mixture of internal and external bank staff. In the three months before our inspection the day service had used bank health care assistants to cover nine shifts in December 2019, eight shifts hours in January 2020 and five shifts in February 2020.

The inpatient unit had used bank registered nurses for six shifts in December 2019, nine shifts in January 2020 11 shifts in February 2020. Bank health care assistants had been used to support 72 shifts in December, 60 shifts in January 2020 and 57 in February 2020.

Bank staff undertook and induction shift where they met their workplace supervisor and undertook an induction to their role.

The service had 231 volunteers in various roles across the company, 132 of these were directly involved in a care capacity. Volunteers helped throughout the service such as befriending patients and motivating them to join in with activities.

Between October 2018 and October 2019 the service had four nursing vacancies, three health care assistant vacancies and one medical vacancy. However, some of these posts were left open while the requirements of the staffing restructure were finalised. Senior staff members had worked clinically during this period when needed. At the time of our inspection the service had appointed to its final vacant posts.

The service had low turnover rates. In the reporting period of October 2018 to October 2019 staff turnover included four medical staff, five qualified staff members and one health care assistant.

The service had low sickness rates. In the three months before our inspection sickness rates of clinical staff was 4% and 2% for non-clinical staff.

The hospice had identified the fact that they were not aligned with the NHS agenda for change staffing pay scales as a potential reason for the difficulties experienced in recruiting full time or bank staff from the local area. In response to this a remuneration committee had been formed to start in March 2020 to look at how staff contributions may be better recognised and reflected.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The hospice's vision was to become consultant led and they had worked with the local trust to design and implement a consultant led model. A palliative care consultant was to be appointed across both the hospice and local trust with half of the clinical hours of the post be worked within the hospice. In the interim a responsible clinician had been appointed from the local NHS trust to oversee the care of patients, they attended the hospice weekly to review patients and lead the multi-disciplinary meetings.

The service had enough medical staff to keep patients safe. The service employed three part time palliative care physicians who between them provided on site medical care to patients Monday to Friday 9am to 5pm.

The service always had a prescriber on call during evenings and weekends, a rota was provided to staff with the details of who was on call and how to contact them.

The service always had a consultant on call during evenings and weekends. The hospice had a service level agreement in place with a third-party provider to provide out of hours medical support from a consultant in palliative medicine. An on-call rota was provided with the details of the consultant to contact.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Patient records were paper based and were securely kept within the nursing office with a keypad entry door.

We reviewed five sets of patient records and found all to be comprehensively completed and fully updated with all relevant information and with risk assessments in place. We saw do not attempt resuscitation forms were prominently displayed within patient records where appropriate. Records assessed peoples' emotional, social and spiritual needs alongside their physical needs.

The hospice conducted an annual in-patient admissions records audit, the audit assessed 12 sets of patient notes that were admitted to the inpatient in the three months before the audit took place. . Overall compliance with the 2019 audit was 85.2%, an improvement from 77.1% in 2018. An action plan for continued improvement was in place. For example, staff were reminded of the importance of documenting all communication with the patient and the family about timescales and arrangements for the admission when they first arrived. The service had also made changes to the admission documentation to ensure all relevant areas of the patient's history and holistic needs were captured.

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. A specialist palliative care pharmacist was employed by the hospice and provided advice and oversight of the safe and secure handling of medicines across the inpatient and day services units. A controlled drugs accountable officer was appointed.

Staff followed current national practice to check patients had the correct medicines. Medicines reconciliation was performed upon patient admission using two sources of information as a minimum. During our inspection we reviewed five medicines charts and saw all to be well completed with medicines administered on time, patient allergies were clearly documented within their notes. Nurses wore red tabards when dispensing patient medicines to indicate that they were not to be disturbed. Medicines charts had been redesigned so that specific charts were in place for percutaneous endoscopic gastrostomy (PEG) fed patients.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drugs registers were in place and checked and totalled correctly. After a suggestion from nurses to improve the services drug process individual controlled drug books for each form of medicine had been introduced to make it easier to locate specific medicines. We saw the stock and balance of controlled drugs were reviewed twice a week by the pharmacist.

The pharmacist was responsible for producing and updating medicines management policies. We found these to be accessible to staff and up to date. We reviewed the managing drug errors policy and found it to have the relevant information for staff of what constitutes a drug error, how to report one and what actions should be completed to ensure the incident is learned from.

Staff were able to discuss the process of stopping delivery of medicines after a patient's death. Staff were able to describe the process of recording, disconnecting and disposal of non-used medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised

and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored

No never events or serious incidents were reported by the service from October 2018 to October 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff understood the duty of candour and the importance of being open and transparent with patients and families. No incidents requiring duty of candour notifications had taken place between October 2018 and October 2019.

Thirty-two incidents were recorded between October 2018 and the time of our inspection. Twelve incidents were classed as near misses, 12 did not involve patients such as drug documentation errors. Eight of the incidents directly involved patients, no harm was recorded from any of the incidents.

Staff knew what incidents to report and how to report them. Staff told us they were confident in completing and submitting the paper-based incident forms and had used these in the past. Staff told us the culture around incidents was one of learning and they were encouraged to report them. Medicines incidents were reported to the pharmacist and matron. A drug error and near miss log was kept and maintained by the pharmacist. The reporting form for drug errors or near misses included a section for duty of candour to be considered and for reflections of staff members involved.

Staff received feedback from investigation of incidents, both internal and external to the service. We reviewed minutes of the clinical standards and clinical services committees and saw that incidents were discussed. Incidents were not a standard agenda item at ward level team meetings however, staff told us they would get verbal feedback after an incident had occurred. The pharmacist produced learning of the month posters based around any medicines related near misses or incidents. We saw these displayed within the clinic room.

Managers investigated incidents and we saw examples of where changes in practice had occurred. All incidents were investigated and reviewed by the management team. We saw all recent medicines management errors and near misses had been presented at the medicines management education day with reminders discussed with staff.

One improvement to practice made following an incident included proof of lasting power of attorney documentation being seen and verified by a staff member during the patients first visit to the service.

Managers shared learning with their staff about incidents that happened elsewhere. The service had analysed their practice against the findings of the Gosport Inquiry and discussed the implications on their practice. Through internal audit they recognised that anticipatory prescribing was rarely needed for patients admitted for respite at their service, therefore anticipatory prescribing to this group as standard had been removed to mitigate the risk of inappropriate prescribing to his group.

Effective systems were in place to receive and respond to external safety alerts and recalls. We saw evidence that the service had assessed themselves against the Medicines and Healthcare products Regulatory Agency (MHRA) alert in October 2019 in relation to syringe pumps to ensure their patients received medicine safely.

Safety Thermometer (or equivalent)

The service did not use the safety thermometer, but did monitor safety information to help improve patient safety.

The service monitored several safety areas including pressure ulcers, falls and medicines incidents. These were presented to the clinical standards and the board quarterly for analysis.

A wound care group was in place and discussed each incident of pressure ulcer formation.

In December 2019 one grade one and two grade two pressure ulcers were reported. No incidents of pressure ulcer development were recorded and in January 2020 and February 2020 two grade one and two grade two pressure ulcers were recorded.

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

Hospice services for adults

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw that a policy update cycle was in place to ensure policies were regularly reviewed and updated.

The service had implemented phase one and two of the Outcome Assessment and Complexity Collaborative (OACC) outcome measures. The service was recording phase of illness and Australian Karnofsky Performance Status (AKPS) in line with phase one and the Integrated Palliative Care Outcome Scale (IPOS) with phase two.

We saw peoples emotional, spiritual and social needs identified, assessed through a specific spiritual needs assessment. A spiritual care team was able to support patients and staff in meeting these needs. Nursing staff had received training in person-centred spiritual care to ensure they could understand and incorporate specific spiritual wishes.

We saw positive implementation of the five priorities of care for the dying person. In the four examples we saw this was implemented in a timely manner which enabled it to be a truly personalised document completed ahead of time with full patient engagement.

At the time of inspection, a sepsis pathway and policy was under development.

Nutrition and hydration

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 made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and those with increased nutritional needs. Each patient was assessed for their nutrition and hydration needs upon admission. The nutrition and hydration assessment tool included consideration of cultural, religious and medical diary requirements such as kosher, vegan and diabetic. The assessment also considered whether the patient was able to make their own food choices, food preferences and preferred meal sizes. The nutrition assessment included a documented discussion with the patient relatives or carers about any concerns they had regarding the patient's nutrition and hydration.

The service followed the International Dysphagia Diet Standardisation Initiative (IDDSI) scoring system for those needing food of a specific texture. We saw IDDSI codes were documented where required within patient notes to ensure all staff were aware of each patients' individual needs. No food thickener was stored in patient areas. During our inspection we checked 12 bottles of nutritional supplements and found all to be within date and stored correctly.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff could request this support through the local NHS trust community teams.

Each patient bedroom had a food menu within it. Allergen information was displayed clearly advising patients, staff and relatives to double check if they were not sure. Hot and cold drinks were available 24 hours a day from the visitor kitchen. All patients we spoke with told us that the was good and they had a choice if they wanted something different to the menu. All patients stated that they were always offered drinks. Mealtimes for both the inpatient and day services unit were protected so that patients could eat undisturbed and staff were available to assist in feeding if needed.

Staff were trained to deliver nutrition by alternate methods including percutaneous endoscopic

gastrostomy (PEG) tubes and nasogastric tubes (NG). The nutrition and hydration assessment tool had space for any specific feeding method and regime to be documented.

We reviewed the notes of one patient who had been placed on artificial hydration. We found that this decision had been pre-planned for and clear documented decision making was recorded within the patient's records.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately. We saw that patient notes had the site of pain identified and the intensity of the pain was recorded before and after pain relief was administered. Staff had access to syringe pumps to administer pain relief where appropriate.

Patients received pain relief soon after requesting it. Patients we spoke with told us their pain was well controlled. We saw nurses explaining what pain relief had been administered to patients and their families and how long it would take for the effects to be felt.

The service did not currently use a recognised tool for assessing the level of pain in non-verbal patients. We were told that discussions had been ongoing about which tool would fit the needs of the service best and that a new pain tool was due to be introduced. All staff we spoke to were confident in assessing non-verbal signs of pain relief.

Management of pain audits were conducted. More frequent audits had been conducted in 2019 de to a drop in compliance. The September 2019 audit showed 79.8% compliance, reasons included fewer than 50% of patients had documents patient's spiritual and psychosocial aspects of pain, following the audit staff were reminded to document the use of non-medical interventions that had been effective for each patient.

Patient pain diaries were in place. Patients were encouraged to use these when away from the hospice to document their pain, the site of pain and any factors that made it better or worse. These were used in order to help staff have detailed information about how the patient felt while away from their care.

Patient outcomes

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

Information about the outcomes of patients care and treatment was collected via informal patient and family feedback and by use of formal outcome measures.

Patients had individualised and comprehensive care plans tailored to their individual needs. We reviewed five sets of patient records and saw that they were designed and implemented in a way that patient needs were identified, assessed and met. The service had implemented phase one and two of the Outcome Assessment and Complexity Collaborative (OACC) outcome measures. The OACC uses a range of measures to assess changes in key domains relevant for patients receiving palliative care. Patients were assessed to determine the phase of illness and to calculate an Australian Karnofsky Performance Status (AKPS) during admission and on each medical assessment. Measures during admission to enable the care team to objectively assess patients and plan the most appropriate care aligned to each patient's stage of their illness and level of function.

The service was also using the Integrated Palliative Care Outcome Scale (IPOS) to assess and monitor symptoms and concerns of patients with advance illnesses, to monitor impact of interventions and to demonstrate quality of care. Patients had a baseline assessment completed and were reassessed on every visit. After three months each individuals' data was used in a progress meeting with the patient to track their symptoms and feelings over time. This enabled informed decisions with patients to be carried out, results were printed in graphs so that patients could see the effect that improvement or deterioration in one measure may be reflected in another.

Improving patient outcomes was embedded across all staff. Health care assistants were able to describe the process of completing IPOS scores with service users and

explain the reasons behind completing the scoring. The hospice was involved in various research and outreach projects all aimed at improving outcomes for patients on palliative care pathways or reaching the end of life.

Managers and staff carried out a programme of audits to check improvement over time. A programme of clinical and non-clinical audits was in place across the service these audits were completed once per year with the exception of hand hygiene which was completed every six months. If lower compliance in an audit was recorded than the frequency would be increased until management were happy with the outcome. Clinical audits included priorities for care of the dying patient, medical gases, infection control and pain management. Nonclinical audits included bereavement support, kitchen and food hygiene. The audit lead for the hospice was a member of the Midland Effective Audit Network. Staff across the service were starting to be trained in undertaking effective audits to ensure wider participation in audit activity.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. New staff and volunteers worked supernumerary for three weeks when they started at the hospice to allow them to shadow current employees.

Competency assessments were in place. End of life care competencies booklets were in place guided by the requirements of the Department of Health (2008) end of life care strategy document. The competency assessments allowed staff and their assessor to assess and monitor progress against clinical practice and leadership, communication, education and training and management quality competencies.

Staff and volunteers had all received evidence-based communications skills training to provide person centred support to someone with emotional concerns. Ten of the services volunteers had been further trained in bereavement support.

Staff received training appropriate to their role in advanced communication skills and application of the Gold Standard Framework.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection 73% of staff had completed their appraisal, remaining staff had appraisal dates in place. The service allowed a variance of 8% for those of long-term sickness and new starters.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. At the time of inspection three staff members had a named supervisor to provide regular clinical supervision. The education team and senior management team worked clinical shifts on occasion to give the opportunity for clinical supervision where requested or needed. Each staff member was allocated a workplace supervisor who worked with the education team on an ongoing basis to identify gaps in learning and knowledge and to provide further training that staff wished for. Staff we spoke with were able to tell us who provided their clinical supervision either internally or externally to the service.

Clinical educators supported the learning and development needs of staff and ensured staff received any specialist training for their role. Various learning events were available for staff. We saw palliative care study days being advertised to staff in areas such as symptom control at end of life and advance care planning free of charge to all staff. Lunch and learn sessions held at the hospice were advertised for staff to drop in to covering topics including central lines and male catheterisation. Funded qualifications in Makaton were being promoted at the time of inspection to clinical and non-clinical staff. Staff told us they valued the ability to improve their own practice and the outcomes for the patients they worked with.

Staff received appropriate training and updates in medicines management relevant to their role. Four non-medical prescribers were used within the service each being assessed for competence yearly with the

assessment based upon the Royal Pharmaceutical Societies competency framework for prescribers. These staff members met quarterly to provide and receive prescriber support. Registered nurses received theoretical and practical competency training on syringe pumps and completed a drug calculation competency test every three years. Nurses completed a two-day medicines management update course yearly.

Multidisciplinary working

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

Care at the hospice was provided by a multi-disciplinary team including consultants, doctors, nurses, therapists, chaplaincy and volunteers. Staff at all levels and in all roles told us they felt respected and listened to and that their input and opinions were listened to.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Multi-disciplinary team meetings were held weekly and attended by all professions. This review included a full review of each patients care plan for the week, led by the responsible clinician. We saw evidence of multidisciplinary input recorded within patients records and care plans.

Staff within all roles worked well together to ensure patients treatment and holistic needs and goals were met.

The hospice employed a social worker to ensure continuity of social support for patients and their families.

There was a clear process in place to admit a patient from hospital to the hospice.

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 per week to support patients who required inpatient care.

The day services unit was open Monday to Friday 9am to 5pm.

The responsible clinician attended once per week for multi-disciplinary meetings. A palliative care physician was on site Monday to Friday. Out of hours consultant support was available via telephone if needed.

A pharmacist was onsite five days per week, 8am to 2pm. Senior managers who provided first on call cover were non-medical prescribers in order to provide out of hours support. They pharmacist was also available out of hours for telephone advice if needed.

A physiotherapist was employed through a service level agreement with another local provider and provided services to the hospice five days per week.

The hospice employed a social worker for 24 hours a week

The Chaplin or a member of the spiritual care team was available 24 hours a day, seven days per week.

Health promotion

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

Assessments used by the service assessed and monitored all aspects of physical and mental wellbeing.

A range of complementary therapies were offered through the hospice and were built into patient care plans. These therapies were also available to relatives and carers. These included massage, aromatherapy, acupuncture and reflexology.

Patients could access a range of activities appropriate to their needs to promote a healthier lifestyle including complementary therapies, arts, crafts and a range of special activities.

Emotional support was offered to people before and after experiencing bereavement by a dedicated team of specially trained individuals.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards.

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.

Hospice services for adults

Staff understood the relevant consent and decision-making requirements of the Mental Capacity Act 2005 and they knew who to contact for advice. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff we spoke to were knowledgeable about capacity and the importance of presuming someone had capacity. We saw staff seek verbal consent before care was delivered and saw this recorded in patient records. We were told that any concerns regarding the mental capacity or changes in the mental capacity of patients would be discussed at the weekly multi-disciplinary meetings.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We were told of an example where an Independent Mental Capacity Advocate had been used with a patient who lacked capacity to support them in their decision making.

Staff could describe and knew how to access the policy on and get advice on Mental Capacity Act and Deprivation of Liberty Safeguards. All policies were available upon the services intranet and staff told us they would ask safeguarding leads and medical staff for support when they had concerns regarding these areas.

Staff explained that they had yet to be in the position to apply for a Deprivation of Liberty Safeguard for a patient in their care however, managers could describe the actions that would be taken in this event. Paperwork had been updated to reflect the national move to Liberty Protection Safeguards (LPS) as a replacement for the Deprivation of Liberty Safeguards by October 2020.

Are hospice services for adults caring?

Outstanding ☆

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

Compassionate care

Staff truly treated patients and those close to them with compassion and kindness, respected their privacy and dignity, and took account of and met their individual needs. Patients' needs were constantly assessed and identified with treatments and opportunities aligned to their needs and wishes. Patients nearing the end of their life were encouraged to think about wish lists to allow the staff and those close to them to fulfil those possible.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw that as part of the admission assessment a religious needs assessment was completed to ensure treatment aligned with the person's faiths and beliefs. We were told of an example where a patient wished for a specific prayer to be read aloud as they died, a laminated copy of this prayer had been left in the patients room to ensure which ever staff member was present could ensure this wish would be fulfilled.

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. Staff had a clear and good rapport with people using the service. We observed staff interacting with patients in a calm and considerate manner, ensuring patients had the time to ask questions. We observed patients having therapy sessions, the physiotherapist calmly encouraged and reassured the patients throughout and gave them time to complete their exercises without feeling rushed.

Staff followed policy to keep patient care and treatment confidential. Staff knocked and waited outside patient rooms before entering, we saw doors were closed and engaged signs used when care was being delivered.

Patients said staff treated them well and with kindness and where overwhelmingly positive about the care they received. Patients told us they felt involved in their care and options and treatments were explained to them throughout. One patient told us 'this place is perfection, staff never complain and are always 100% professional and carry out their duties with a smile of their faces' a further patient stated 'very good care, totally unbelievable.' From October 2018 to October 2019 the hospice had received 85 compliments about the care it provided.

Staff were able to give us examples of where the service had gone above and beyond to meet patients needs and wishes. On one occasion a patient had wished for their

dog to stay with them as they neared the end of life. Staff arranged for their dog to come to the hospice to stay with the patient in their room. Staff and volunteers helped to walk and care for the dog on their breaks.

We were told of a patient who got married very young and had never had the 'white wedding' they had always dreamed of. Although her husband had since died staff at the hospice arranged for a special service to be conducted at the local church to bless her wedding ring. A wedding dress was donated for the patient to wear and staff members attended the service to ensure she had the day she had always dreamed of.

As part of their wish list one patient had told staff that they had always wanted to stroke a horse before they died. Staff arranged for a horse to be brought onto the car park as a surprise for the patient who was supported outside in their wheelchair. The patient was able to spend time outside with the horse and died shortly after.

A further example involved a patient who had told staff they had always wished to visit Australia but now would never get the chance. Staff managed to source a virtual reality headset for the patient which enabled them virtually walk around Sydney Harbour.

Relatives, carers or those close to the patient were assessed upon the patient's admission to ensure that their emotional needs were also planned for. After a patient had died staff told us they made sure they were not intrusive but also ensured that loved ones did not feel isolated during this time. When loved ones came to collect the deceased belonging's, they were given a booklet containing details of practical support such as information on funeral costs, funeral arrangements and bereavement services to help them through the initial stages of their loss.

Bereavement support was offered through the onsite dedicated bereavement team. After a patient who had engaged with the services had died, the bereavement team had a structure to ensure bereavement support was offered after two weeks, two months and six months to their loved ones. The bereavement team were able to be responsive to drop in and ad hoc support that was required. The service was also able to refer people who needed it to local psychological support services.

Care after death was dignified and respectful. Any religious wishes of the patient would be identified before the point at which they died however, a spiritual care co-ordinator was available to ensure any final wishes could be met. Staff described to us how the deceased person would washed in a way that maintained patient dignity and advanced wishes made by the patient or family for specific clothes or jewellery to be worn would be met. All staff would be made aware that a patient had died to ensure the area was kept as quiet as possible to respect the patient and their family.

The hospice did not have a cold room or mortuary on site. The doctor on duty would certify death and the deceased person would be moved to the nominated funeral directors. If the patient or family had not finalised these arrangements the hospice had a local funeral director on call each month where the deceased person would be moved to as a temporary arrangement.

At the time of inspection an organ donation policy was not in place. We saw in meeting minutes that organ donation had recently been discussed and staff had requested further training in this area to help with approaching this conversation with patients and families.

Emotional support

Staff gave patients and those close to them help, emotional support and advice when they needed it to minimise their distress. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff provided emotional support to patients, families and carers to minimise their distress. Nursing staff and volunteers provided day to day emotional support to patients and their loved ones. Staff were there to provide companionship when needed but were respectful and provided patients and those close to them time to be alone to be together or to grieve as appropriate.

We reviewed comments within the family visitors book and saw loved ones had left comments including, 'the care here was incredible, kind, thoughtful and special in every way', 'words can't describe how grateful we are for all the love, care and attention shown to mum in her final days'.

Staff and volunteers had all received evidence-based communications skills training to provide person centred support to someone with emotional concerns. Ten of the

services volunteers had been further trained in bereavement support. The hospice participated in the VOICES survey of bereaved people. The results from 2019 showed the 67/71 respondents rated the emotional support they received while their loved one was using the hospices services was either good or excellent.

A range of family support services for carers, families and friends of people under the care of the hospice were provided by and facilitated by staff and volunteers. Staff also ensured to support patients who used the hospice after a person they knew through the service died.

The service had responded to the needs of their users and set up a young widows' group to allow those in a similar situation to meet, make friendships and receive support. The service had arranged for a volunteer school teacher to be present during this time to work with the children to allow the adults to time to interact with each other.

Bereavement support was provided as a part of the holistic care package at the hospice. The service delivered pre-bereavement work for children. Two healthcare assistants had completed a training course on compiling memory boxes and this had been implemented across the practice of the hospice. Various equipment was available to allow families to make memory boxes, handprints, and memory bracelets where each bead represented a different memory with their loved ones before they died. We were told of one example where staff had made and laminated hand prints of a service user who had young children. The children were encouraged to keep these in their pocket so they could place their hand on them when they felt lonely.

Understanding and involvement of patients and those close to them

Staff supported patients and those close to them to be fully involved in making decisions about their care and treatment and understanding their condition.

Staff told us they ensured to ask patients if they had any worries no matter how small that they wished to discuss on arrival at the hospice. This ensured they had time to discuss and any specialist input could be provided during the visit.

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Families and carers of patients were involved in planning the patient's end of life care, this was evidenced in the personalised completion of the priorities of care for the dying documentation.

In the VOICES 2019 survey 83%of bereaved people stated that they were given the opportunity to speak with a doctor about their loved ones' treatment. Additionally 87% of respondents to the survey said they felt involved in decisions regarding their loved ones' care.

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

Outstanding ☆

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

Planning and delivering services which meet people's needs.

People's individual needs and preferences were central to the delivery of tailored services. The service had innovative ways to provide integrated person-centred pathways. Services were flexible to meet patient's needs.

Facilities and premises provided met the needs of a range of people who use the service. Seven of the 10 inpatient bedrooms were en-suite, the three remaining rooms all had access to toilets and bathrooms within the immediate area of their rooms these rooms were only allocated when all others were full and patients were assessed for suitability. A ceiling hoist was installed in each room. There were two communal bathrooms within the inpatient unit and one within the day service unit with a range of hoisting equipment available for the safe transfer of patients. Seven of the rooms overlooked the hospices garden and patio area. Six of the rooms had double patio doors to enable beds to be taken out onto the patio area in warmer weather if the patient wished,

electric points were also available outside for beds or medical machines to be moved out with the patient. Patient rooms were large and bright and consisted of a bed, chair, television and storage for patients' belongings.

The service had facilities that met the needs of patients' families. A family flat was available for use. The flat was large and spacious and consisted of a double bedroom, bathroom, lounge with sofa bed and a kitchen area. The flat was comfortable and well equipped. The flat was in an area away from inpatient rooms and the day service area so families would not be disturbed. Camp beds were available for those who wished to sleep in the same room as the patient. A patient and family lounge with a kitchen was available so visitors could make themselves drinks and snacks 24 hours a day. A children friendly room was in place within the inpatient unit where children could spend time with the patient they were visiting or with members of the bereavement team.

The service was proactive in meeting the needs of people from the whole community and responded to identified gaps in service provision. The service had focused some of its outreach work towards the local Muslim population. Through engagement activities at a local library the service had identified that a lot of patients of this faith who were nearing the end of life stayed at home to be cared for by relatives. It had been highlighted that the carers among this community felt under a lot of pressure and may benefit from further tailored support. At the time of inspection, the service, along with a Muslim faith advisor were formulating an action plan of how best to engage with and offer tailored support to this group in the community.

The service had helped to facilitate 'death cafes' where people were encouraged to talk about death and the impact that it has. The service had realised there was a need to tailor this into a separate bespoke service for the under 30 years age group to discuss deaths that had occurred due to knife crime, suicide and road accidents.

The bereavement and education team had responded to a need to improve bereavement knowledge and support within schools. The service had engaged with local schools for each to nominate a bereavement link who received training on supporting bereaved children in the school environment through the onsite education centre.

The service provided an integrated approach to developing person-centred initiatives that involved other service providers. The staff at the hospice had responded to the story of a homeless man who died on the street despite being identified as end of life and being known to the local emergency services. The diversity and inclusion lead and matron had performed outreach work at local homeless hubs and delivered education sessions to local police officers on how to recognise and support people at the end of life and how to refer patients to the hospice that could benefit from their services.

The service held drop in dementia sessions which were open to everyone in the local community. These could be used to receive support and staff could signpost on to further services that could be useful.

Staff from the service had participated in the PRIDE parade in 2019. The hospice had a float in the parade with the aim to raise awareness that the hospice provides care for everyone regardless of gender identification and sexual orientation. Staff told us they were proud to attend this event and to tell everyone about their service.

The service had reviewed the needs of the local population and wider health system and worked to improve local end of life care provision. The hospice was a part of the Dudley Palliative Care Network, jointly the service had identified that between 2017 and 2018, 122 people identified as being at end of life had died within hospital after being admitted from care homes out of hours. The hospice had responded by devising a business plan to place a health care assistant with specific end of life care training overnight to care homes to avoid inappropriate hospital admissions for end of life patients. The local Clinical Commissioning Group (CCG) had recently commissioned the service and during our inspection we saw plans were in place for this to commence in 2020.

The hospice was an integral part of the Dudley Macmillan specialist care at Home service, a joint venture between Macmillan, the local CCG, the local trust and the hospice. It aimed to provide specialist single point of access care to those who need it across the Dudley borough. One of the roles of the hospice in the partnership was to recruit and train a group of volunteer carers to work with patients in the community. Through the helping hand at home service the hospice volunteers had provided 82.5

hours of support in November for 12 patients and eight volunteers, 64.5 hours of support in December 2019 to 12 patients and two carers and 77 hours of support in January 2020 to 14 patients and five carers.

The service relieved pressure on other services where they were able to do so. The hospice let the local NHS trust know their bed status daily so they could refer any appropriate patients to service. The two providers had been working together to improve the transfer pathway from the hospital to the hospice to make this a quicker and easier experience for patients and families.

Meeting people's individual needs

The service took a proactive approach in understanding the needs and preferences of different groups of people and delivered care which met these needs. Staff made reasonable adjustments to meet the needs of patients, including those with protected characteristics.

Patients using the inpatient service had their needs and wishes extensively assessed through holistic pre admission assessment and care planning. Care plans and assessments took account of medical, social, religious and cultural needs to ensure these were all address with equal importance. In four of the care plans we looked at staff had taken account of the five priorities of care for the dying person and individualised each step to the patient. Clear evidence of the care plan being made with the patient and their family involvement was documented, including the identification of outcome goals. The service had truly embedded the five priorities for care and had recognised the importance of starting this process early so patients were able to fully engage in the process, this resulted in pre-planned personalised end of life care.

Day service users worked with staff to complete an about me questionnaire, this helped to ensure the care was personalised to each individual. Questions included assessing what is important to the patient, to the people in their life and what they would like to experience more and less of in the next few weeks. We saw these were fully completed in the patient files that we looked at. Staff had then gone further with each patient to assess barriers and issues that may stop them from achieving their goals and further plans had been put in place to avoid or overcome these problems. Patient files were designed in a way that these identified goals were clearly visible to all those reading the notes.

Staff had access to communication aids to enable patients to become partners in their care and treatment. Documentation was available in easy read and pictorial format, including advance care planning documentation. The service had utilised local disability networks to assess their documentation and ensure it met the needs of the target audience. At the time of inspection clinical and non-clinical staff were being encouraged to complete a course in Makaton funded through the hospice to ensure staff were continually expanding their ability to communicate with all patients and visitors. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed.

The environment was designed to meet the needs of patients living with dementia. Pictorial signage had been introduced around the hospice to help orientate patients living with dementia. The service had recently been awarded a grant to enable them to redecorate the patient bedrooms to make them more dementia friendly. Dementia clocks were available for use and the service had reversible mirrors which could be turned around to display a dementia friendly picture on the reverse, these could be used with patients who may be made anxious by their reflection. Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports. At the time of inspection 168 staff and volunteers had been trained as dementia friends.

Care plans and admission documentation were inclusive and allowed patients to express the gender they identified as and their spiritual and cultural beliefs. The service ensured individual spiritual and religious beliefs were catered for from admission. Upon admission services users were assessed for their spiritual needs to ensure this was reflected in their care plans and we saw this inpatient notes. Staff had also received spiritual awareness training to enable them to understand and facilitate wishes of those from different faiths. Two peace rooms were available within the hospice with blessings from various faiths available in print format. A Wudu area

was in place in the bathroom closest to the peace room to allow Muslim worshipers to perform the washing ritual of Wudu before prayer. Staff were due to receive further training on LGBT+ on planned study days.

A carers support group met monthly within the hospice for ongoing advice and support to be given and received. The service worked to put carers who were new to the hospice in contact with another carer known to the hospice to provide informal support and encourage them to participate in the services offered.

Access and flow

People could access the service when they needed it in a way to suit them and received the right care promptly.

Referrals could be made to the inpatient unit for symptom control, terminal care, respite care and crisis intervention. The service had an effective process in place to manage timely referrals. To improve access times for patients the referral system has recently been changed so that referrals could be sent straight to the hospice via secure emails. The referral form to refer a patient to the hospice was also readily available on the services website.

The service predominately took admissions to the inpatient unit Monday to Friday between 9am – 5pm. However, a process was in place to receive unplanned admissions over the weekend from the local NHS trust for patients identified as being near the end of life. The service did not have a waiting list for admissions to inpatient beds at the time of the inspection.

There was a clear process in place to admit a patient from hospital to the hospice. The process had been streamlined so that the hospice would accept patients from the hospital if they had been reviewed by the palliative care consultant at the trust, removing the pre-admission assessment performed by a hospice staff member.

The average length of stay for inpatient in 2019/2020 was 11.8 days. Bed occupancy rates for 2019 were 75% on average, with a high of 85% in May 2019 and a low of 58% in September 2019.

The service was able to arrange specialist bereavement support through specialist palliative care bereavement services and psychologists by referring to other local networks for patients who needed it. The service also provided links and contact numbers to other bereavement associations such as the Samaritans, National Bereavement Helpline, Lesbian and Gay bereavement and parent line plus.

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 clearly displayed information about how to raise a concern in patient and communal areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us that formal complaints were very rare. Staff described how they would discuss any concerns or queries with patients or family members at source. Staff told us if they could not satisfy the complainant, they would escalate the concerns to a more senior member of staff.

The service had received one formal complaint between October 2018 and October 2019. We reviewed the complaint file and found the investigation was thorough and a detailed response to the complaint was given. We saw that staff reflections had also been recorded within the complaint file. The complaint was answered within the time scale of twenty days set out within the complaints policy.

We reviewed the complaints policy and found it to contain all necessary information to support staff in recognising, reporting and responding to complaints. However, the complaints policy stated that if a complaint could not be resolved it should be referred to the Care Quality Commission for review. This was not correct as the Care Quality Commission do not handle or investigate individual complaints about care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service used a range of immediate feedback and national surveys to gain feedback from service users and their loved ones. The service was due to start

participation in a pilot study of a picture-based feedback tool to collect stories of palliative care patients journeys to ensure that detailed feedback could be collected from all service users.

Staff could give examples of how they used patient feedback to improve daily practice. Feedback from responses to the VOICES survey was that family members appreciated it when contact was made with them it was done by a staff member who had looked after their loved one during admission, so wherever possible the service ensured this took place. The service had acted on feedback received from a patient who was not sure what all the different staff uniforms meant, pictures of different staff uniforms and what their job titles were now displayed in patient information booklets and on the information screens in the hospice. One patient had commented that they found it hard to read at night without the main lights being on, the service had responded by buying reading lights for use in inpatient rooms.

Are hospice services for adults well-led?

Good

Our rating of well-led improved.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 the service to have an established, stable and well embedded senior leadership structure. The service had recently revised its nursing staff structure to strengthen reporting lines and to promote development and succession planning below the senior leadership level. This included the addition of ward managers and shift leaders. We found compassionate, inclusive and effective leadership at all levels.

The chair of the board of trustees was well informed of the skill mix of the board, the chair had identified areas where the board could be further developed in line with the ongoing vision of the service. Trustees completed an induction programme to familiarise themselves with what the trustee role entailed, the chair and senior leaders confirmed the trustees provided an appropriate level of challenge to reports presented to them.

Leadership development was encouraged the Matron had completed the Hospice UK leadership course and band 6 leadership competencies were in place to encourage development.

Leaders looked beyond their own service to ensure effective provision and operation of palliative and end of life care networks and collaboratives in the local health system.

Leaders had an in-depth knowledge of the risks and opportunities of the service.

We saw that leaders were visible within the service. Staff told us that there was open door policy with the ward managers and matron, and they were happy to approach them. Staff told us leaders regularly engaged with them. The chair of trustees made themselves available once a week for drop in sessions with staff to discuss any concerns or ideas they had. All staff we spoke with told us they felt supported by their immediate line manager and from all levels of management within the service. Volunteers told us they were well supported by all staff and encouraged to raise issues or ideas across the service.

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 fully aligned to local plans within the wider health economy.

The service had a clear vision which was to 'provide a safe, compassionate environment, with highly-skilled staff with time to listen, advise and create personalised holistic programmes of care.' Three supporting mission statements were in place, 'Provide care and support to everyone that needs us', 'communicate our care, compassion and kindness' and to 'ensure a sustainable future'.

Hospice services for adults

The values of the service were care, compassion and kindness and we saw that all staff embodied these values throughout their work, we saw staff took the time to interact with patients and their families and were genuinely invested in providing a positive experience

A strategy was in place that spanned to December 2020, the aims and objectives were clear and included to improve end of life care for people living with dementia, improve the effectiveness and accessibility of inpatient care, maximise the usage of the day service unit, to establish Mary Stevens Hospice as a provider of a range of community-based services and to ensure that the hospice is at the centre of palliative and end of life care across the Dudley Metropolitan Borough. Throughout our inspection we saw the service had made progress towards and achieved set service change and service enabling programmes aligned with their strategy. Sustainability and income generation were key parts of the enablement of the strategy and had sufficient focus and priority.

There was a demonstrated commitment to system-wide collaboration and leadership. The strategy from 2020 onwards was due to start being developed by the board and the executive team and was to be devised with system wide collaboration through the new partnerships and networks forged by the 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 we spoke with across all areas were proud of the organisation as a place to work and spoke highly of the culture of compassion and openness. There was a common focus on improving the quality and sustainability of care and peoples' experiences. All staff we spoke with were passionate about their work and providing the best possible care to patients and their carers and relatives by going the extra mile. The senior leadership team displayed a shared purpose in the work of the hospice and motivated their staff to succeed.

There was a strong emphasis on the safety and well-being of staff. Staff were aware of the lone working policies and procedures that were in place to protect them. Emotional well-being was supported internally and externally. A staff well-being employee assistance programme was in place giving staff access to confidential support 24 hours a day, 365 days per year. The service was in the process of developing a compassionate colleague network to give a more formalised approach to the emotional and psychological support staff could offer each other by training staff to recognise the circumstances of another person or group and feel compelled to take action to improve these circumstances. A cycle to work scheme was also offered to all staff to encourage physical wellbeing.

Policies and procedures were in place to support staff in confidently speaking up and raising concerns both formally and informally. We reviewed both the whistleblowing and complaints procedure for staff and found both to provide the information needed to support staff on formally raising concerns.

There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion among the workforce. The hospice engaged with the access to work scheme to enable them to effectively hire disabled people with the skills needed or to retrain employees who developed a disability or long-term condition.

Learning and development of all staff members was encouraged and supported. Development opportunities both internal and external were continually advertised and promoted to staff. One staff member told us that with support provided by the hospice they had finally managed to complete their degree.

There was strong collaboration between the hospice and the wider health system in order to improve the provision of service to the local population and provide sustainable joined up care.

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.

An effective and defined governance structure was in place to ensure accountability and delivery of the strategy was maintained. We were told the system had recently been reviewed and independent chairs assigned to each board sub-committee to ensure consistent and appropriate challenge at all levels.

The governance structure included board, clinical governance, clinical standards, hospice wide governance, clinical services and team-based meetings. We reviewed meeting minutes from all groups and saw that performance, staffing, finance and incident information including was discussed at each level. Committees received and reviewed the minutes and actions of related subcommittees.

We saw that minutes were available within nurses' offices and also upon the intranet system for staff to review.

A programme of clinical and internal audit was in place to identify areas of risk and improvement and actions were taken to improve performance.

The chair of the board of trustees had confidence in the data presented to board and stated that her and the board of trustees were happy to query and ask further questions around reports presented.

The hospice received independent financial auditing of its charity and subsidies. The last audit had been completed in March 2019 and found the accounts reflected a fair and true account of the business and were in accordance with the Companies Act (2006).

Managing risks, issues and performance

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

A risk register was in place covering all areas of the service. The risk register was laid out in a way that risks were listed by the staff member responsible for overseeing the risk. Risks were rated by the impact that it could have upon the safety or provision of the service. We saw actions listed against highly rated risks. However, we noted that some low risks had been on the register for a significant period of time with no update. Risk register review was a standing agenda item for the board meetings but was not always discussed. We saw that new risks being entered upon the risk register where presented at board meetings for approval.

Staff we spoke to could articulate the main risks to the service with the loss of key staff members, medical oversight, information security and funding being the main risks to the clinical arm of the hospice. Staff at all levels could describe the actions taken to mitigate the risks these posed to the service.

Managers thoroughly assessed the risks involved in the development of and supporting new care programmes and initiatives across the wider health system.

Performance data was analysed and presented at committee meetings. We saw within clinical standards meeting minutes safety indicators such as infection rates, pressure ulcers and falls were reported and discussed. Performance data including audit outcomes were also presented.

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 service managed information well and kept records safe. We observed that staff locked computers when they were not in use.

The provider submitted statutory notifications to the Care Quality Commission as required, for example, after the death of a patient or a serious injury had occurred.

The hospice was subject to a data security breach in April 2019. Appropriate action and learning was undertaken as a result with the relevant bodies being notified. The hospice took further steps to strengthen their existing security measures and notified all those who may have been affected. Information governance training and

General Data Protection Regulation (GDPR) training had since been mandated. Information security risks on the risk register had been graded as extreme until the board were happy with all the controls in place. In order to encourage staff to remain vigilant phishing scam exercises were being conducted with feedback to staff being given on how many staff members had inappropriately accessed the contained links. At the time of inspection, the service had completed 90% of the NHS data and security protection toolkit.

Integrated Palliative Care Outcome Scale (IPOS) data was collected for each patient and presented in an easily understandable format to allow staff to have informed conversations with patients and their family about their care, symptoms and treatment over time.

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.

Staff members were proud of the engagement activities they were able to offer both internally to current service users and within the wider community. An employee forum was in place to allow staff to voice ideas and to be engaged in the ongoing provision of the hospice's services. A staff suggestion box was also available for ideas to be shared.

Service users and their families were involved in shaping care and decision making around the services offered. We saw that patient feedback had led to improvements in the delivery care such as the addition of extra reading lights, uniform descriptors and a staff picture board being on display. The peace rooms within the hospice had been created after consultation with various faith advisers, patients, volunteers and staff.

The children's room at the hospice had been designed with the help of children who had previously used the hospice services to ensure that it met the needs of those who would be using it. Learning disability networks had also been engaged in the design of easy read documentation.

The service took a leadership role in its local health system to identify and proactively address challenges and meet the needs of the population. The hospice was a key part of the Dudley Palliative and End of Life Care network which saw different providers working together to improve provision and to simplify the process of moving between different health care providers.

The service had built positive and collaborative relationships with external partners to help improve the quality of end of life care across the local area. The service was a regional training centre for care homes, aiming to enhance the end of life care for people within care homes and enabled staff to deliver personalised care consistent with patient wishes. At the time of inspection, the Care Homes Champion programme had been delivered to two staff members from each care home in the borough. The service was also a co-founder of the Midlands Palliative and End of Life Care for People with Learning Disabilities Network. At the time of inspection, the hospice had provided education and competency support for 23 learning disability care home staff.

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.

The hospice was committed to improving palliative service provision across the local area. They were a strategic partner in developing and improving the palliative care provision across the Dudley area.

The hospice had a strong record of sharing work locally, nationally and internationally. Staff were supported to attend and present research at national and international conferences. For example, the service had presented their innovative hard to reach population investigation nationally and internationally.

The hospice was member of the national association of clinical educators and a teaching hospice providing placements for students from local universities and the ministry of defence**.**

The hospice was an approved Sage and Thyme teaching centre and at the time of inspection had trained over 750 delegates from the local area in partnership with the Dudley Palliative Care Home project.

Outstanding ☆

Hospice services for adults

The hospice had its own education and research facility onsite where training sessions for internal and external professionals was held. The service had achieved research ready status and at the time of inspection was involved in a national study.

The hospice was due to start participation in an innovative pilot study of a symptom tracking mobile application to allow patients to report their symptoms and feelings when outside the hospice to promote constant engagement between service users and those responsible for delivering their care.

The hospice and its staff had been nominated for and received various local and national awards.

The hospice won the working in partnership award for 2019 from the local CCG for their involvement and work on dying matters. The hospice was a runner up in the Guardian Public Service awards in 2019 for the work it had conducted around dementia, learning disability and homelessness. The volunteer service was awarded the Queens Award for Voluntary Service in 2019, which recognises outstanding work by volunteer groups to benefit their local communities.

Outstanding practice and areas for improvement

Outstanding practice

The Australian Karnofsky Performance Status (AKPS) and Integrated Palliative Care Outcome Scale (IPOS) measures were embedded into practice to assess and monitor symptoms and concerns of patients with advanced illnesses, to monitor impact of interventions and to demonstrate quality of care.

The service had engaged with local schools for each to nominate a bereavement link who received training on supporting bereaved children in the school environment through the onsite education centre.

Patients using the inpatient service had their needs and wishes extensively assessed through holistic pre admission assessment and care planning. Care plans and assessments took account of medical, social, religious and cultural needs to ensure these were all address with equal importance.

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Areas for improvement

Action the provider SHOULD take to improve
Following our inspection, we found six areas where improvements should be made.

The service should ensure that adult and children safeguarding policies reflect the most up to date guidance and clearly identifies routes of escalation in and out of hours (Regulation 13 (3)).

The service should ensure that a recognised tool of assessing pain in non-verbal patients is introduced (Regulation 9 (3).

The service should ensure that the complaints policy advises complainants on the correct way to escalate their concerns (Regulation 16).

The service should ensure that all risks are proactively manged and updated (Regulation 17(2)b).

The service should ensure that a sepsis pathway in line with national guidance is put in place (Regulation 12 (2) a-c).

The service should consider the frequency at which audits are conducted to improve practice and outcomes.