St Clare Hospice

Quality Report

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Date of inspection visit: 3 and 11 December 2019
Date of publication: 23/03/2020

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St Clare Hospice is operated by St Clare West Essex Hospice Care Trust. The hospice has eight beds. Facilities include the inpatient unit, day therapy services and hospice at home services.

The hospice provides specialist care for adults that require palliative care.

We inspected this service using our comprehensive inspection methodology. We carried out the initial unannounced part of the inspection on 3 December 2019, along with a second unannounced visit to the hospice on 11 December 2019.

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

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

The main service provided by this hospice was specialist palliative care.

Services we rate

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

We found outstanding practice in relation to the hospice care:

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

  However, we also found the following issues that the service provider needs to improve:

Summary of findings

Patient medication administration by staff for planned short leave periods should follow national and local management of medicines guidance.

Heidi Smoult
Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	• The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. • Staff provided outstanding care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff always treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, were active partners in their care and helped them understand their conditions. Staff recognised and respected the totality of patients' needs and provided emotional support to all patients, families and carers. • The service planned innovative care to meet the needs of local people, proactively took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. This included people protected under the equality act and people in vulnerable circumstances. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients

Summary of findings

receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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Background to St Clare Hospice

St Clare Hospice is operated by St Clare West Essex Hospice Care Trust. The hospice opened in 1990. It is a charitable and NHS funded hospice in Hastingwood, near Harlow Essex. The hospice primarily serves the communities of West Essex and East Hertfordshire but accepts patient referrals from outside this area.

The hospice is registered to provide the following regulated activities:

- Personal care
- Treatment of disease, disorder or injury

The hospital has had a registered manager in post since 11 February 2019.

Our inspection team

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

Information about St Clare Hospice

The hospice provides specialist palliative care through inpatient, day therapy and hospice at home services, as well as a range of other specialist advice, support and care such as that provided by hospital palliative care teams.

The inpatient unit has eight beds and provides 24 hour care, assessments and specialist palliative care to relieve the physical effect of patients' conditions such as pain, breathlessness and nausea. It incorporates medical, family, bereavement, spiritual, physiotherapy and occupational therapy (OT) support.

The palliative care and community service enables people to remain in their preferred place of care, at home, at the end of their life. The community team collaboratively works alongside community nursing services in an end of life partnership to provide seamless care to patients. Services provided include; 24 hours and seven days a week single point of access support, advice and coordination line, palliative register referral and management, planned visiting service, night sitting service, family support and bereavement service. The day therapy service helps people living with long term conditions to avoid unnecessary trips to hospital, as well as offering social opportunities alongside others experiencing similar circumstances. There is a triage system and eight week skills for living service. It offers a rolling programme with access to physiotherapy, complimentary therapy, family support, OT and carers support.

During the inspection, we visited the inpatient unit, day therapy services and hospice at home service. We spoke with 18 staff including registered nurses, health care assistants, reception staff, medical staff, , and senior managers. We spoke with two patients and one relative. We also reviewed patient feedback received by the service. We reviewed six sets of patient records and equipment.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected twice before, and the most recent inspection took place in October 2016 which found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity (April 2018 to March 2019)

Summary of this inspection

- In the reporting period from April 2018 to March 2019 there were a total of 3,669 patients seen by the service which included 231 inpatients,1001 day therapy cases, 973 patients seen by the community service, 673 patients seen by hospice at home services and 229 patients attended the bereavement services.
- The regular resident medical officer (RMO) worked on an on call rota. The service employed 22.99 fulltime equivalent (FTE) registered nurses, 19.16 FTE care assistants and 550 volunteers worked for the hospice as receptionists, gardeners, fundraisers and the hospice had its own bank of staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety for the service;

- Zero never events
- 85 clinical incidents with 48 categorised as no harm and 37 as low or moderate harm.
- Zero serious injuries
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- Five complaints were received for the same report period with presenting themes which included staff miscommunication, donations, care plan and medication changes.

Services accredited by a national body:

The hospice offered support to other local services with the delivery of the Gold Standard Framework (GSF). This quality improvement framework aims to improve supportive care for all people as they near the end of their lives. The local general practitioners hold monthly GSF meetings where a member of the hospice team attends to support the care of any patient recorded on the GSF register.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Pharmacy service
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Responsible Medical Officer provision

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. They used control measures to prevent the spread of infection before and after the patient died.
- 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 staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- 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 appropriately.
- Staff gave patients enough food and drink to meet their needs and support their health. They used special feeding and hydration techniques when necessary.

Summary of this inspection

- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

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. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support to help them live well until they died.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Outstanding

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

Summary of this inspection

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs and are empowered as partners in their care.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. People's emotional and social needs are highly valued by staff and are embedded in their care and treatment.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. People who use services are active partners in their care. Staff are fully committed to working in partnership with people and making this a reality for each person. Staff always empower people who use the service to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs are always reflected in how care is delivered.

Are services responsive?

Outstanding 

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care and improve services
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- The service made adjustments for patients' religious, cultural and other needs.

Are services well-led?

Good 

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

Summary of this inspection

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

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.

Mandatory training was comprehensive and met the needs of the patients and staff. Courses covered key areas such as infection prevention and control, manual handling and basic life support and medicines management. Training was available through e-learning and face to face sessions.

Staff told us about their responsibility in completing mandatory training and that the training they received was relevant to their role.

Volunteer staff were supported and attended mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update by email or at their monthly one to one meeting. Training was monitored by the manager monthly and staff were supported in completing training within working hours.

Managers received reports regularly about mandatory training which meant they were able to raise any concerns when identified.

All staff received and kept up-to-date with their mandatory training. Staff were up to date and had met the hospice's target for ten out of the eleven mandatory training courses. The hospice had set a target of 90% for completion of all mandatory training courses which had been achieved for most staff through monthly mandatory training days organised throughout the year.

All staff we spoke with had received training about the needs of people with mental health conditions and dementia.

The clinical educator was employed part time by the hospice and supported staff training and development. There was a structured induction programme for new staff and all volunteers confirmed they had attended.

All healthcare support workers had completed a customer care certificate which was supported by the service.

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.

There were clear systems and processes and practices to safeguard adults, children and young people from avoidable harm, abuse and neglect that reflected legislation and local requirements.

The service had a safeguarding policy version five which was last reviewed March 2017 (next review due March 2020). The policy was accessible to all staff through the services intranet. Safeguarding information was displayed in all patient areas which advised how to access support if they were in an abusive situation.

Links to safeguarding external resources were available to staff through the trust webpage. We saw contact names and numbers for staff who provided support for concerns that related to adult and children and young people safeguarding.

The designated lead for safeguarding adults and children and young people was known by staff and available to provide support, supervision training and updates.

Staff knew how to identify adults and children at risk of harm and worked with other agencies to protect them, for example general practitioners, police and the local safeguarding authority. Information provided following the inspection stated that there was a safeguarding supporters group. There were safeguarding champions in every department, including the non-clinical ones. The safeguarding supporters group met regularly for updates on safeguarding policy, and to ensure that all hospice colleagues understood their role and responsibility for safeguarding vulnerable adults and children. The group promoted the confidence and competence of all hospice staff in recognising and raising safeguarding concerns. Minutes of the meeting reviewed from October 2019, December 2019 and January 2020 showed discussion about disseminating training to all staff and planning training events. There was evidence that actions from previous meetings were followed up.

Medical staff received training specific for their role on how to recognise and report abuse, all staff were able to access the safeguarding resource folder and confirmed the service had set a target of 95% for safeguarding training compliance. Staff training showed the following compliance up to December 2019:

Safeguarding training Level 1 Adults 96% Children 98%

Safeguarding training Level 2 adults 97 % Children 95 %

Safeguarding training Level 3 100 % and Children 100 %.

Safeguarding information was displayed in all locations we visited with posters promoting contact numbers which advised how to access support if abuse was suspected or experienced.

Staff knew how to make a safeguarding referral and who to inform if they had concerns, there were no safeguarding alerts reported from August 2019 to December 2019.

Staff followed safe procedures for children visiting the hospice, we saw children visiting the hospice who were supervised by family members while they played in the family room.

Safety was promoted in recruitment and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could commence work at the hospice. Managers told us that all employed staff had DBS checks which were resubmitted three yearly. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

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.

The inpatient unit (IPU) and day therapy areas were visibly clean and had suitable furnishings which were well-maintained. There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored with daily and weekly checks to maintain good infection prevention and control practices.

The service generally performed well for cleanliness. Staff carried out daily safety checks of specialist equipment. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All cleaning records reviewed were fully completed from September 2019 to December 2019 and showed that all areas were cleaned daily and compliant to national standards. The service used the infection prevention and control national audit tool developed by Help the Hospices, now known as Hospice UK.

We reviewed the IPC monthly audit plan from January 2019 to March 2019 which showed an average of 94% compliance to IPC standards. There were clear improvement actions taken to meet all the standards, for example, the in-patient manager and facilities manager now met monthly to monitor corrective actions taken and reported progress or concerns immediately to the senior manager or at their weekly meeting. We saw examples where staff had been reminded to remove jewellery to maintain compliance with monthly hand hygiene audits.

We reviewed hand hygiene results from June 2019 and September 2019 which achieved 96% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All patient clinical areas had access to sinks with hand wash and paper towels. Each sink area displayed the hand hygiene national poster on the correct hand hygiene process for all staff and visitors to follow. The inpatient unit sinks had no electronic sensor or elbow operated taps which would support effective hand hygiene for staff during patient care. Hand sanitiser gel was seen at the main reception area, entrance to the in-patient unit, corridors and day therapy areas.

The service had an Infection Prevention and Control policy (IPC) which was last reviewed in February 2019 (version five) and staff told us they could easily access the updated policy on the intranet page. Staff maintained bare below the elbow practices when working clinically and were observed to adhere to best hand hygiene practices. The IPC training compliance for staff was 97% up to December 2019.

Staff cleaned equipment after patient contact and labelled equipment to show when this had last been completed. We saw all equipment with an 'I am clean' label when not in use.

Staff followed infection control principles which included the use of personal protective equipment, which was seen available throughout the hospice. Staff told us about the systems and processes in place which prevented a recent potential infection outbreak.

There was a regular programme of monthly IPC audits to ensure good practice was embedded across the service and assessed compliance against national and local guidelines. The hospice had a designated lead for IPC who completed and signed off the monthly IPC audit results.

Staff described how they washed and prepared the patient after death and maintained good IPC controls in line with national guidance.

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. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

The hospice was situated in a rural location adjacent to a motorway but positioned in a peaceful setting which offered easy access and free parking for visitors, although the service was not accessible by local bus route following a recent review of bus services. Managers had written to the local bus company to request that the service be reconsidered for those service users who did not drive.

The hospice was accessed through a secured door with a reception desk where day patients and visitors were required to sign in or out. Access to the inpatient unit was secured out of hours and the entrance accessed by an intercom pad to prevent unauthorised visitors.

The design of the environment followed national guidance. The service had suitable facilities to meet the needs of patients' families, and risk assessments were in place where the environment posed a risk to patients and visitors, for example the loss of resources, for example electricity, heating or staff .

The patient rooms were large and light with access to the gardens and countryside surrounding the hospice, this allowed staff to push beds outside when requested by the patient. All areas of the hospice were made to look as homely as possible, although some areas decoration looked old and tired. Staff told us this was part of the programme of redecoration due to start in January 2020 when the hospice had less patients.

Patients could reach call bells and staff responded quickly when called. We observed that call bells were answered promptly during both our inspection days.

Staff carried out daily safety checks of specialist equipment. Staff carried out daily checks of emergency equipment and we saw check sheets that were fully completed.

The service had enough suitable equipment to help them to safely care for patients, there was no defibrillator situated within the service and although there is no

legislation which obliges certain businesses or premises to provide a defibrillator. We discussed this with the registered manager who confirmed the purchase of a defibrillator was currently being reviewed.

Effective processes were in place to ensure equipment was well maintained and fit for purpose. The hospice maintained a record of equipment which was sent to a local hospital maintenance of equipment service who maintained and calibrated the service's equipment.

We checked the store supplies and consumable items and all were within date. Staff disposed of clinical waste safely, waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. The sharps containers were clearly dated and labelled, not over filled and with details completed for traceability. This was in line with national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare)Regulations 2013: Guidance for employers and employees (March 2013).

Cleaning equipment was stored in a locked cupboard and the 'Control of Substances Hazardous to Health' (COSHH) folder contained completed risk assessments for each product. The COSHH regulation 2002 required employers to either prevent or reduce their workers' exposure to substances that are hazardous to their health.

The service had clearly signposted gender neutral toilets available as well as individual gender toilets for patients and visitors.

The gardens were maintained by volunteers and each patient room had access to the surrounding gardens without being overlooked by others within or outside of the hospice.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

The supportive & palliative care indicator tool used helped staff identify people with deteriorating health due to one or multiple advanced conditions, and guided holistic assessment and individualised care planning.

Staff completed risk assessments for each admission or first point of contact and updated them with recognised tools, for example, malnutrition universal screening tool (MUST) and Waterlow for risk of pressure ulcers.

Staff knew about and dealt with any specific risk issues. All six patient records reviewed had completed and comprehensive risk assessments for; risk of falls, nutrition, hydration and pressure ulcers.

Staff undertook two hourly comfort rounds to check on patient's symptoms such as; pain, skin integrity, elimination, nutritional requirements and personal care. We reviewed six patient comfort round forms and all were fully completed and signed. Staff identified and quickly acted on patients at risk of deterioration.

Staff managed increased risks experienced by patients at the end of life. For example, patients at risk of falls were reviewed more frequently as indicated by their individualised care plan, Bed rails were used only when appropriate following a risk assessment, staff lowered beds to reduce the risk to the patient.

Staff assessed and identified patients who were at risk of pressure ulcers and those with existing pressure ulcers. Pressure ulcers were managed appropriately, and documentation was clear and concise. All staff attended further training to ensure that pressure ulcers were categorised correctly,

Staff shared key information to keep patients safe when handing over their care to others and included any risks on patient discharge documentation to handover to other professionals responsible for the patient's care.

Patient care plans and risk assessments were reviewed weekly by staff caring for the patient or more frequently should the patient's condition change. All care plan changes were discussed with the patient and their loved ones as appropriate.

Shift changes and handovers included all necessary key information to keep patients safe. Staff handovers included all necessary key information to keep patient's safe and ensure all information was available for staff who cared for the patient and their families. Patients were

discussed at the daily multidisciplinary meeting; this covered all aspects of patient care, including those with 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place, current patient risks, preferred place of death and current vital signs observations. All patient's notes reviewed had DNACPR orders in place.

A multidisciplinary assessment was carried out when patents were identified to be within the last phase of end of life. Consideration included advance care planning, symptom management, nutrition and hydration, as well as spiritual and psychological needs. All end of life care plans reviewed were individualised and developed in accordance with the wishes of the patient. All patients with end of life care plans were reviewed every two hours.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff told us they would contact emergency services when indicated.

Staff understood their responsibilities in the event of a fire, 96% of staff had completed fire training up to December 2019.

The hospice had clearly identified fire exit doors which were free from obstruction. The inpatient unit and day therapy services had fire extinguishers and fire blankets that were all checked within the last year.

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 and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed staffing levels and skill mix, they planned and reviewed staffing in line with the national workforce modelling recommendations for hospices.

The number of nurses and healthcare assistants matched the planned numbers. The inpatient unit establishment, was two registered nurses and two healthcare assistants on duty during the day and two registered nurses and one healthcare assistants during the night. The actual staffing levels met the planned numbers during our inspection.

The managers could adjust staffing levels daily according to the needs of patients. The inpatient unit manager completed the staffing roster for each shift manually and co-ordinated patient activity. The manager was given supernumerary time to enable them to have oversight of the unit, attend meetings and support staff.

Current staffing levels and vacancies were as below:

Nurses (RNs) - 22.99 FTE staff, 1.6 FTE vacancies

HCA - 19.16 FTE staff, 0.8 FTE vacancies

AHP - 10.6 FTE staff, 4.7 FTE vacancies

Medical - 4.05 FTE staff, 0.2 FTE vacancies

Medical staffing

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

The service had enough medical staff to keep patients safe. The hospice employed two medical consultants, and 1.8 whole time equivalent (WTE) senior specialty doctors who all had experience and postgraduate qualifications in palliative medicine and also covered community services. A consultant or speciality doctor was on-site Monday to Friday 9am to 5pm. They were supported by trainee GPs and/or foundation doctors. A foundation doctor is a grade of medical practitioner in the United Kingdom undertaking the foundation programme. This two-year general postgraduate medical training programme forms the bridge between medical school and specialist/general practice training.

Out of hours, the on call doctor was available overnight and at weekends to provide advice and support.

Records

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

Patient notes were comprehensive, and all staff including bank staff, were able to access electronic records easily.

Records were kept securely in a locked room in a lockable notes trolley.

We reviewed six sets of patient records which included individual risk assessments. These were reviewed every time they received support from the service and included holistic assessments. These had been completed fully on admission to the service, and we saw individual care needs, patient's wishes and risks to their wellbeing recorded.

The service has had an information technology system for patient records, for the past three years. This included community records made by the district nurse or general practitioner but not the local hospital's patient records. All staff completed electronic patient records as needed. This included bank staff and health care assistants updated patient care plans and patient story care plans which focused on the patient's social needs.

There was an individualised care plan for the dying patient on the electronic system for those patients who had been identified at that phase of care. All individual care plans reviewed had been completed and included; falls assessments, skin care and Mental Capacity assessments.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The hospice commissioned clinical pharmacy product services from an external provider through a service level agreement. A pharmacist technician visited the hospice weekly to monitor stock, storage and review patient prescription records. A report was shared with the service of any concerns and highlighted any prescribing errors.

A medicines file was maintained daily and included the audit of fridge storage temperatures, short date stock and safety warnings. Medicine stocks were requested by nursing staff as needed and were identified as a stock requirement.

Staff accessed out of hour pharmacy from a local pharmacist with a doctor completing a prescription form (FP10). Blank FP10 prescription pads were stored securely and monitoring systems were in place to ensure all prescriptions were accounted for. The audit record detailed each prescription issued, the patient name and prescription number which was in line with national guidance (NHS Counter Fraud Authority v1 March 2018 Management and control of prescription forms).

Staff stored and managed medicines and prescribing documents in line with best practice. Medicines were stored securely. Checks were in place to ensure emergency medicines were available and safe to use. Controlled drugs (medicines subject to additional security measures) were stored securely in a locked cupboard. Two members of staff were required to check the stock numbers against the stock levels and record in the controlled drugs register daily. We reviewed the controlled drug register, stock was checked, and no gaps were seen for the last six months.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. The service had a medicines management policy which was last reviewed December 2019 version five. We saw patient medication reviews were part of the ward round and handover discussions. Staff spoke with patients about their medication which was documented clearly in the patient records reviewed.

We reviewed six prescription records and found they were signed, dated, timed and legible. Patient allergies were documented, and medicines were given as prescribed. Patient medicines were reviewed and included anticipatory medicines for when the patient required additional pain control. 'Anticipatory' drugs in a palliative setting are those drugs that are prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life.

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

Staff followed current national practice to check patients had the correct medicines.

Nursing staff checked patients who had medicines administered through a skin patch or as an intravenous infusion (directly into a vein). This ensured that patches remained in the correct position and intravenous lines remained in place and were working.

Medicines were disposed of safely and records of destruction were documented. Controlled drugs (CDs) destruction kits were used to dispose of CDs and this was seen to be used correctly and not over filled.

Unwanted or out of date medications were kept secure and away from other medicines and disposed of correctly through pharmacy.

The patient's own drugs were signed onto the medication charts kept on the patient files and returned to the patient on discharge. The medicines were stored in a locked cupboard in the treatment room whilst the patient was on the inpatient unit.

The service had systems to ensure staff knew about safety alerts and incidents to support safe medication administration.

Staff knew how to report medication errors or incidents. All incidents were investigated and learning outcomes shared with relevant staff. Managers audited medicines management against best practice and identified all areas for improvement.

There were three controlled drug documentation incidents reported in the last 12 months but no administration incidents in the last 18 months. Those incidents reported and categorised as no patient harm.

The medication rounds on the inpatient unit were completed at 8am, 12am, 2pm,4pm, 6pm and 8pm during the day. We observed the registered nurse who completed the medication round wore a red tabard with "Do Not Disturb" on. This tabard was introduced 18 months ago when the last incident occurred for medication administration error. Since this was introduced there had been no further administration medication incidents have been reported .

The service had a named lead for medicines management who was responsible for championing best practice. The inpatient managers attended the quarterly medicines management meeting and agenda items included, for example, medication errors and lessons learned which was shared with all relevant staff.

However, we asked staff how patients on short leave breaks were given their medications while away from the hospice. Staff told us they labelled a lidded pot which contained the required medication. We raised our concerns about the process of 'to take away' (TTA) medications found with managers as part of the initial inspection written feedback. On the second unannounced visit the ward manager told us how she had reviewed other hospice services and with agreement from the pharmacy service confirmed blister packs would be issued on the same day when the service presented the prescription before 1200 and stock was available.

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.

There were no serious incidents or never events reported from April 2018 to December 2019.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

Managers investigated incidents thoroughly and all incidents reported were reviewed daily by the senior team. Managers shared learning with their staff about never events that happened elsewhere.

Managers debriefed and supported staff after any serious incident. Staff told us managers debriefed and supported staff after any serious incident.

Staff knew how to report incidents and reported near misses and incidents through the electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Outstanding ☆

Hospice services for adults

All staff could access the incident reporting system and community staff could access the system through their laptops. Staff said they were supported in reporting all incidents and felt confident to do so.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations, when appropriate.

Staff received feedback and felt informed about incidents reported. The monthly clinical governance meeting included incidents as an agenda item. Staff told us of examples of change that resulted from an incident reported and understood the principles of duty of candour. The duty of candour a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with patients and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors, through a monthly balance score card which reported performance and included the number of falls, acquired pressure ulcers and healthcare associated infections.

The service continually monitored safety performance, patient safety was presented at the clinical governance monthly meeting. We reviewed minutes from three meetings from April 2019 to August 2019, which were detailed and included actions taken.

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

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed eight policies which related to the hospice service. All policies were up-to-date and had review dates on them. The policies were developed by the senior team, referenced national guidance, were available on the service's electronic intranet page and as hard copies. For example, policies included reference to NICE guidelines QS13 End of life care for adults, NG31 Care of Dying Adults in the Last Days of Life.

Staff told us they were able to access up-date-policies to plan and deliver high quality care according to best practice and national guidance. Staff were informed of updated guidance through team meetings, clinical governance meetings, newsletters and emails.

The service had recently introduced Barthel a dependency scale which is part of Outcomes and complexities collaborative suite of measures(OACC). OACC is a popular suite of measures that hospices use to demonstrate their effectiveness when dealing with patients and meeting their activities of daily living.

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice, staff told us how they supported patients, knew how to access policies and contact appropriate staff for support when needed.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We attended a staff handover and ward round, where staff discussions included all aspects

of the patients and family's needs. Staff discussions about patient care in the last days and hours of life was delivered in accordance with the 'Five priorities for care of the dying person'.

All individuals had a clear personalised care plan which reflected their complex needs. From the six care plans we reviewed, all were up to date and in line with relevant good-practice guidance and set out clear goals.

All patients cared for by the hospice were asked to develop an advanced care plan which we saw in the patient's files when they were admitted to the in-patient unit.

Senior staff had committed to meeting the aims of 'Ambitions for Palliative and End of Life Care', which is a national framework for action and reflected the framework in the recent improvements across the service. This includes the 'hospice without walls' model that provided a seamless approach for more patients and their families across the region, from the first point of access across all teams.

We reviewed six patient's records and saw each patient had a recommended summary plan equivalent to the ReSPECT guide which included discussions between patients and health professionals and included agreed clinical recommendations for care and treatment in the event of an emergency. This was in line with national guidance (Hospice UK). ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

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, particularly those with specialist nutrition and hydration needs. Staff supported patents with their nutritional and hydration needs to promote their wellbeing and meet the patient requests.

Staff fully and accurately completed patients' fluid and nutrition charts where needed, we reviewed patient records and saw that all fluid balance was updated and signed by staff.

The hospice's kitchen had recently had an upgrade and the chef proudly informed us of the wide range of fresh foods available and the freshly made meals prepared on site. The catering team encouraged patients to eat again by ensuring that the food was well presented, served at the correct temperature and of an appropriate portion size.

There was a wide range of foods available that suited cultural, religious and individual needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. On admission the staff weighed the patient and completed the malnutrition universal screening tool (MUST) which was reviewed weekly or when the patients' nutritional needs changed. The chef visited each new admission to find out the individuals preferred foods and time of eating.

Catering staff visited patients daily to discuss individuals preferred menu options, which encouraged patients to eat.

Families and carers could order hot and cold food from the menu at a small charge. We were informed that this was reviewed on an individual basis to support patients and their families.

Food and drinks were available outside of expected mealtimes. The inpatient unit had a kitchen where patients and their families could have hot and cold drinks, as well as cereals and toast. Families and carers also brought in their own microwavable meals which we saw clearly labelled and sealed in the kitchen freezer.

Specialist support from staff such as dietitians was available if patients needed it. Staff provided support and advice to patients and families in meeting the patients dietary needs, for example, utilising meal replacements and fluids depending on the patient's ability to eat and drink. Staff undertook daily oral assessments and mouth care as required to ensure patient comfort.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a national pain assessment tool to assess patients' pain. The tool incorporated a numerical rating scale for patients not able to communicate and a descriptive box for those patients who could communicate. Staff observed patient's expressions and cues to assess if they were in pain when the individual had limited communication.

Patients received pain relief soon after requesting it. Pain relief was given in line with individual needs and best practice. The patient's pain levels were assessed at least four times during a 24 hour day or more frequently if identified as a requirement.

Patient records reviewed showed appropriately completed individual care plans that included pain diaries, pain assessment and pain management plans.

Staff prescribed, administered and recorded pain relief accurately. Staff assessed each patient's ability to tolerate oral medicines. If necessary alternative routes would be prescribed when indicated; for example, pain relief patches or intravenous infusion.

Anticipatory medicines with individualised indications for use, dosage and route of administration were used for patients in their last days of life. Prescribing medicines in anticipation can prevent a lapse in symptom control, which can cause distress for the person who is dying and their loved ones. This was in line with national guidance (NICE, Care of dying adults in the last days of life: quality statement 3 (March 2017). 'Anticipatory' drugs in a palliative setting are those drugs that are prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life.

Patients told us they received pain relief soon after requesting it, the hospice policy required two nurses to administer controlled drugs to ensure there was no medication administration error.

Patients cared for at home had their pain managed by GPs, district nurses and specialist nurses. Palliative care staff monitored patients' pain levels during visits and escalated any concerns when needed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The hospice participated in one regional audit which was a system point prevalence led by the local clinical commissioning group (CCG) in May 2018. System point prevalence measure used, provided the number of people affected by a life threatening illness across the local population.

From 2017 to 2019 there were no national clinical audits and no national confidential enquiries that related to palliative care in a hospice setting.

Managers and staff used the results to improve patients' outcomes, managers aimed to continuously improve the quality of care it provided for patients, their families and carers. We reviewed evidence from the quality account for 2018 to 2019 that supported improvements.

The hospice's annual local clinical audit programme from 2017 to 2019 included a comprehensive audit plan that included, for example medicine management, controlled drug log book audit, an outcome assessment and complexity collaborative (OACC) audit. All areas were reviewed and showed compliance. Outcomes and complexities collaborative (OACC) suite of measures, were completed on admission. The is a validated suite of outcome measures that aimed to measure, demonstrate, and improve for and families.

Managers shared and made sure staff understood information from the audits, the service used the hospice UK audit tools where possible to complete audits and all recommendations were included and addressed on the action improvement plan which showed good results. Staff were able to confirm these achievements.

Hospices used these measures to demonstrate the services effectiveness and included the Australian

Karnofsky Performance Scale (AKPS), Phase of Illness (POI) and Palliative care outcomes scale. Reviews were completed on admission, then twice weekly, and/or if a patient's performance status or condition changed. If a patient's performance status or condition changed, this triggered other risk tools to be completed for reassessment, such as waterlow for tissue viability, and falls assessments to reduce falls.

The service had recently introduced the Barthel scale which was a further measure to confirm performance with patient activities of daily living (ADL).

The OACC audit showed 98% of patients had the three tools implemented and documented as part of the patient's holistic assessment by the community palliative care team during 2019. The audit monitored the implementation and documentation of the measuring tools with an agreed standard set at 100%.

There were 50 randomly selected patients who had the holistic assessments completed. These randomly selected patients were from referrals spread evenly throughout 2019 as part of the audit, with the following outcomes achieved, 96% of patients had their phase of Illness recorded, 98% of patients had the AKPS recorded, 100% Integrated palliative outcome scale (IPOS) was used however different parts of it showed the following;100% had reports of pain, breathlessness, weakness, nausea, vomiting, appetite, constipation, sore mouth, drowsiness and mobility recorded,98% had the patient's list of main concerns recorded,92% had anxiety of the patient and anxiety of family members recorded,88% had addressing of practical problems recorded and 86% had the adequacy of information given, depression, someone feels at peace and they were able to share information recorded.

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. Clinical staff were required to complete training and competency training to ensure they had the appropriate skills and knowledge to manage patients safely and effectively.

Staff shared with us the education competencies developed (November 2019) for the inpatient unit. Competencies were in line with the Ambitions for Palliative and End of life care guidance (2015-2020).

Managers ensured that all staff, including bank and agency staff completed a full induction programme before they started work. Staff told us they had received a good induction and were supported to work in a supernumerary capacity until managers were confident with their work and their competencies were completed.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data supplied showed that 100% of staff had their appraisal completed within the last 12 months.

Staff told us how they were supported by managers with several staff completing the leadership development training. One staff member started as administrative support and after extensive training was promoted within the service.

Managers made sure staff attended team meetings or had access to full notes when they could not attend, the ward manager told us how she communicated with staff in a variety of ways if they were unable to attend a team meeting. They also included topics within the staff handover and newsletters.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had regular meetings with their line manager to monitor their performance and were given opportunities to discuss their training needs.

Managers made sure staff received any specialist training for their role, staff told us how they were supported to attend further training and to develop further competencies. All working professionals received their ongoing registration and revalidation from the registered bodies including 'General Medical Council', 'Nursing and Midwifery Council' and other registration authorities.

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

Staff received regular clinical supervision and supervision sessions were arranged to support staff when needed.

Staff involved in any complaints or incidents were supported by their manager and completed a reflective statement to discuss how they would change their future practice to prevent reoccurrence.

The head of education supported the learning and development needs of staff. The service had recently appointed a part-time clinical educator who supported staff development and provided monthly training sessions as identified by staff. We attended a multidisciplinary staff training session that was organised about blood transfusions, the speaker attended from the local NHS hospital.

Volunteers were used by the service and all we spoke with confirmed they had completed induction training, which included support for the roles they had undertaken.

Multidisciplinary working

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

Staff held regular multidisciplinary meetings to plan and deliver holistic patient care. Staff told us that all staff worked well together and promoted the "hospice without walls" ethos. The hospice "without walls" approach provided patient care that was seamless across the hospice and community services.

We observed the multidisciplinary handover and ward round which was attended by doctors, physiotherapists, nurses and social workers. Each patient was discussed in detail with care and treatment plans agreed in line with the patients' physical, psychological, emotional, spiritual and social needs and the patient's wishes.

There was a clear process for the transfer of care from hospital to the hospice and from the hospice to home or another place of care.

Staff told us about their attendance at relevant external meetings and how information was shared with others appropriately.

Staff worked across health care disciplines and with other agencies when required to care for patients. A clinical nurse specialist or specialist doctors attended the Gold Standard Framework (GSF) and network meetings with GPs to discuss patients on the end of life register and how they could best be supported. The GSF is a framework which promoted best practice for end of life care. It is used by many GPs, hospices and hospitals to enable earlier recognition of patients with life-limiting conditions, to support them in making plans to live as well as possible.

Managers attended weekly meetings at the local NHS hospitals to identify how the service could support patients identified for palliative and or end of life care within the hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health. The hospice had access to a consultant psychiatrist who could be contacted for psychological advice for patients. Staff worked closely with social workers who could also signpost patients and family members to specialist support when identified as a requirement.

Staff told us how they worked well with other organisations, for example, local schools to support and increase awareness in younger members of the community.

Seven-day services

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

The inpatient unit was operational 24 hours a day, seven days a week to provide timely patient care when needed. The hospice had an open visiting policy and friends, family and carers of patients admitted to the service were welcomed to visit at any time of the night or day.

A consultant or speciality doctor led the daily ward round. Staff were able to contact the doctor or consultant on-call for advice and support at any time.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The community team were available to provide support and advice over the phone 24 hours a day, seven days a week. Night sitters were also available to provide personal and emotional care to patients from 9pm to 7am.

Health promotion

Outstanding ☆

Hospice services for adults

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

The day therapy service provided a rolling eight week programme which aimed at empowering patients to live well, with support and skills to manage their condition, maintain independence and meet others in a similar situation programme was provided by a multidisciplinary team which included a physiotherapist, occupational therapist, palliative social worker, complementary therapist and spiritual care coordinator. Therapy programmes were developed to meet individual patient needs and goals. A variety of methods were used to help patients, for example, complementary therapies.

Consent and Mental Capacity Act

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care, staff understood the relevant consent and decision making requirements of legislation and guidance which included the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and they knew who to contact for advice. The service had an up-to-date consent policy which staff could access through the hospice's intranet page. Staff understood their roles and responsibility regarding consent and MCA.

Staff understood how and when a patient had capacity to make decisions about their care. When patients did not have capacity, staff made decisions in their best interest, taking into account the patients' wishes and following discussions with the family or carer. We saw do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were made appropriately and in line with national guidance.

Staff clearly recorded consent in the patients' records. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they told us they knew who to contact for advice and could access the relevant policies to support their actions.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Appropriate consent forms were in place and completed in the records reviewed.

MCA and DoLS staff training for December 2019 was 96% with the hospice target set at 95%.

Staff could describe and knew how to access the policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards, staff had received appropriate training and were able to access support when identified.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary, we saw monthly reports were presented to the senior managers as part of the quality performance safety checks.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation, staff has received appropriate training and were able to obtain support from within and outside the service if they had concerns. Staff spoken with told us they had no concerns in implementing and reviewing these safeguards.

Are hospice services for adults caring?

Outstanding ☆

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

Compassionate care

Staff treated patients with compassion and kindness, truly respected their privacy and dignity, and took account of their individual needs and are empowered as partners in their care.

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. We observed staff caring for patients and family members

in a respectful and considerate manner. Staff took time with patients and families, dealing with them in a friendly, calm and compassionate manner. We were given examples where staff met patient's individual wishes and went to great lengths to achieve their requests, for example, staff had contacted a film company to organise a preview of a film before the release date. A patient had mentioned they would have loved to see a particular film but not expected to be alive on the film release date.

All volunteers we spoke with were relatives of patients who had been cared for by the hospice and spoke positively about the care their loved ones had received. One example of feedback for staff included "Thank you for bringing joy back into our day", after the service had developed a bereavement support programme for children and young people.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us how they developed strong relationships with all their patients and families which was evidenced by the complimentary feedback cards and letters staff received. Staff presented as being non- judgemental and provided care to all their patients which was supported by individualised care plans.

Staff told us how families maintained links with the hospice many years after the death of their loved one. Volunteers supported this feedback and told us of the high quality care experiences their family members had received and how this made them want to support the service and help others.

Information provided after the inspection detailed that the hospice ran a compassionate neighbours project. The project was led by volunteers who offered support to local people nearing the end of their lives, and who were socially isolated and lonely, in their own homes to offer emotional support and companionship. Examples shown on the hospice's website showed that patients and volunteers went on days out together and engaged in activities such as golf and fishing. The volunteers were trained and supported by the hospice to offer a befriending service to patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There was a strong visible patient-centred culture. Staff were motivated to provide care that was compassionate, kind and promoted dignity. All staff we spoke with told us that everyone put the patients at the centre of all discussions and they were proud to work for the hospice.

Patients said staff treated them well and with kindness. Feedback from patients and family members was all positive about how staff looked after not just the patient but the whole family. Staff went beyond what was expected when providing care and support, for example, staff were thanked by one relative for bringing joy into their children's lives and putting smiles back on their faces after the loss of their mother. Another patient told us, "The staff are lovely, so caring and that's everyone not just the nurses".

We read many thank you cards and letters from relatives which included praise about the way they had supported their relatives and respected their wishes, "Nothing was too much trouble for the staff", " the staff are lovely- so caring, and that's everyone, not just the nurses".

The hospice at home service stated that each staff member was caring, understanding and patient which provided an excellent service.

The community team we observed provided care that was gentle, professional and ensured the patient's dignity was maintained at all times. The bereavement service compliment included that everyone was friendly and supported the patient who was reluctant to initially attend the service.

Staff cared for patients and respected their spiritual and cultural wishes before and after death. Family members and carers were asked if they wished to assist with the care of their relative and if they had any special requests, for example personal care of hair, perfume or aftershave and clothing.

Staff told us how they picked fresh flowers from the hospice garden and left them with the deceased patient. Feedback from the local undertakers had been received and confirmed the high standard of personal care given to patients.

Staff we observed ensured that all patient's privacy and dignity needs were respected and protected at all times.

There were signs on doors that were closed indicating when privacy was required or when no entry was permitted. Staff were seen knocking on doors and waiting for the response before entering patient's rooms.

Staff spoke to us with compassion and sensitivity when they described the care they had given for patients who had died.

Feedback from the patient and relative survey from January 2018 to July 2019 showed 98% of respondents felt their relative was always treated with respect and dignity by staff. We reviewed the internal inpatient unit bereavement questionnaire from January to March 2018 which showed 98% and above with positive feedback about staff.

Staff wanted to make a good end of life experience for patients and their families. Staff told us about ways in which they had provided opportunities for patients to meet their goals; for example, when a young patient told them about their wish to see a local singer, staff arranged for tickets and took the patient to attend their next concert. Another patient request was met with a videocall from a celebrity who arranged for gifts as a patient was unable to leave the hospice. Staff told us about several weddings and blessings they had organised at short notice.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. People's emotional and social needs are highly valued by staff and are embedded in their care and treatment.

Staff gave patients, carers and those close to them emotional support and advice when it was required. Staff told us how a life threatening condition impacted on those close to the patient. Staff described how they supported the patient and those close to the patient in a variety of ways. This was support in the quiet room with family members. Staff encouraged family overnight stays to allow the information to be understood and time for further questions. We observed staff providing this support to patients.

Information provided following the inspection showed that the hospice ran 10 bereavement cafes per month in community venues across West Essex as well as the hospice itself. The bereavement cafes were hosted by trained hospice volunteers who were supported by hospice staff. The cafes were open to anyone across West Essex coping with grief; they did not have to be connected to the hospice or have experienced care there to attend. A case study on the hospice website demonstrated that the cafes helped people to develop positive supportive relationships with those they met, which had a positive influence on their emotional wellbeing.

The hospice ran a cooking course for bereaved men during October and November 2019. The hospice chef ran the course to teach a small group of bereaved men who had no cooking skills over the course of a few weeks. The aim of the course was to teach the participants some practical life skills so they could enjoy cooking for themselves whilst living alone. It also allowed them to connect with others who had shared experiences so that they could continue to meet with each other outside of the hospice and build a supportive network of friends. The hospice planned to run a second course in 2020 and funding for this was already secured.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff spent time with patients and those close to them to reduce distress and answer any questions to reduce concerns. Feedback from family members included " The team always had time to speak to myself and other family members and were very approachable, nothing was too much trouble."

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereavement support and trained counsellors were available to help families and friends in coming to terms emotionally after a loved one had died. Support groups included, one to one counselling, informal and formal drop in bereavement groups.

Patients and their families emotional, spiritual and social needs were identified, assessed and supported by staff in a number of ways. We were told of examples of clinical nurse specialists in the community team who gave emotional support to those they visited. The hospice at

home team feedback reviewed showed that the health care assistants who provided personal care to patients also provided support to patients and those close to them.

The counselling questionnaire completed from January 2019 to March 2019 demonstrated that all family members were extremely likely to recommend this service. Feedback included, "The counselling support was professional and sympathetic", "All goals were met following the expert help from the counsellor" and " I am in a better place now than before counselling sessions".

The hospice had a quiet room with symbols of different faiths, prayer book and tree of remembrance for those that preferred a quiet space away from the patient area.

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 to keep in touch with their friends and family. Staff supported all visitors to the patient which included any family pets. The hospice supported pets to visit and had a pet visiting policy. There was work being completed to have a 'Pets as therapy' link to comfort patients and family members. We reviewed feedback from a family who thanked staff for allowing a cat to visit which meant a lot to their mother. What the family member remembered most was that once their mother had died nursing staff had told them that they were now part of the St Clare family, which meant so much to them emotionally.

Staff ensured that patients who did not have family, friends or carers were supported physically and emotionally. Patients were given time to talk and were listened to by staff and their wishes were met as far as staff were able to. Patients were not left alone at the end of their life and staff told us how they sat with them and offered them comfort.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. People who used services were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff always empowered people who used the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care was delivered.

Staff made sure patients and those close to them understood their care and treatment, we saw fully complemented documentation which outlined discussions from the notes we reviewed.

Staff supported patients to make advanced decisions about their care. Patients we spoke with confirmed that staff provided them with the information they needed to understand their condition and make informed and advanced decisions about their care.

Staff supported patients and those close to them to make advanced decisions about their care in line with their emotional, cultural, spiritual, personal and physical needs.

Staff told us "I am proud of the excellent care we give, we are a great team and everyone works well together. We always want to get better for those we care for".

Feedback received about staff showed that the care and support given to patients and their families was highly praised in all cases.

Patients whose preferred place of death was home were cared for by the palliative care hub hospice at home service. We read many compliments from family members who thanked staff for the care and support they had provided to meet the final wishes of their loved one to die at home surrounded by their family.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Family members told us they never felt rushed and that all staff encouraged them to ask questions if they needed further information or for information to be repeated.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback from the inpatient unit bereavement

questionnaire January 2018 to March 2018 showed that 100% of respondents felt they had the opportunity to ask questions and that staff gave their undivided attention and were very approachable.

Staff supported patients and families when they delivered bad news to their loved ones; for example a young father was supported with visual aids when telling his young family about their mother's condition.

Patients gave positive feedback about the service. Patients and their families were encouraged to give feedback about the staff and service. Staff recognised the importance and dealt with concerns promptly. This was to ensure that the service provided the patient with the best possible care for the patient and their families. During the inspection we asked if anything could be improved and one relative told us that the service was amazing and the staff would go beyond what they expected.

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.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care and improve services.

Managers planned and organised services so they met the needs of the local population. The hospice provided and reflected the needs of the population it served and promoted flexibility, choice and continuity of care. The hospice provided in-patient, day therapy services, outpatient specialist support service, community services and a 24 hour hospice at home services. This provided patients with options when considering their preferred place of care and death.

The day therapy team supported individuals with a holistic approach in understanding individual's specific needs, caring for patients and families to enhance the quality of life, promote independence and build self-confidence. This may be through therapeutic and creative activities which were available as well as meeting others with similar illnesses. This team included physiotherapists, occupational therapists, complementary therapists, social workers and a chaplain to support the individual as required. The quality performance reviewed showed that the day therapy team saw 1472 patients from April 2016 to 2017, 1255 patients from April 2017 to March 2018 and 1,001 patients from April 2018 to March 2019.

We spoke with patients who had attended a wide range of drop-in groups held at the hospice. There was a creative group where individuals could learn a new creative skill and drop-in sessions were organised for every other week. The physiotherapy group held an exercise group every week to support individuals in remaining active and independent and reduce the risk of falls. A breathlessness group which taught individuals techniques to improve coping skills with this symptom. The neurological group was held with support from professionals from the local NHS hospital and offered individuals education on the common problems associated with their illness and on how to best manage them. Individuals were offered opportunities to reflect and offered further support with others who were in a similar situation.

Facilities and premises were appropriate for the services being delivered, the hospice was a calm, well-organised location, with a welcoming reception area. There was a staff photograph board to help visitors identify staff. There was a daily board with the names of staff on duty and the hours they were working. The hospice's day therapy service provided services for patients dealing with long term conditions and offered an eight week rolling programme that gave patients, families and carers the necessary knowledge, skills and support to manage their symptoms, and promote wellbeing. This included exercise sessions and techniques to reduce the difficulties of breathlessness and tiredness.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia, staff

were able to describe how they requested support and the on call system which supported them with complex situations. Staff told us they were able to obtain support without delays from senior staff.

Complementary sessions were offered to give patients extra support to manage symptoms, re-gain confidence to cope better at home and maximise quality of life with a range of patient-set goals or ambitions. We reviewed performance records from 2018 to 2019 that stated 355 complementary sessions had been completed which included; reflexology, reiki, aromatherapy and massage.

The service had systems to help care for patients in need of additional support or specialist intervention, for example, dementia friends were identified across the service and staff were able to identify the known champions.

The hospice worked with others to design and plan specialist palliative care and end of life services. It offered short term nursing care, personal care and emotional support for patients and their families dealing when dealing with life-limiting conditions. The service provided visits by palliative care nursing assistants who supported patients with personal care as well as emotional support.

The night sitting service was available for patients who needed support between 9pm and 8am to enable patients to remain in their own home. At the time of inspection there was no crisis visiting service but managers spoke about the first contact team that received and assessed all referrals and offered a more robust 24 hour advice line for patients, families and healthcare professionals to access.

The hospice had identified where people's needs and choices were not being met as they were unable to access the service easily and used this information to improve and develop services. The service had developed the bereavement café for family and friends, a twice monthly drop-in group for anyone that has experienced bereavement. The café group offered a place to meet and connect with other local people who had similar experiences across the region. The Café Clare group met every Friday in the dining room of the hospice and was run by a day therapy assistant and was open to any patient that attended this service.

Volunteer drivers were available to pick up patients and carers from home to the hospice when needed.

There were communal areas within the hospice for patients and their loved ones to sit outside of the inpatient area, a lounge area with comfortable seating, a seated patio area, a sanctuary area which was a multi-faith and spiritual room and a quiet room. The kitchen area had a large freezer for patient's preferred foods. There was a small selection of children's toys, books and DVDs in the lounge area. Hot drinks and biscuits were available for all visitors and patients. The patient bedrooms were large and relatives could stop overnight if they wished. There were toilet and shower facilities available for visitors who had stopped overnight.

The hospice had a social media community service which provided information and advice about a wide range of subjects, for example making a will, fundraising or supporting the hospice shops.

Family and friends feedback meant that all walking areas around and within the hospice had been levelled off with drop kerbs installed to promote ease of access for visitors with reduced mobility or wheel chair users.

The bereavement service launched bereavement cafes in February 2019 which were open to any bereaved person across the region whether connected to the hospice or not.

The hospice launched the new children's bereavement service in April 2017, which was funded by a major grant from 'Children in Need' and additional gifts from trust charitable funds. The development of a specialist bereavement service for children, young people and their families had been a long-held ambition of the organisation which expanded the current service delivered by the patient and family support team. The dedicated children's bereavement service enabled staff to offer a holistic service for every patient and their family and loved ones. In the past year work had progressed in partnership with colleagues within schools to empower teachers and those who work with children, to be able to support children who were bereaved, further sustaining the work commenced at the hospice.

Staff were involved and gave examples when they had supported patients to choose their care home. While patients were unable to visit care homes staff had worked

collaboratively across the hospice network to collate photographs of care homes so that patients could select their preferred home by looking at photographs of the bedrooms.

Staff and volunteers gave us examples of how they supported and fundraised for the hospice. We saw examples of dog funding raising walks, quiz evenings and Christmas 'shine a light' campaigns.

The service had relevant information for patients to help them live well towards the end of their life and to help their families cope following their death. Information available included financial and practical advice. Staff supported families and carers in providing relevant information to signpost them to other agencies as required. Families and carers were offered bereavement counselling as required before, during or after their family member had died.

The hospice's community-led compassionate neighbour well-being project won a regional award from the local county council in May 2019. This project had trained 64 volunteers to provide social and emotional support to patients towards the end of their life. The project aimed to ensure that fewer people within the community faced death on their own.

Staff attended "PRIDE" in London in 2019 to demonstrate their commitment to this movement from this service.

The service had recently reviewed and employed a range of volunteers to reflect the demographics in the area to support patients of different cultures and backgrounds accessing the hospice services.

The service had implemented conscious and unconscious bias training in the hospice for staff to ensure that care for patients and staff attitude remains unbiased.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The hospice was committed to providing access to services for those within the local community that required its services. Staff told us they rarely needed an interpreter but they could access the service when required.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs, all patients had individualised care plans and carers were encouraged to support the patient during all hospice attendances.

Staff had access to communication aids to help patients become partners in their care and treatment. A hearing loop system service was available for those patients or family members who had partial hearing loss.

The hospice provided all patient services on the ground floor with support for patients with reduced mobility and wheelchair users. There were bathroom and toilet facilities for patients and visitors who needed extra support with specialist equipment.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents, we reviewed patient details recorded which included for example their preferred name and what was important to them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss, staff confirmed they were aware how to access the care of the vulnerable adult policy and spoke confidently about the needs of patients with learning disabilities, mental health and those living with dementia. Staff told us they had completed additional training to support this care, although we saw no data to confirm how many staff had completed this training.

The service had information leaflets available in languages spoken by the patients and local community. Staff had access to communication aids to help patients become partners in their care and treatment, such as language line and could access interpreters when required.

Staff delivered holistic, patient-centred care which was not limited in terms of diversity, ethnicity or culture.

Patients were given a choice of food and drink to meet their cultural and religious preference, staff asked this question on the patient's initial admission to the service and we reviewed fully completed documentation in the patient records that supported this was completed.

Staff had also updated a patient day therapy letter which asked patients to notify the team if they had any specific dietary requirements. This included texture of food tolerated by the patient, for example, we saw feedback where a patient was not able to eat cake offered at an initial session. An alternative to cakes was now specified in the patient invitation letter.

Patient's spiritual, religious, psychological, emotional and social needs were respected. We heard many examples where staff had supported patients in making the most of their last days with family members, pets and arranging weddings.

Staff involved in care were informed of a person's advance care plan and preferred place of care and death (PPC and PPD). Managers completed quarterly audits of the PPC and PPD from the patients admission records. These were one of the key performance indicators set by the clinical commissioning group and were electronically recorded to show their compliance.

Patients were supported to develop an advance care plan which included a summary plan for emergency care and treatment where appropriate. Advance care plans were seen within patient documentation and were fully completed, dated and signed.

Staff understood the needs of people in vulnerable circumstances and planned care to meet the patient's individual needs. The service had arrangements in place to address any inequalities and to meet the needs of local people, for example staff had developed a caring for homeless patient policy version one which had been introduced in December 2019 and gave the homeless patient access to the hospice and ensured they received end of life care and support they needed.

The hospice developed a framework to ensure the hospice was accessible to everyone, no matter what protected characteristics they may have had. The framework enabled the hospice to identify what they were doing well for groups with protected characteristics and what could be improved to remove any barriers to access to the hospice. This also applied to recruitment processes. For example, the framework was used in December 2019 to identify how to improve services for people living with dementia. This enabled the hospice to develop a funding bid for new work and equipment to create a more caring environment and service for people living with dementia.

Care after death was managed by staff in a sensitive manner. Staff described to us a recent patient death, which assured us that the staff respected and protected their patient and the family members after the patient's death. Staff supported families and made sure they understood the arrangements that were needed after the patient's death and helped family members in any way they could, both physically and emotionally.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The hospice had effective processes in place to manage admissions to the service. Referrals came from GPS, specialist palliative care nurses, community teams and the local NHS hospitals. All referrals for the inpatient unit were assessed at the daily review meeting and patients were prioritised for admission according to need

We reviewed the bed occupancy rates for 2019 and saw the average in-patient bed occupancy rate was 86%. Managers told us on the day of inspection one patient was waiting to be admitted.

Managers attended weekly multidisciplinary meetings at the local acute NHS hospital to identify patients who would benefit from the service. Managers took action to ensure more patients could access the specialist palliative care services when they need it; for example attending GP surgeries and care homes to raise awareness of the service and encourage earlier referrals so that support could be put in place as required.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Hospice services for adults

The service provided planned visiting, fast track and night sitting services which prevented unnecessary and unwanted hospital admissions and supported the patient to be in their preferred place at the end of their life.

Managers monitored patient transfers and followed national standards. There were discharge processes in place so that patients could be safely discharged home to their preferred place of death when possible.

Staff supported patients when they were referred or transferred between services, the discharge process included care packages set up with the community teams and hospice at home service so that the patients could be discharged or transferred when required without delay.

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 hospice had processes to ensure complaints were dealt with effectively and in line with the complaints policy. The service had policies for dealing with complaints (version nine) and procedures for handling complaints (version five) which were last reviewed in February 2017.

The service clearly displayed information about how to raise a concern in patient areas, including the reception area and dining area.

Staff understood the policy on complaints and knew how to handle them. Staff could easily access the complaints policy via the hospice intranet. Staff told us they knew how to handle complaints and if concerns could not be resolved informally they supported patients and their families to make a formal complaint.

Staff told us they received feedback from complaints and that the service received very few complaints which was confirmed by the numbers the service received.

Managers shared feedback from complaints with staff and lessons learned were used to improve the service and prevent reoccurrence.

Managers investigated complaints and identified themes. When individual members of staff were named in a complaint, managers set up one to one meetings and staff completed reflection papers to review future practices.

From April 2018 to March 2019 the service received five complaints. All were fully investigated with appropriate actions taken and shared with staff through staff meetings and from the clinical governance committee. Family members were invited to attend meetings and be involved in the investigation. The complaint response was received by the complainant within 14 working days.

The hospice received several written compliments about each area, see caring for detail.

Are hospice services for adults well-led?

Good

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

Leadership

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

The senior leadership team (SLT) consisted of the chief executive, director of patient care, medical director, director of finance and facilities, director of HR and director of income generation. The SLT were a new team who had experience from another hospice service and worked together as a cohesive SLT.

There was a clear management structure with lines of responsibility and accountability, the day to day running of the hospice was managed by the senior leadership team (SLT) who were responsible to the board of trustees. The SLT and trustees attended quarterly meetings to ensure they met their governance responsibilities which

allowed them a good understanding that the three year strategy was being delivered. The trustees supported the development of a quality improvement culture, with an ethos of a "hospice without walls" that was committed to delivering a seamless and equitable high quality care for local people. The medical team supported the senior team which included the leads from each service.

Staff we spoke with were mostly positive about the leadership and told us that things had improved following recent changes within the service. Staff supported all changes which had the patient at the centre of the change.

Staff told us the leadership team were visible, approachable and staff felt supported. This was representative of what we observed during the inspection. The volunteers told us they were well informed about hospice activities.

Information provided after the inspection stated that the hospice has strengthened the board of trustees by taking a new approach to recruitment. The hospice used a specialist agency to recruit high quality candidates on the basis of skills and expertise frameworks to ensure that all key functions of the hospice were covered by trustees' professional expertise.

Staff who worked in the community told us they were connected to the hospice and felt included in with all communication updates.

The service supported staff development with opportunities undertaken to develop leadership and management skills. For example, we were told that senior staff were good at investing in education. Staff had attended the inspirational leadership training course provided by an external training company. One of the staff on the leadership course told us, "I feel as though I learnt something new each day after the hospice supported us in networking with training held at other hospices".

The director of patient care held weekly 'leadership workshops' with the clinical middle management. The workshops were put in place to support and empower the middle management to enable them to lead and develop effective services with positivity and to support them to lead change. On review of minutes taken from October 2019, January 2020 and February 2020 we saw a focus on empowering managers to appropriately challenge senior leadership, culture and managing any arising concerns.

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 strategy was fully aligned with plans in the wider health economy and there was a demonstrated commitment to system-wide collaboration and leadership.

The service had a vision that every adult with a life-limiting condition in the local community should have access to palliative care services wherever and whenever they needed them so that they could make the most of every moment.

The three year strategy included; reaching and supporting more people in the local community, to seek partnerships with other organisations, to deliver a seamless care approach for patients and grow as a strong sustainable and effective organisation, in line with national recommendations.

The mission was to provide both specialist clinical services and volunteer-led social support that met the complex medical and social needs of local people around the issues of death, dying and loss.

The service had an established set of values which included compassion, integrity, respect, excellence and teamwork.

Leaders and staff understood and knew how to apply the values and monitored progress, through a variety of staff and patient forums, schwartz rounds (reflective sessions) and staff and service user feedback.

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.

There had been many changes implemented across the service led by the leadership team over the last 18 months, for example, the remodelling of day service activities available that allowed the service to reach more patients than in previous years. Staff discussed their concerns about the many changes made in the last year and although most staff agreed they were given feedback they felt they were not informed about the reason behind the changes. Managers recognised staff concerns detailed in staff feedback and had acted to address this by holding more frequent staff communication sessions. Information provided after the inspection stated that the director of patient care and chief executive officer (CEO) held away days with all clinical teams and invited them to share their ideas and express their concerns. This was to ensure the changes were not enforced upon the teams. We reviewed evidence that four away days took place between April 2019 and June 2019, and saw that actions were raised following them.

All staff described their commitment, the support they received and respect across all teams within the service. Staff were kind to patients and spoke with passion about how they delivered care to all patients and families.

Staff told us they enjoyed working at the hospice and were committed to ensure the patients and families had the best possible care. Staff described how it was a privilege to care for patients at the end of their life. During the inspection staff interacted with patients and their families in a respectful and positive manner.

Staff confirmed that they felt supported, respected and valued and described the culture as open and positive. Leaders were visible and accessible and supportive. The senior management team had an open door culture and staff confirmed they felt confident to raise any concerns.

Staff told us they were aware of the whistleblowing policy and concerns that had been raised in the last few months but praised the current leadership changes. The service had launched the 'Our Voice' staff project. This project aimed to support staff engagement, listen to staff concerns and work towards meeting the aims and ambitions of the hospice.

Staff agreed the culture of the service was to put the patients and their families at the centre of all care.

The hospice had a staff safety culture and had measures in place to protect the safety and well-being of staff who worked across the services. The hospice had a manned reception area from 8.30am until 5.30pm after this time, the front door was secured with access through the entrance security system on the inpatient unit. All community staff had access to a laptop or mobile phone with one touch access to emergency services. All staff were aware of where the panic button was sited and confirmed senior staff responded promptly when this had been used. A counselling service was available for staff to access to support their mental wellbeing.

The culture supported openness and transparency with processes to ensure the duty of candour was met. All staff spoken with were aware of duty of candour and told us how they were supported to be open and honest when things did not go as planned with patients, families and carers. From April 2019 to November 2019 the hospice did not report any incidents which required duty of candour to be instigated.

The service had promoted equality and diversity as part of its daily work. The new human resources department had started a policy in which all employee data regarding race, ethnicity and protected characteristics are recorded. Since 2018 all patient ethnicities have been recorded within the hospice admission assessment.

All policies had been updated to underpin and reflect the services' commitment to equality and diversity for patients and staff. In the 2019 staff survey an improvement was seen for the responses to the question "diversity is valued at this service" with an increased response of 17% from the previous survey.

Managers had supported a project within the hospice to enable education and training for Pakistani nurses who will complete placements in the hospice.

In December 2019 managers attended an event held in the Pakistani High Commission in London for the launch.

Governance

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

There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and high standards of care. Monthly clinical governance meetings were held and followed a set agenda with safe, effective, caring, responsive and well-led items discussed in line with the CQC key lines of enquiry. We reviewed three sets of meeting minutes held from April 2019 to July 2019 agendas included; incidents, risks, complaints, audits and training. These were presented as a performance and quality report to the board with assurances provided by the clinical managers, quality and audit lead, senior leadership team, the service provided NHS commissioners with a quarterly patient activity report. The hospice used CQC key lines of enquiry as the main framework for decision making, monitoring of progress and the development and management of governance structures and processes

Since the last inspection, the hospice made changes to the governance structures and processes by streamlining the board committee structure from six committees to four, and introducing a 'scheme of delegation' which supported a more robust decision-making process with clarity over roles, responsibilities and where decisions were made. Staff within the hospice were clear about their roles and had a clear understanding of their accountabilities and responsibilities. Staff were committed to improving the service provided to patients.

Staff told us the outcomes and complexities collaborative suite of measures steering group meeting included the review of admission information and frequency of their review at the change of phase and weekly to demonstrate the effectiveness of the measures.

Service level agreements (SLA) were in place and reviewed on a regular basis, for example, managers told us the waste management SLA was now under review.

We saw the minutes from monthly multidisciplinary staff meetings held from January 2019 to September 2019 with agenda items for regular discussion including training sessions, complaints and patient harm.

We reviewed team days and communication events organised by senior staff to address staff survey responses which stated that staff had requested more engagement and knowledge of planned changes within the service.

Leaders understood the issues, challenges and priorities in the service and we saw evidence including an action plan that demonstrated active improvements, for example, pressure ulcer training for staff following a concern raised by another service.

Managing risks, issues and performance

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

There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospice had up-to-date policies which included risk management, complaints, incident reporting, medical records, care of the vulnerable adult and a cardiopulmonary resuscitation policy. All were reviewed and referenced relevant national guidance.

The aim of the risk management policy was to promote staff knowledge of risk awareness and ensured that systems were in place for identifying, assessing and controlling key risks to ensure that a consistent approach was followed.

The hospice had a risk register which included a description of the risk and used a colour coded system which identified the severity. Each risk was scored according to the impact and likelihood of occurrence. We reviewed 15 operational and 11 strategic risks on the risk register which included three risks which were rated as major 21 risks were rated as moderate seven risks were rated as minor risk. The identified major risks related to income generation fundraising, reduction of retail income and voluntary income. All risks were dated and included actions taken. All were reviewed by the senior team and monthly governance meeting.

Incidents reported were reviewed weekly by the manager and themes or trends were identified. Staff received feedback from the audit results and improvement actions to prevent reoccurrence. The senior team had oversight of all incidents reported.

Staff confirmed they received feedback on incidents and performance in a variety of ways such as team meetings, notice boards, newsletters and emails. Although, staff were not able to confirm how risks on the risk register were shared across the teams.

The service had a business continuity plan which was accessible to staff and detailed actions to be taken in the event of loss of resources, for example, information technology.

Staff told us, and we saw how they were involved in decision-making and used resources for the benefit of the whole community and made sure nobody was excluded, discriminated against or left behind and avoided the high quality of patient care being compromised. We saw many ways in which the service raised fund through projects which included vintage shops across the community, retail gift aid, weekly hospice lottery, memory tree, open gardens and treks and challenges.

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.

Staff followed policy to keep patient care and treatment confidential, the service had a computer on wheels which allowed staff to access information and update records without being overlooked by others. Patient information was not displayed for other visitors to read and staff told us they would only discuss the patient's care with those family members named by the patient.

Clear and robust performance measures were reported and monitored. Staff had access to quality and performance data through the monthly integrated quality performance report. We reviewed data reports which included data on a range of performance and quality indicators, for example incidents, staffing, complaints and patient and family feedback.

Success stories and areas for improvement were shared with all staff which included those employed as bank or agency staff.

Staff had access to up-to-date and comprehensive information regarding patient's care and treatment. The electronic system used by the service was used by the majority of general practitioners and staff confirmed there were secure processes to send data to those not on the electronic system.

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

The registered manager and director of patient experience was the Caldicott guardian and controlled drugs accountable officer.

There were effective arrangements in place which ensured data and statutory notifications were submitted to external organisations, for example local commissioners and the Care Quality Commission. We saw the service was open and transparent in sharing their information with stakeholders.

We saw the service had achieved full compliance for the quality improvement and innovation goal through the commissioning for quality and innovation payment framework (CQUIN) for neighbourhood support for end of life care for people living with dementia in 2017-18.

The information governance monthly steering group reviewed all new policies, training, innovations and any information governance issues. All staff had completed online training for information governance.

The service submitted level 3 NHS Information Governance toolkit, now known as the data security and protection toolkit. The service exceeded the required standards as a registered voluntary organisation from 2018 to 2019. This meant all systems are certified under the government cyber security recommendations 'Cyber Security Essentials Plus' standards.

The information governance steering group (IGSG) consisted of senior staff members across the hospice and ensured compliance with all requirements, related to information governance issues. All policies submitted were approved by the IGSG and the board of trustees. Additionally, staff were asked to sign a declaration which outlined the terms of access to the information technology systems containing confidential and sensitive

information, including patient information. The declaration detailed staff requirements in relation to confidentiality, data protection and access to information. This ensured the service met General Data Protection Regulation (GDPR) which came into force in May 2018 and was designed to modernise laws that protected the personal information about individuals.

The head of clinical services and data analyst met monthly to review all data collected to ensure it was accurate and relevant. All data was signed off as accurate by the clinical managers and approved through the trustees.

Staff had access to up-to-date and comprehensive information regarding patients' care and treatment plans. There were arrangements to ensure the confidentiality of patient information. Computers and laptops were encrypted, protected by password and staff were observed challenging each other to close the system down when it was left unattended to prevent unauthorised access.

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.

Patients, families and carers were engaged to provide feedback to the hospice about the type of service they wanted for their loved ones. Feedback was reviewed by staff and used to improve the service. We saw feedback cards available across the service for all visitors to complete and reports that included patient feedback comments with actions completed to address areas of concern.

Staff encouraged patient or loved ones to feedback, so that concerns could be dealt with quickly and provide the patient with the quality of care that all staff wanted for every patient. We saw patient feedback that the car park light disturbed the patient during the night. This was fed back to staff who immediately looked to resolve the concern with black-out blinds.

Patients were asked about their experience of care at the hospice such as introduction to the facilities and staff on arrival, the opportunity to ask questions, patient confidentiality, dignity and respect and how team communicated to patients and relatives.

The hospice undertook a survey of bereaved relatives and friends and data reviewed showed that from January 2018 to November 2019 98% of respondents rated the service high.

The 'St Clare News' was published three times per year for all stakeholders. Along with the hospice's website it provided information on the services and celebrated all achievements across the hospice. This gave patients, carers, staff and volunteers an opportunity to comment on the work of the hospice.

Staff worked with stakeholders and other agencies to deliver high-quality, patient and family-centred palliative and end of life care services. Senior management in the hospice invited members of the local Islamic centre to share an iftar meal during Ramadan in May 2019. Iftar is the meal eaten by Muslims after sunset during Ramadan. The purpose of the event was to offer hospitality to the local Islamic community, and to listen to the community's requirements and anxieties around the hospice's ability to care for their community members according to their faith requirements. The hospice was later invited to the Islamic centre for a family fun day, which senior leaders attended to share food and build further relationships.

Learning, continuous improvement and innovation

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

The hospice had made several positive changes since we last inspected with the introduction of a more inclusive service for the local population and continued to deliver quality care for more people. The remodelled day therapy service developed more clinics that had condition specific groups and activities that enabled staff to reach more patients.

The hospice participated in a study titled: 'An observational study investigating the prevalence and impact of alcohol-related problems in cancer patients'

and their caregivers'. This was a qualitative, questionnaire based multi-centre study. Data was collected and submitted to the chief investigator at the leading hospital.

The hospice had also enrolled its site to recruit patients for another study titled: 'Open label, multinational, multicentre, prospective, real world observational study of Naloxegol for patients with cancer pain diagnosed with Opioid Induced Constipation (OIC)'. This was a single arm, open label, multinational, multicentre, prospective, real world observational study of Naloxegol in adult subjects with Opioid Induced Constipation and inadequate laxative response.

The hospice was a recognised teaching hospice for Cambridge university, the medical director continued as a senior clinical tutor at university of Cambridge clinical school. The hospice also received students from various institutes for training including Anglia Ruskin university (nursing, physician associates, AHPs), St Bart's (physician associate students) and University of Cambridge (medical students).

The hospice was a recognised training centre for the east of England deanery for general practice vocational training scheme (GPVTS) training and foundation school for foundation doctors. The medical director was an accredited clinical supervisor for GP and foundation year training. The hospice received students from Anglia Ruskin university for nursing training and students from allied healthcare professional and counselling training. The GPVTS is the route to training of UK General Practitioners on completion of the Foundation Year Programme.

The Hospice was a recognised teaching hospice for Cambridge University, the Medical Director is a Senior Clinical Tutor at University of Cambridge Clinical School.

All working professionals received their ongoing registration and revalidation from the registered bodies including General Medical Council, Nursing and Midwifery Council and other registration authorities.

Outstanding practice and areas for improvement

Outstanding practice

- Staff thought laterally to meet the patient's individual wishes and went to great lengths to achieve their requests even if they were beyond expectations. For example, a patient asking to see an unreleased film and staff contacting the film company.
- There was a strong visible patient-centred culture. All staff we spoke with told us that everyone put the patients at the centre of all discussions and they were proud to work for the hospice.
- Feedback showed that the care and support given to patients and their families was extremely highly praised in all cases.
- The service had developed the bereavement café for family and friends a twice monthly drop-in group for anyone that had experienced bereavement, including those who outside this hospice.
- The development of a specialist bereavement service for children, young people and their families which expanded the current service delivered by the patient and family support team.
- Managers attended weekly multidisciplinary meetings at the local acute NHS hospital to identify patients who would benefit from the service. Managers took action to ensure more patients could access the specialist palliative care services when they need it; for example attending GP surgeries and care homes to raise awareness of the service and encourage earlier referrals so that support could be put in place as required.
- The service had arrangements in place to address any inequalities and to meet the needs of local people, for example staff had developed a caring for homeless patient policy version one which had been introduced December 2019 and gave the homeless patient access to the hospice and ensured they received end of life care and support they needed.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that patient medication administration by staff for planned short leave periods should follow national and local management of medicines guidance.