Beaumond House Community Hospice

Beaumond House Hospice Care

Inspection report

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Date of inspection visit: 06 - 07 December 2023
Date of publication: 01/03/2024

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

- Staff had the required training in safeguarding adults and children to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- 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 could not identify the outcomes measure and actions on a number of different audits.
- Staff did not always check patients had the correct medicines when they were admitted, and outcomes of medicines audits were not always clear.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service stayed the same. We rated it as good.

Summary of findings

Contents

Summary of this inspection

Background to Beaumond House Hospice Care

Beaumond House Hospice Care provides specialist care for people living with a terminal illness. The service was first registered with CQC in December 2010.

The hospice works with other partner organisations to provide high quality care to patients and their families. Funding is provided by the local NHS, charitable donations, and grants. The hospice also provides training and education to local support groups.

The hospice cares for patients at the hospice location, in the community, or in their own homes.

The hospice provides care to adults through inpatient services, day hospice and community services. Bereavement, counselling and complementary therapy services are also provided to patients and their families.

There was a new registered manager in post and the service is registered to provide treatment of disease, disorder or injury and personal care.

How we carried out this inspection

We carried out an announced comprehensive inspection on 6 and 7 December 2023. The inspection team consisted of a CQC inspector and a specialist adviser with a background in palliative care. We looked at all key questions including safe, effective, responsive, caring, and well led.

During the inspection we spoke to 18 members of staff, 13 patients and we reviewed 10 sets of patient notes and 5 staff files. We attended 1 of the service handover meetings for staff and a daily huddle meeting. We visited 2 patients in community settings with the hospice at home team.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Outstanding practice

The service employed a voluntary Soul Midwife to provide comfort, continuous support, and reassurance in helping a dying person to experience the death they want for themselves.

Areas for improvement

Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Summary of this inspection

- The service should ensure staff are confident applying training they have received in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The service should ensure it reviews its audit programme in order to demonstrate outcomes or action plans to address the issues raised.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Is the service 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.

Staff received and kept up to date with their mandatory training.

All staff spoke positively about the training programme.

Staff received mandatory training in safe systems, practices, and processes.

Mandatory training was delivered as a mixture of face-to-face training and online completion by staff. Training modules included basic life support, equality and diversity, fire safety, infection prevention and control, data security and Freedom to Speak up.

The mandatory training was comprehensive and met the needs of patients and staff.

Mandatory training was split into job roles and staff would have a personalised list of training for them to complete.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Staff received a full induction when they started work at the hospice.

Mental health first aid training not part of mandatory training but was part of additional training.

Mandatory training rates were 95% against the hospice target of 100%. Training completion data showed 100% compliance for safeguarding, equality and diversity and data security awareness.

Managers monitored mandatory training using an electronic system. and alerted staff when they needed to update their training.

All staff and volunteers were expected to keep up to date with their training. Staff could check when training was due on the hospice's computer system. The system would send out reminders to staff via email that their mandatory training was due, needed to be completed or was outstanding. In addition, managers would be alerted by the system when their staff's training needed updating.

Mandatory training rates were monitored each quarter of the year by the senior management team to make sure mandatory training was being kept up to date.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Staff told us they followed the safeguarding guidelines and had attended safeguarding training, which was part of their annual mandatory training requirement.

Staff received training specific for their role on how to recognise and report abuse and training was completed at an appropriate level in line with national guidance.

Staff received training in safeguarding adults and children at levels 1 and 2, All staff had completed this training in line with the local authority safeguarding adults board. The 2 safeguarding leads were trained to safeguarding level 3 for both children and adults.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The hospice had 2 safeguarding leads who provided 24 hour safeguarding advice 7 days per week. Both safeguarding leads were trained to level 3 adults and children. Named professionals trained to level 4 were accessible through the local NHS trust.

Staff were able to name the leads and knew how to contact them. Staff would speak with 1 of the safeguarding leads for advice.

There were clear systems, processes, to safeguard patients from avoidable harm, abuse and neglect that reflected legislation and local requirements. However, some staff we spoke with were not clear on what these practices were.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

All staff we spoke with had a good understanding of what constituted harassment and discrimination and what actions to take should they identify this.

Staff followed safe procedures for children visiting the hospice. A 'Safeguarding Children and Young People' policy was in place and provided staff with information about preventing and identifying possible risk or abuse, procedures to be adopted to ensure children and young people and their families and carers were safeguarded from any potential risk of abuse and clear guidance on actions to be taken if there were concerns or allegations of risk of or abuse.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients and transporting patients after death.

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

All areas we inspected were visibly clean. Staff used records to identify how well the service performed with cleanliness, infection control and hygiene.

We reviewed infection control audits which recorded a high level of compliance. Audits and registers covered appropriate areas of cleanliness to check and complete.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was a hand sanitising gel available in all areas we inspected, and we saw reception staff requesting that visitors used the gel before entering the main hospice. All staff adhered to the arms bare below the elbow policy.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Quarterly Infection prevention and control cleaning audits were completed by appropriate supervisors.

Cleaning records were completed on daily and weekly check list sheets. Colour coding of cleaning materials were in use.

From January to November 2023, there was a 100% compliance with the cleaning schedule.

Staff followed infection control principles including the use of PPE.

Staff wore PPE and washed and gelled their hands regularly; hand gel was readily available throughout the building and posters displayed the 5 moments of hand hygiene.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

We saw that after staff cleaned had cleaned equipment they attached a 'Green I am clean' sticker labelled equipment to show when it was last been cleaned.

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.

Patients could reach call bells and staff responded quickly when called.

We saw call bells within reach of patients, and they told us they were answered quickly.

Good

Hospice services for adults

The design of the environment followed national guidance but was not always suitable for certain types of patients.

Patients were cared for in 4 individual rooms with en-suite facilities. At the time of our inspection, there were 2 inpatients.

The building was a 2 storey building with offices, staff facilities a meeting room and patient side rooms on the first floor, however, due to the layout of the property which included stairs and a landing, this would not be appropriate setting for a confused patient who was known to wander. The hospice advised that sometimes they were unable to admit patients who were stretcher bound, due to the stairs and a small lift which required patients to be able to be seated or standing.

On the ground floor of the hospice. There were 2 receptions areas, where day therapy patients' groups were held which was light and welcoming.

The service had suitable facilities to meet the needs of patients' families. This included facilities for refreshments and quiet space for reflection and to have private conversations.

There was a small outside garden area with benches for patients and families to sit on, this was a specially designed space called the garden room for complementary therapy.

Staff mostly carried out daily safety checks of specialist equipment.

The service used specialist syringe drivers for patients who required a continuous infusion of medication to help control their symptoms.

Syringe drivers were kept on site and mostly maintained and used in accordance with professional recommendations.

The service had 9 syringe drivers stored in the clinical room on site and regularly used within the hospice. However, 1 of the syringe drivers was found to be out of date for a service This was reported to the nurse in charge who took the syringe driver out of action immediately.

The service had enough suitable equipment to help them to safely care for patients.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. The multidisciplinary team worked together to identify any equipment needed to provide care and treatment in the home.

Staff disposed of clinical waste safely.

There were sufficient clinical waste bins throughout 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 completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. When patients were admitted to the inpatient unit staff carried out risk assessments in relation to Braden, moving and handling, falls, nutrition and hydration, venous thromboembolism and bed rails. Within the 2 patient records we reviewed; all appropriate risk assessments were completed.

Staff we spoke to told us they knew the action to take for a patient who was assessed as deteriorating.

Staff knew about and dealt with any specific risk issues.

We saw that staff monitored patient risks such as falls, pressure ulcers and mouth sores. Staff were aware of the importance of monitoring these risks and recording them appropriately.

Nursing staff were proactive in establishing an advanced care plan with patients and families on admission, which ensured patients' wishes for their care were clearly documented and known to the clinical team.

The service had 24-hour access to mental health liaison and specialist mental health support from the local NHS trust

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff we spoke with knew how to refer patients with mental health needs to the GP. They told us as soon as a patient exhibited any suicidal ideation or self-harming intention, the first action was to ensure the patient was never left alone. However, none of the staff we spoke with could remember the last time a patient had suicidal ideation or self-harming intentions.

Staff shared key information to keep patients safe when handing over their care to others.

We attended the team handover meetings and saw that relevant patient information was shared with other health providers, for example GP services and other teams involved in patient care.

Staff received information as to whether a patient had a ReSPECT form in place, were palliative or were end of life. During handovers, staff were made aware of any patients who were at risk, for example, those at risk of falls or those who were confused.

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 staff of relevant grades to keep patients safe.

The inpatient unit had a nursing establishment based on 4 beds. At the time of the inspection occupancy levels on the inpatient unit were low and there were 2 patients being cared for.

Good

Hospice services for adults

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The number of nurses and healthcare assistants matched the planned numbers.

Staff to patient ratio was high, with 2.5 staff to patients during the day and 2:2 at night, with a registered nurse is on duty at all times.

The managers could adjust staffing levels daily according to the needs of patients.

Weekend staffing level requirements were reviewed at a weekly planning meeting where any extra resources were identified and arranged as required.

Advice from a senior nurse was available out of hours.

The number of nurses and healthcare assistants matched the planned numbers on the inpatient unit and for the hospice at home provision.

The skill mix and competencies of staff in the home care services reflected the needs of people being cared for at that time. For example, patients at the end of life where being cared for by staff that had been trained in palliative care.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Leaders at the service told us they used internal bank staff only who were familiar with the service and did not use agency nurses.

Managers made sure all bank staff had a full induction and understood the service.

Staff in the day care service told us there were enough staff to deliver good care.

Staff told us they had plenty of time to spend with patients and develop relationships. Comments from patients reflected this.

The hospice employed a bereavement counsellor and a Complementary therapist to support patients and their loved ones.

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

The managers could adjust staffing levels daily according to the needs of patients. Staff worked flexibly to cover shifts and the hospice had their own team of bank staff to provide cover, including some at short notice. The number of nurses and healthcare assistants matched the planned numbers.

Managers made sure all bank and agency staff had a full induction and understood the service.

Good

Hospice services for adults

Records

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

Patient notes were comprehensive, and all staff could access them easily.

The electronic system was compatible with some other primary services within the locality and therefore, accessible to other staff involved in the patient's care with appropriate permissions and consent.

We received a record keeping audit after our inspection dated 4 October 2023. Data showed there were 12 separate errors. However, we were unable to see any actions identified following this audit.

Records were stored securely.

An electronic and paper and patient record system were in use which staff could access. The electronic system was password protected.

Staff told us that they were able to access the information they needed, when they needed it, in an easily organised manner.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always check patients had the correct medicines when they were admitted, and outcomes of medicines audits were not always clear.

Staff followed systems and processes to prescribe and administer medicines safely.

Medicines were prescribed by GP's or community nurse specialists and obtained from a local pharmacy.

Staff followed systems and processes prescribing, administering, recording, and storing medicines. We saw medicines appropriately stored in cupboards and fridges within locked rooms in line with legislation. There were systems to ensure compliance with safe storage and expiry dates for appropriate disposal in line with the provider's policy.

Medicines were kept at the right temperatures and the temperature of the clinic room and medicines fridge were appropriately monitored.

Staff stored and managed all medicines and prescribing documents safely.

The clinical lead nurse was the controlled drugs accountable officer responsible for all aspects of controlled drug management within the hospice.

We saw that all controlled drugs were stored securely.

Data we received showed controlled drugs audits for the period January to December 2023. Audits were completed quarterly; however, they did not show outcomes or action plans to address the issues raised.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Controlled drugs, such as hospice stock medicines and patient's own medicines brought into the hospice with them were stored correctly, securely and administered correctly.

Staff completed medicines records accurately and kept them up to date.

Staff did not always check patients had the correct medicines when they were admitted, or they moved between services.

Anticipatory medicines were not prescribed for a patient who was admitted to the hospice for the symptom management of nausea and vomiting this was as a result of the patient not bringing their medicine chart from home. Anticipatory medicines are medicines which are prescribed for key symptoms associated with last days of life (for example, pain, agitation, excessive respiratory secretions, nausea and vomiting and breathlessness).

The medicines were documented on the electronic system by the GP as a note but not transcribed into a prescription to enable staff to administer medicines as required.

This meant there could have been a delay in managing key symptoms for this patient had they been experiencing them. We raised this to the nurse in charge and this was acted on immediately. Following our inspection, the service had updated their medicines policy to direct staff to contact an out of hours GP if medicines needed to be prescribed.

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.

Staff knew what incidents to report and how to report them.

The service had systems to monitor and manage accidents and incidents to maintain patients' safety. Staff were aware of the process to report any incidents and accidents.

Staff raised concerns and reported incidents and near misses in line with hospice policy. Data showed that between October 2022 and 30 September 2023 there were no never events or serious incidents reported. Never events are serious incidents that are wholly preventable.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

The hospice had systems to ensure that incidents were learnt from. The service confirmed incidents were reported through their electronic incident reporting system. Incidents were reviewed by the lead nurse and responded to in a timely way.

Staff reported serious incidents clearly and in line with the service's policy.

Managers described the process used to investigate incidents thoroughly, including the involvement of patients and their families in these investigations. The service had a clear process for reporting and investigating incidents.

Good

Hospice services for adults

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

The duty of candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that has led to moderate or significant harm. Staff we spoke with understood the duty of candour and when this should be applied. The service had an up to date duty of candour policy.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff told us they received information on learning and trends from incidents and complaints. Learning from incidents was discussed in staff meetings and specific changes to practice were emailed directly to all relevant staff members.

Is the service 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.

Staff holistically assessed people's physical, mental health and social needs, and delivered care and treatment in line with legislation, standards, and evidence-based guidance.

Overall, we found that care provided was evidence based and followed recognised national guidance. Staff were clear of their roles in care pathways and were aware of the national guidelines relevant to their scope of practice. For example, we observed staff giving evidence-based advice to another staff member about the medication being prescribed for a patient.

New policies and procedures were communicated to staff through staff meetings, emails, and weekly updates. All staff were able to demonstrate they received regular communication from team leaders and above. This meant that staff were able to keep up to date with current practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At the handover and daily huddle meetings we attended, we saw staff refer to the psychological and emotional needs of patients, their relatives, and carers. Staff routinely discussed with patients any concerns they might have about the progression of end of life including preferred place of care or death, concerns about medications and side effects, emotional support for family members or friends and financial concerns.

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.

Each patient had a detailed care plan with specific details on dietary, feeding and hydration regimes which was updated at every admission to the hospice.

Processes were in place to ensure staff fully and accurately completed patients' fluid and nutrition charts where needed.

Fluid balance charts were used to record a patient's fluid intake and output to monitor a patient's fluid balance to prevent dehydration or over hydration for those patients who required a restricted fluid intake. There were no patients requiring fluid balance at the time of our inspection.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

We saw the malnutrition universal screening tool (MUST) being used to assess patients who were malnourished, at risk of malnutrition or obese. We saw as part of the nurses intentional rounding, they regularly offered patients drinks and asked if they wanted anything to eat. Intentional rounding is the structured process whereby nurses carry out regular checks, usually hourly, with patients using a standardised protocol to address issues of positioning, pain, personal needs, and placement of items.

The hospice had a catering team onsite and each morning patients were asked what they would like to eat and if there were any special dietary needs. There were a number of different aspects to the food served by the kitchen. For example, culturally appropriate, vegetarian, vegan and specific diets concerned with food allergies. Catering staff told us they were passionate about providing the best possible nutrition to their patients. The staff showed a clear understanding of the difficulties this patient group could have with nutritional intake where often their appetite is poor or oral intake can be difficult due to swallowing problems. There was an extensive dietary plan available which we saw and also a more individual menu available for patients where needed, or smaller plates of food so as not to be overwhelming. There was provision for patients who did not want regular meals or who did not want to eat at set times. Staff told us they always kept a selection of sandwiches, soups, and cereals for patients.

Patients and their family members told us the food and the catering staff were of a high standard and staff took time to make meals times as pleasurable as possible. One patient told us when they were admitted to the hospice they had not eaten in properly recently as they had very little appetite, however, the food was so delicious and so well presented at the hospice they had been eating very well.

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 two different pain tools appropriately, a numerical rating pain scale was used alongside a face pain scale. Both were readily available if needed. The two pain scale tools were designed to assist in the assessment of pain in patients who are unable to articulate their needs for example if they had any communication issues. Staff recorded information concerning patients' pain in the nursing notes.

Patients pain and symptom control was regularly discussed with them, and they were reassured about pain control and the plan for management of pain moving forwards.

Patients received pain relief soon after requesting it.

Patient records we reviewed evidenced appropriate pain relief medicines were given to patients to manage symptoms. Where pain relief was given, records showed this was followed up within 30 minutes to check if pain relief was adequate.

Day therapy staff told us that they assessed people's pain as part of their on-going assessment.

Staff employed by the hospice did not prescribe pain relief. However, they administered, and recorded pain relief accurately.

There were no specialist staff employed by the hospice, however, the service worked closely with the specialist palliative care nurses who were employed by the local NHS trust and were part of the End-of-Life Care Together Alliance. Which is a partnership working to deliver integrated palliative and end of life care.

The service did not prescribe pain relief however, they would contact the patient's GP if pain relief was required. Staff encouraged patients to take their own prescribed pain relief in line with individual needs and best practice.

People's pain was generally well managed. Pain assessments were carried out, documented and the outcome of treatment monitored so that doses of medicines would be changed if needed.

People's care records demonstrated that staff made referrals to other healthcare professionals whenever there was an identified need.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, it was not clear where improvements had been made as a result of audits.

The service participated in relevant national clinical audits.

The hospice followed up to date guidance to ensure patients received effective and high quality care. These included National Institute for Health and Care Excellence (NICE) guidance this included but was not limited to; Care of dying adults in last days of life (NICE QS144 and NG31, QS13), Controlled drugs: safe use and management (NICE NG46) and Leadership Alliance for the Care of Dying People: One chance to get it right.

The hospice delivered the priorities in a variety of ways such as through the provision of palliative study days, patient survey results, embedding of the Karnofsky performance status assessment tool scale and information provision for families and service design.

Preferred place of patient care or death was audited annually, and the results shared with the After death analysis audit with learning shared with staff.

Managers did not always use information from audits to improve care and treatment.

The service had a systematic approach to audits which could be used to check improvement over time. Some data was collected regarding patient outcomes, but we were unable to see how these could be used to improve patients' outcomes. For example, there was a programme of annual audits which included infection control, record keeping and controlled drugs. Data showed that from the period November to January 2023 there were 6 controlled drug errors. Actions were identified following these audits, however, although there were recommendations on how improvements could be made, we were unable to see any action plan to ensure these were achieved.

The service used the Integrated Palliative Care Outcome Scale (IPOS) tool, which is nationally recognised. The IPOS tool is a questionnaire which assesses a patient's physical symptoms, social and psychological wellbeing, and their relationships with others.

'We saw in day therapy; staff collected some data on the IPOS which led to a personalised care plan for patients. At the time of our inspection we did not see evidence to show how the information was being used to drive improvement'.The service had a lower than expected risk of readmission for elective care than the England average. From March to August 2023, the hospice had 1 patient re-admission within 24 hours of discharge home.

Managers shared and made sure staff understood information from the audits.

Staff advised that e-mails were sent to them to share general learning from audits, where a gap was identified in their knowledge for an individual was identified, a further e-mail was sent with any actions required, for example, to seek a supervision of practice in a certain area.

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.

Staff completed training appropriate to their role. This included additional training, such as syringe driver training, drug calculations and infection prevention and control.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through constructive appraisals of their work.

Staff we spoke with told us they had a recent meaningful appraisal and that they found it useful.

Data showed 100% of staff were up to date with their appraisals.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff told us they attended funded conferences and training courses relevant to their practice and that managers made sure they were able to attend team meetings or had access to full notes when they could not attend.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings minutes were comprehensively completed and available to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, we saw that one staff member had been supported to undertake a course in counselling skills.

Managers recruited, trained, and supported volunteers to support patients in the service.

Volunteers were trained to fulfil their role and had regular supportive meetings with managers to identify training and support needs.

At the time of our inspection, the service had 170 volunteers registered, who supported the hospice in a variety of roles including retail assistants, drivers, day therapy volunteers, inpatient support, housekeeping catering, reception, gardeners, Complementary therapists, soul midwife, bereavement support and administration. Volunteers were Disclosure and Barring Service, as well as reference checked and completed a specific volunteer induction day.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. These were held weekly. Staff discussed how they could best support patients and contacted external support if it was needed. Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff worked across health care disciplines and with other agencies when required to care for patients.

We reviewed patient records which evidenced that routine input from multi-disciplinary staff and healthcare professionals took place.

We noted there was a regular MDT working with other healthcare professionals, including regular meetings and input from GP's, a local NHS trust and with the local community palliative care nursing team.

The hospice had a daily huddle every weekday morning which included nursing and support staff input to review resources and patient risk.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Staff were not able to make a referral directly to the mental health team as the referral pathway was via the GP. For urgent crisis support staff would refer as above or contact 999 if appropriate.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Staff could call for support from nurses and other disciplines, including mental health services, 24 hours a day, 7 days a week.

The hospice was a nurse led unit.

Patients could access the service 7 days a week, 24 hours a day if needed. Specialist nursing and medical support was available seven days a week and patients were reviewed daily.

There was nurse support and safeguarding advice 24 hours a day seven days a week as an on-call rota was in place.

The hospice at home team of nurse and health care assistants provided care at home from 8am to 8.30pm, 7 days a week.

Housekeeping staff were on site 7 days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support available to patients and their carers.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff showed a clear understanding of the difficulties patients accessing hospice services could have with nutritional and maintaining a healthy diet. There was an extensive dietary plan available with healthy and nutritious food available.

The service displayed information for patients on eating well, self-care and there was a wellbeing service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, they were sometimes unsure how to support patients who lacked capacity to make their own decisions.

Mental Capacity Act and Deprivation of Liberty Safeguards training was included in the hospice monthly training plan dated 2023.

Evidence was provided to us that 97% of healthcare staff had undertaken this training. However, staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

Some staff were unsure how to access policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. However, a lead nurse for mental capacity was available to staff as a resource and for advice and support. All staff were aware of how to access this support.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Good

Hospice services for adults

Staff clearly recorded consent in the patients' records. We reviewed 2 patient records and saw consent had been documented in all applicable circumstances.

The service utilised the ReSPECT form, which was transferrable across the health economy and when patients were discharged, they took with them the original document.

We saw comprehensive documents recording patient's wishes in regard to, their priorities relating to end of life care (for example, symptom control, preferred place of death).

Staff documented do not attempt cardio-pulmonary resuscitation (DNACPR) orders which were recorded in patient records and patient files which were part of the ReSPECT paperwork. We looked at 5 DNACPR orders and found that all were completed correctly.

Staff could not describe and did not know how to access policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Mental Capacity Act and Deprivation of Liberty Safeguards training was included in the hospice monthly training plan dated 2023. However, we did not see evidence to show when and if staff had completed this training. This meant we could not be assured staff had the necessary training or understanding to appropriately apply Deprivation of Liberty Safeguards.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients in a way that enabled them time to ask questions, gain clarity and an understanding of treatment and care.

Staff followed policy to keep patient care and treatment confidential.

Patients told us staff respected their privacy and confidentiality at all times. We saw staff knocking on patient doors before they entered and closing doors behind them.

Patients said staff were very kind and caring and treated them with dignity and respect.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, we saw the daily menus provided by the catering service had been translated into a different language for a patient who did not have English as their first language.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

We saw staff were positive and attentive to the needs of patients at the hospice. We observed staff providing kind, thoughtful, supportive, and empathetic care, support, and advice. Relatives also commented on how supportive the staff were.

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.

The service emphasised that family or a caregiver's emotional needs were equally important to that of a patient. The service put both patients and their family at the centre of their care and made sure people received the support they needed. Staff promoted support for patients as well as the needs of family or caregivers. Activities at the well-being centre were available for both patients and their families, for example, aromatherapy massage, reflexology and hypnotherapy.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff told us they had enough time to sit and talk to patients about their care and answer any questions they may have. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients told us they always had opportunities to express their views in conversations with staff and knew who to contact if required. Staff supported patients to make informed decisions about their care. Patients and their families gave positive feedback about the way staff supported and involved them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

The hospice utilised a patient questionnaire for patient feedback. All feedback was provided to staff.

Patients gave positive feedback about the service.

Data showed that or the period July to September 2023, the patient questionnaire had 5 inpatient responses, 4 rated the service as outstanding and 1 patient rated the service as good. For the same period hospice at home had 7 responses to patient questionnaires. All rated the service as outstanding.

Good

Hospice services for adults

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, however the premises did not always meet the needs of the local population.

The community and the inpatient unit services offered a flexible and responsive service to meet the needs of the patients who used the service. Managers told us there were often variances in demand for services for both community and the inpatient service.

The hospice provided 2 main areas of activity. The hospice services incorporated a day hospice and an inpatient unit. The location had good transport links. A car park was provided for patients and their family/carers.

The hospice inpatient unit provided 24-hour care for specialist palliative care patients and a hospice at home service. Specialist admissions could be undertaken for symptom control or end of life care; however, the facilities and premises were not always appropriate for the care being delivered. Due to the layout of the property. We were advised that this had been addressed in plans for a new building which was to be the new location for the hospice.

The service held 2 planning meetings weekly, where patients needs and choices were discussed. Where patients needs and choices were not able to be met for example, if they were too complex or needed a medical focus they could be referred to another provider as the hospice worked within an alliance with other palliative service providers.

Managers monitored and took action to minimise missed appointments. The service did not have a policy for missed appointments. However, these were flagged up by staff from the necessary teams and documented. The missed appointments were then discussed at the planning meetings, where the decision is made as to whether a home visit is necessary.

The hospice undertook a 'Teapot group' every 2 weeks to support the loved ones of patients treated at the hospice to attend the group and discuss their feelings whilst having a cup of tea.

The service had systems to help care for patients in need of additional support. For example, during our inspection we saw the service had created the 'light up a life services 2023' to remember family and friends sharing memories and lighting candles in memory of those loved ones who had passed away.

The service also had a 'Be Bright Blue' campaign, to address the feelings of isolation and loneliness following a terminal diagnosis. The campaign encouraged communication to reduce loneliness in patients by offering a number of services. For example, 'pocket hugs' these were small, knitted hearts which could be given 'From me to you'.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. Within the hospice, there was trained bereavement counsellor and staff who could provide mental health support to patients.

Care plans and risk assessments for patients were person-centred and tailored to each individual patient's needs. Each person's care plan was devised in discussions with the patient about what was important to them. The care plans were regularly reviewed and updated, and referrals were made to members of the multidisciplinary team (MDT) according to each patient's needs.

Staff supported the choice of patients and their families through advance care planning. The hospice team worked proactively to deliver care in a way that met the needs of patients. This was evident in the handover and MDT meetings we attended and from feedback from patients, their loved ones, and families.

Where patients had a preferred place of care or death, attempts were made to facilitate this. Partnership working took place with hospice services and other external agencies to enable discharges so patients could die at home if this was their wish.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Staff had training to be able to support patients with complex needs such as learning disabilities, mental health concerns and dementia. Staff told us, if needed, they would liaise and involve relatives, specialist practitioners in the local community who were already involved in the patient's care to make sure they supported patients appropriately and to make sure there was continuity of care.

Meeting people's individual needs

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

The service had information leaflets available in languages spoken by the patients and local community.

Staff we spoke with said they had access translation or interpretation services if needed.

The hospice had a no referral acceptance criteria, this meant that anyone could make a referral, by telephone, in person or electronically. For example, families, patients' other organisations and health professionals.

'Forever feathers' was an initiative where people could buy a feather in memory of a loved one. These were handmade personalised glass feathers. Each feather formed part of a collective wall display at the hospice.

The hospice had volunteer chaplaincy team, which people of all faiths and non-religious people.

The hospice employed a volunteer soul midwife. Soul midwives are non-medical, holistic companions who guide and support the dying person in order to help facilitate a tranquil death when the person is at the end of their life. Soul midwives aim to provide comfort, continuous support, and reassurance in helping a dying person to experience the death they want form themselves.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

The service was able to provide information leaflets in languages spoken by the patients and local community.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

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

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers monitored all delayed discharges and worked with other health agencies and professionals to reduce them.

Managers and staff started planning each patient's discharge as early as possible.

There were discharge processes to ensure patients could be safely discharged home to their wherever possible. These included working with other health professionals and liaising with other hospice services such as occupational therapy team and pharmacy to ensure an appropriate care package was in place.

Managers monitored the number of patients whose discharge was delayed.

Information received after our inspection showed there were a number of reasons for unmet referral of a patient from the service. For example, for one patient due to be discharged, there was no capacity for staff night sitting in the community. All referrals which had unmet needs were monitored and reported to the Integrated Care Board which is an NHS organisation responsible for planning health services for their local population.

Staff supported patients when they were referred or transferred between services.

The service had effective processes to manage admission to the service. Referrals came mostly from GPs, specialist palliative care nurses, community clinical nurse specialists and the local acute NHS hospital.

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.

Good

Hospice services for adults

Patients we spoke with said they would feel confident to raise a complaint with staff if they needed too. Staff told us they would escalate patient complaints to their managers. The service displayed information at the feedback point in the main corridor which explained about how to raise a concern in patient areas, and it had an up to date complaints policy.

Following the inspection, we were advised that the service had not received any complaints for the period December 2022 to 2023.

The service clearly displayed information about how to raise a concern in patient areas.

Patients and relatives are offered the 'Tell us What you Think' leaflet. This is given as part of the welcome pack and explained how to how to give feedback and how to complain about the service.

The leaflets were in all the bedrooms for in-patient use.

The complaints policy and all methods of feedback were also available on the hospice website.

Staff understood the policy on complaints and knew how to handle them.

The service had a complaints and concerns policy. Staff understood the policy on complaints and knew how to handle them. They understood the system and had access to the policy and procedures to guide them in managing complaints. Staff we spoke with knew how to acknowledge complaints and concerns appropriately.

Is the service well-led?

Good

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

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.

There was a clear management structure with lines of responsibility and accountability. Staff we spoke with were positive about the leadership team and told us that managers were approachable and visible. Staff knew the different managers and their areas of responsibility. We observed positive interactions between staff and managers. Staff told us they felt comfortable and able to raise any concerns they had with the management team.

Managers within the service demonstrated knowledge of the demographics of the area, and the needs of the local population. There was collaboration with external agencies, such as other local hospices, the NHS and the intergraded care board.

Managers were passionate about their roles and were proud to work at the hospice.

Good

Hospice services for adults

Managers recognised the challenges and priorities faced by the hospice. They engaged with staff and external stakeholders to address issues effectively. They ensured the experience of patients, and their families were central to decisions made.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy was a 5 year plan from 2023 to 2028 which focused on 4 strategic goals.

- We will deliver outstanding hospice care to those who need it.
- We will be seen as a place for people to work and volunteer.
- We will lead our hospice well.
- We will generate the income needed to provide our services.

Consultation was undertaken to develop the strategy using feedback forms and workshops from people in the service, staff and volunteers and stakeholders.

The strategy was launched with a series of staff meetings to talk through the goals. Staff appraisals has been revised and aligned to the strategy to enable staff to demonstrate how they were working towards delivering the strategy. New members of staff were introduced to the strategy during induction. There were copies around the hospice and the layout of the booklet which is easy to read and understand.

Internal progress against the strategy was monitored through the leadership team meetings and 3 sub committees. The strategy was monitored by each leader for their area of responsibility and collectively as a leadership team with oversight from subcommittees for scrutiny. There was an annual update to the board. The last presentation was on 10 November 2023.

Sustainability of services were aligned to local plans within the wider health economy. Leaders were committed to fulfilling the strategy, part of which was to work with others to meet people's needs. The service had developed sustainable partnerships with the wider health and social care economy. The hospice was part of the End of life Care Together Alliance and worked closely to monitor capacity and demand in the local geographical area.

The service had a monthly staff newsletter with a section dedicated to vision and strategy to ensure staff were aware of the strategy, kept up to date with its progress, and were able to be involved.

The hospice had a set of values, which included openness and honesty, collaboration and patient centred care, which staff were knowledgeable about.

Culture

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

Staff described an open culture and told us they would have no fear about raising concerns. Staff said they would be able to approach leaders if they had anything they wanted to discuss. There was a clear sense of teamwork across the hospice staff and the hospice at home staff. Everyone spoke highly of their colleagues. When speaking with staff it was clear their priority was focussing on the needs of the patients they cared for. Staff were passionate about making the services the provider supplied work well.

The service had a named Freedom to Speak Up Guardian.

The service had a duty of candour policy which staff were knowledgeable about.

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 was a well embedded governance structure to ensure organisational, team and individual responsibility and accountability. Clear goals and ambitions were set out within the organisational strategy. Senior leaders and the board of directors worked together to deliver the strategy and culture. Governance within the hospice was overseen by the board of trustees and executive management team through the information governance framework.

The framework, and supporting policy, provided the structure for managing and reporting on a range of auditable metrics to the board and to the clinical commissioning groups. Board-led sub-group committees, all of which were attended by a trustee, included the finance and income generation committee, care services development and the operations committee. Policies were regularly reviewed, kept up to date and ratified by the board or sub committees as appropriate. Staff were clear about their roles and accountabilities and who to report to.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues. However, where audits had been carried out we did not see where actions had been identified to address any concerns raised. Leaders had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior leaders could articulate the risks facing the service which were appropriately reflective of the wider health economy, system pressures and speciality sector. For example, the reduction of income donations and legacies for 2023.

We reviewed the risk register during our inspection. There were 6 current open and ongoing risks The risk register contained information on when the risk was raised, the date of review, category of risk, the risk score which was rag rated, and who owned the risk and any mitigation of risk.

We saw evidence the risk register was reviewed and updated at the monthly management meeting. At this meeting risks were identified and discussed, and a plan put in place to eliminate or reduce them.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The service had a business continuity plan to manage specific risks relating to service delivery.

The service had a systematic approach to audits which could be used to check improvement over time. However, we were unable to see how these could be used to improve patients' outcomes. Although there were recommendations on how improvements could be made, we were unable to see any action plan to ensure these were achieved.

Information Management

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.

Managers understood performance targets including quality, data from audits and finances. Information was shared across the hospice to key committees to provide assurances on the quality, risk, and performance within the service.

The hospice collected a variety of data and analysed it to understand performance, make decisions and improvements. Information was collated and shared with staff, patients, and visitors, for example the results of friends and family survey results.

Paper and electronic records were used for patient care data. Paper records were stored in a secure manner which was accessible to staff who needed it. Other business critical records such as policies and procedures were stored electronically on computers which could be password protected.

IT systems were integrated and secure, to prevent unauthorised access of information.

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.

Managers had a shared purpose and collaborated internally and externally to provide effective services. The service engaged well with patients, staff, volunteers, the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.

The service had a Freedom to Speak Up Guardian in place for staff to speak with. Staff told us that they felt confident to speak to up should they feel the need to

Freedom to Speak Up Guardians support workers to raise issues without fear of negative consequences. They also help their organisations identify and address barriers to speaking up.

The service used patient feedback forms which asked patients and carers about the quality of the service and any additional comments they would like to make.

Patient/carer feedback and actions were discussed at clinical governance meetings where trends were identified and if needed, learning shared across the organisation.

The hospice sent out a quarterly newsletter to staff. Items in the letter included but were not limited to service developments, support sessions, and dementia friends' workshops.

Good

Hospice services for adults

The hospice had a number of initiatives to support engagement with their patients and the wider community. For example, hospice user group meetings were held quarterly with feedback and any actions responded to on issues raised by patients and staff, animal therapy groups undertaken during school holidays and planned visits to day therapy patients who were home alone over Christmas with mince pies.

Learning, continuous improvement and innovation

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

The hospice used quality improvement methodology such as clinical audits and surveys to identify areas for action and improvement. This included monthly key messages where all learning points from audits, incidents and were collated and shared with staff.

The hospice had developed links and working relationships with other hospice providers in the area with the aim of sharing good practice.

Work was being carried out to continuously improve the care and treatment provided by the hospice. For example, a new research initiative was being launched in conjunction with a local university on nature based interventions.

The hospice had a 'This is me' form for patient completion with the objective of providing staff information to personalise their care and support.

The hospice had links with the local college and received students from there on placement.

The hospice were in discussions about creating a new build property which would provide a more patient friendly accommodation and increase bed capacity.

Work was in progress going into schools to raise awareness of nursing and caring for relatives. This was being progressed by the clinical nurse lead and the wellbeing lead.

In addition, the service had been providing more family friendly activities during open days to encourage and welcome people of all ages into the hospice.

The hospice won the Newark business award for 2023 for team of the year.