

# Sue Ryder - St John's

## Quality Report

St John's Road  
Moggerhanger  
Bedford  
MK44 3RJ  
Tel: 01767 642410  
Website: [www.suerydercare.org](http://www.suerydercare.org)

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

### Ratings

#### Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

### Overall summary

Sue Ryder – St John's is operated by Sue Ryder, a national charitable organisation which specialises in providing palliative and neurological care to people living with life-limiting conditions. The hospice has 15 inpatient beds. Facilities include an inpatient unit, day therapy unit, palliative care hub, lounge, multi-faith and spiritual room, conservatory and garden.

The hospice provides end of life and palliative care for adults. We inspected all services provided.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 27 September 2019. We gave staff two days' notice that we were coming to ensure that everyone we needed to talk to was available. We also inspected on the 3 October 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

# Summary of findings

needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

## Services we rate

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

We found outstanding practice in relation to:

- Staff treated patients and their families with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- It was easy for people to give feedback. Concerns and complaints were taken seriously and investigated, and improvements were made in response to feedback where possible. Patients could access services when they needed them.
- Leaders ran services well using best practice information systems and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued.

Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

- The palliative care hub service worked collaboratively with partner organisations to ensure patients received the best care possible at the end of life, in their own homes. Feedback from relatives and carers who had been supported by the palliative care hub was overwhelmingly positive, and staff were often described as "angels" and having gone above and beyond what was necessary.
- Staff were involved in an innovative project to support patients to choose their own care home. The palliative social worker recognised that patients discharged from a hospice to a care home often had their choice and control compromised because they had to rely on others to choose a home on their behalf. To address this, staff visited all nursing homes who agreed to participate in the project and photographed the bedrooms. This meant patients who were not able to view nursing homes themselves were given more choice and control regarding where they would like to go. The photograph folders were also used by staff to open up discussions with patients about what to expect in a nursing home.

We found good practice in relation to:

- Despite some staff vacancies, the service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients and acted on them. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- The service provided care and treatment based on national guidance and best practice. Staff 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

# Summary of findings

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.

We found areas of practice that require improvement:

- Patients preferred place of death was not always documented.
- The real-time patient feedback rate was significantly below the Sue Ryder target.

- Two 'aroma steam' machines required electrical safety testing.

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

## **Heidi Smoult**

Deputy Chief Inspector of Hospitals (East)

# Summary of findings

## Our judgements about each of the main services

### Service

**Hospice services for adults**

### Rating

**Outstanding**



### Summary of each main service

We rated this service as outstanding for caring, responsive and well-led, and good for safe and effective.

# Summary of findings

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Outstanding



# Sue Ryder - St John's

## Services we looked at

Hospice services for adults

# Summary of this inspection

## Background to Sue Ryder - St John's

Sue Ryder – St John's is operated by Sue Ryder, a national charitable organisation which offers specialist palliative care and treatment for adults living with life-limiting conditions. The hospice is located in a quiet rural setting in the village of Moggerhanger, near Bedford. It primarily serves the communities of Bedfordshire and Cambridgeshire.

The hospice has had several registered managers in post since 2011. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in August 2019.

The registered manager is the hospice's accountable officer for controlled drugs.

## Our inspection team

The team that inspected the service comprised of two CQC inspectors, one CQC assistant inspector and a

specialist advisor with expertise in end of life and palliative care. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection, and Kim Handel, Inspection Manager.

## Information about Sue Ryder - St John's

The hospice provides inpatient, day therapy and community-based end of life and palliative care services. Palliative care is the care and support given to people living with life-limiting conditions, for example, cancer, heart failure and lung disease. It aims to give people the best quality of life possible by focusing on managing pain and other symptoms over the weeks, months and years someone is living with a life-limiting condition.

The inpatient unit has 15 beds comprising of 10 single rooms which can accommodate family/carers, six of which have ensuite facilities. There is also one two-bedded bay and one three-bedded bay, both of which have ensuite facilities. The day therapy unit includes three treatment suites, a conservatory, reception area, toilets, quiet room and kitchen facilities. Services include a lymphoedema clinic, which supports patients with chronic swelling because of a life-limiting condition, as well as physiotherapy, complementary therapies, occupational therapy and family support services. The palliative care hub provides palliative care for patients who chose to receive care at home.

The hospice accepts both male and female adult patients.

The hospice is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we inspected the inpatient unit, day therapy unit and palliative care hub. We spoke with 24 staff including registered nurses, health care assistants, medical staff, volunteers and senior managers. We spoke with nine patients and two relatives. We observed the environment and care provided to patients and one home visit. We reviewed five patient records and two prescription charts. We also reviewed information that we held about the hospice and information requested from the hospice, including performance data, policies and meeting minutes.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected four times, and the most recent inspection took place in April 2016, which found that the hospice

# Summary of this inspection

was meeting all standards of quality and safety it was inspected against. We rated the hospice good for safe, effective, caring, responsive and well-led. The hospice was rated good overall.

## Activity (May 2018 to April 2019)

- In the reporting period May 2018 to April 2019, 2,148 patients were treated for palliative care. Of these, 610 (28%) were aged between 18 and 65 years, and 1,538 (72%) were aged over 65 years.
- 1,570 patients receiving care died.

Track record on safety:

- Zero Never events
- Zero serious incidents

- Zero incidences of healthcare associated MRSA
- Zero incidences of healthcare associated Clostridium difficile (C. diff)
- Zero complaints

## Services provided at the hospice under service level agreement:

- Clinical and or non-clinical waste removal
- Laundry
- Maintenance of medical equipment
- Pathology, histology and microbiology
- Pharmacy
- Medical gases

# 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 	Outstanding 	Outstanding 
Overall	Good	Good	Outstanding 	Outstanding 	Outstanding 	Outstanding 

# Hospice services for adults

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

## 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 patients and staff. Courses covered key areas such as fire safety, health and safety, basic life support and infection prevention and control. Training was mostly provided through e-learning courses, with some practical face-to-face sessions such as manual handling and basic life support. Staff understood their responsibility to complete mandatory training and told us the training was relevant to their roles.
- Managers monitored mandatory training and alerted staff when they needed to update. Staff could monitor their own training needs through the hospice's electronic system, which sent an email alert when due. Managers received regular reports about mandatory training compliance. This meant they had oversight of staff compliance and could address any areas of non-compliance when needed.
- Most staff were up-to-date with their mandatory training. The hospice set a target of 90% for completion of all mandatory training courses. As of September 2019, completion rates for mandatory training courses were:

- Equality and diversity (e-learning) 97%
- Fire safety (e-learning) 93%
- Fire safety induction (face-to-face) 99%
- Infection prevention and control (e-learning) 95%
- Manual handling (e-learning) 94%
- Moving and handling inanimate objects (practical) 85%
- Moving and handling people (practical) 82%
- Information governance and General Data Protection Regulation (GDPR) (e-learning) 86%
- GDPR for non-clinical staff (e-learning) 92%
- GDPR for clinical staff (e-learning) 95%
- GDPR for administration staff (e-learning) 100%
- Health and safety induction (face-to-face) 99%
- Health and safety (e-learning) 94%
- Basic life support (practical) 87%
- Most staff we spoke with had received training to make them aware of the needs of people with mental health conditions and dementia. Sue Ryder had recognised it needed to be more effective at equipping staff with tools to manage mental health. This need was being addressed and in October 2019, an e-learning module on mental health was launched. Staff were able to undertake a six-month distance learning course in mental health awareness. At the time of inspection, 10 staff members were taking this course and on completion, it was planned that they would become mental health champions for the hospice. Most nurses



# Hospice services for adults

were 'dementia friends' and had completed dementia awareness training. However, most staff had not received training to make them aware of the needs of people with learning disabilities and autism. We were told they planned to source external autism and learning disabilities training once the clinical educator post had been recruited to.

## 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, processes and practices to safeguard adults, children and young people from avoidable harm, abuse and neglect that reflected legislation and local requirements. Safeguarding policies and pathways were in-date and were accessible to staff. Links to external resources were also available to staff through the trust's intranet, with advice on how to refer children and young people, and who to contact for advice and guidance on all matters relating to safeguarding. Safeguarding information was displayed in all locations we visited during the inspection. We also saw posters displayed on the back of toilet doors advising people how to access support if they were experiencing abuse.
- The hospice had a designated lead for safeguarding adults and children, who was available to provide support, supervision, training and updates for staff. The safeguarding lead had produced a resource folder which contained information for staff on safeguarding related matters, such as how to notify the Care Quality Commission (CQC) of abuse or allegations of abuse and how to make a safeguarding referral to the local authority. These were available in each department. Staff confirmed they could contact the safeguarding lead if they needed advice or support with any safeguarding concerns.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could explain the process of safeguarding a patient and provided us with examples of when they had done so. Staff liaised with other professionals and agencies, such as GPs,

the police and the local authority safeguarding leads, when needed. The safeguarding lead attended regular meetings with their counterparts from other Sue Ryder hospice sites and local authority safeguarding meetings. Topics discussed included national safeguarding guidance and learning from serious case reviews.

- Staff received training appropriate for their role on how to recognise and report abuse. Staff were required to complete safeguarding adults and children training at level two. The safeguarding lead had completed safeguarding training at level three. Managers told us a member of the community team would also be trained to level three to provide additional support when needed. Safeguarding training was provided through e-learning courses. Training covered all aspects of safeguarding, including professional responsibilities, the Mental Capacity Act, categories of abuse and safeguarding processes. The hospice set a target of 90% for completion of safeguarding training. As of September 2019, 94% of staff had completed safeguarding adults level two training and 97% had completed safeguarding children level two training.
- From May 2018 to September 2019, the hospice had submitted 13 notifications regarding abuse or allegation of abuse to the CQC. These were all in relation to patients who had developed pressure ulcers in the community and/or because of life-limiting conditions. We saw appropriate action had been taken to safeguard these patients.
- Safety was promoted in recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the hospice. We saw all staff had submitted a DBS check prior to employment and these 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



# Hospice services for adults

- **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 clinic areas we visited were clean and had suitable furnishings which were clean and well-maintained. There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve infection prevention and control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all departments. The monthly IPC audit assessed compliance against national and local guidelines, use of personal protective equipment (PPE), hand decontamination, sharps and waste disposal and staff training, for example. Results of the IPC audit carried out in May 2019 showed overall compliance was 95% (Source: Provider Information Request, P24). In August 2019, an external IPC audit assessed the hospice against 16 areas of infection prevention, including governance and documentary evidence, expertise, clinical equipment, decontamination of environment and urinary catheter management. Overall compliance was 88%, with seven areas scoring 90% or more. We saw evidence that corrective actions were taken to improve compliance where indicated. For example, the audit reported a written local policy for the management of residential/visiting pets should be available. We saw this was available on inspection. From May 2018 to April 2019, results from the relatives' survey showed 96% of relatives felt the hospice was always clean and tidy and 4% felt it was usually clean and tidy (Source: Provider Information Request, P29 Staff Surveys and Patient Feedback, P29 Palliative – Relatives Experience May 2018 to April 2019).
- Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. The hospice had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. The daily cleaning checklists were completed in 100% of the records we reviewed.
- Staff cleaned equipment after patient contact and labelled equipment to show when this had last been done. We saw all equipment not in use had a dated, 'I am clean' label to indicate to staff when it was last cleaned.
- Staff followed infection control principles including the use of personal protective equipment (PPE). Clinical areas had access to hand washing facilities and PPE, such as gloves and aprons. Hand sanitiser gel dispensers were available throughout the hospice, such as reception, corridors, bedrooms and clinical areas. We observed reception staff reminding visitors to use hand gel on arrival. Community staff carried a supply of IPC equipment for use when they visited patients at home, such as hand sanitising gel, gloves and cleaning wipes. We observed staff wash their hands before and following patient contact. This was in accordance with national guidance (National Institute for Health and Care Excellence (NICE), Infection prevention and control: QS61, quality statement 3 (April 2014)). Monthly audits were carried out to monitor staff compliance with hand hygiene. From April to July 2019, audit results showed hand hygiene compliance was 86% on average (Source: Provider Information Request, P24). We saw action was taken to improve hand hygiene compliance where indicated. This included additional training and email reminders sent to all staff. We observed staff adhered to the hospice's 'arms bare below the elbows' policy when working clinically. Patients and carers were also asked to audit staff for compliance with hand hygiene. Forms completed during inspection showed staff were 'arms bare below the elbows', hands and wrists were free from jewellery, nails were free from nail varnish, and staff washed their hands before and after patient care. From April 2018 to March 2019, results from the relatives survey showed relatives rated staff as 'excellent' for washing their hands before providing care (Source: Provider Information Request, P29 Staff Surveys and Patient Feedback, P29 IPU Relatives Survey 2018-2019).
- Effective measures were in place to ensure the health and safety of everyone who came into contact with a deceased person's body after death. Staff we spoke with were knowledgeable about these IPC measures and could describe how they washed and prepared the body after death.



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- The hospice had a designated lead for IPC who was available to provide support, advice, training and updates for staff. The IPC lead had produced a resource folder which contained information for staff on IPC related matters, such as national and local guidance, healthcare associated infections, hand hygiene and the correct use of PPE and cleaning materials.
- The hospice had up-to-date policies for IPC and related topics, such as aseptic non-touch technique (ANTT), care after death (Last Offices) and waste management. Staff could access these for guidance through the hospice's intranet. There was also detailed guidance regarding the cleaning requirements for the patient room when a patient with a suspected or known infection was discharged. Room cleaning records we reviewed showed patient rooms were cleaned in accordance with the level required following patient discharge.
- Staff were required to complete IPC training during their induction and then annually at the level appropriate to their role. As of September 2019, 95% of staff had completed IPC training.
- From August 2018 to September 2019, the hospice reported zero incidences of healthcare associated MRSA and C. difficile (a bacterium which infects the gut and causes acute diarrhoea).
- Patients could reach call bells and staff responded quickly when called. We observed call bells were answered promptly during the inspection.
- Staff carried out daily checks of emergency equipment. A defibrillator (used to treat a life-threatening abnormal heart beat) and grab bag were situated by the main reception desk. The IPU had emergency boxes containing essential equipment needed in the event of anaphylaxis (a life-threatening allergic reaction) and hypoglycaemia (low blood sugar level). Records showed these were checked daily. Glucometers (used to check a patient's blood sugar level) were checked weekly, in accordance with manufacturer's guidance.
- Effective processes were in place to ensure equipment was well maintained and fit for purpose. The hospice maintained a record of equipment and when it required servicing and safety testing. Most electrical equipment we reviewed had been serviced and safety tested when required. However, we did find two 'aroma steam' machines (used to diffuse essential oils into the air) which should have been safety tested in March and April 2019. Staff told us they would report any faulty equipment to on-site maintenance, who responded promptly. The hospice had enough syringe pumps. These were maintained and used in line with manufacturer's guidance. Staff maintained a record of all syringe drivers, so they could track where they were when a patient was discharged home with one, for example. Specialist equipment needed to provide care and treatment at home was identified following assessment of patient and family need and was available in a timely way.

## Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**
- The design, maintenance and use of facilities were suitable for their intended use. Risk assessments were in place where the environment posed a potential risk to patients and visitors. For example, according to the risk register a finial (decorative feature) had fallen from the roof. This had caused no injury, but the service had commissioned an external company to remove the remaining finials from the roof.
- On entering the hospice, there was a reception desk where day patients and visitors were required to sign in/out. Access to and from the inpatient unit was secured with an intercom/key pad to prevent access by unauthorised persons.
- We checked a sample of consumable items for expiration dates and all were in-date. Store rooms were tidy and well organised.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Sharps containers were clean, dated, not overfilled and were labelled with the hospice's details for traceability purposes. This was in line with national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for



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employers and employees (March 2013)). Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

- The hospice had appropriate facilities to safely store deceased patients. The mortuary could store up to two deceased patients while awaiting collection by funeral directors. Records showed the room was maintained at the correct temperature. The mortuary register was completed each time it was used. The register included details regarding the patient and details of any personal belongings with them, such as jewellery. Each entry was signed by two staff members.

## 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 and updated them when necessary and used recognised tools. We reviewed five patient records and saw comprehensive risk assessments were carried out. These included risk assessments for moving and handling, falls, nutrition and hydration and pressure ulcers. Recognised tools were used, such as the Braden scale and Waterlow (both used to identify patients at risk of pressure ulcers) and the malnutrition universal screening tool, commonly referred to as 'MUST'.
- Staff managed increased risks experienced by patients at the end of life. Patients at risk of falls were reviewed hourly, or more frequently if indicated. Bed rails were used where appropriate, following risk assessment, and beds were set to their lowest height with mats placed on the floor, to minimise the risk of any injury if a patient fell. Other equipment used to prevent falls included bed and chair fall prevention sensors. In February 2019, an audit of falls risk management showed overall compliance with best practice standards and local policy was 91%. The audit included actions taken to improve areas of non-compliance (Source: Additional Evidence Request, Falls Risk Management Audit 2019).

- Staff identified and assessed patients at high risk of pressure ulcers and those with existing pressure ulcers. We saw pressure ulcers were managed appropriately and in accordance with patient wishes. For example, wound dressings were applied, pressure relieving equipment was put in place and patients were offered regular repositioning. The service had named leads for falls prevention and pressure ulcers who were responsible for championing best practice and provided support, training and advice to staff as needed.
- Patient records we reviewed and observations we made during the inspection demonstrated that risk assessments, action planning and reviews were developed in collaboration with the patient and their family and supported patient choice. Patient care plans and risk assessments were reviewed weekly or if the patient condition changed.
- Shift changes and handovers included all necessary key information to keep patients safe when handing over care to others. Patients were discussed daily at the multidisciplinary handover. We observed all aspects of patient care were discussed and planned, including those with 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders in place, current patient risks and observations.
- An initial multidisciplinary assessment was carried out when patients were identified to be within the last days or hours of life. This included consideration of advance care planning, symptom management, nutrition and hydration, as well as spiritual and psychological needs. We saw end of life care plans were individualised and developed in accordance with patient wishes, following discussion with them and those close to them. Patients with end of life care plans were reviewed a minimum of two-hourly. Staff took into account symptom and comfort measurements, including pain, elimination, mouth care, secretions, agitation and pressure care.
- Staff completed intentional care rounding assessments. Intentional care rounding is a structured process where staff are required to perform regular checks of patients at set intervals. Checks carried out



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by staff included assessment of patient comfort, mobility, falls risk, skin condition and position. We saw these were completed in the five sets of patient records we reviewed.

- Staff could summon emergency assistance through 999 when indicated, such as if a visitor collapsed. Due to the nature of the service, most patients had DNACPR orders in place.
- Staff understood their roles in the event of a fire in the hospice. We saw fire safety equipment was available in all areas of the hospice, such as fire extinguishers. Fire doors were closed and free from obstruction.

## Staffing

- **Despite some staff vacancies, 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.**

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. Managers had calculated staffing establishment requirements using a professional judgement tool and national workforce modelling recommendations for hospices. We were told an establishment workforce planning tool designed for hospices was currently being considered by the corporate team, with the aim of introducing it across the Sue Ryder organisation. We observed the hospice had enough staff of an appropriate skill mix, to keep patients safe and provide effective care and treatment on the days of our inspection. No staffing shortages were seen on the rotas we reviewed. The inpatient unit was consistently staffed as if it were at full capacity, no matter how many patients there were. This meant enough staff were always available to ensure patients were admitted promptly. A senior nurse co-ordinated the inpatient unit activity for each shift. They were supernumerary, which enabled them to have oversight of the unit and support staff as needed.
- A consultant or speciality doctor was generally on-site Monday to Friday, 9am to 5pm. They were supported

by trainee GP and/or foundation doctors. Out of these hours, a speciality doctor and consultant in palliative medicine were on-call to provide advice and support as needed. First on-call provision was provided by the speciality doctor. They could refer to the consultant on-call when needed. The consultant on-call also covered other hospices and hospitals within the region.

- As of October 2019, the service reported 7.56 full-time equivalent (FTE) vacancies. A breakdown of vacancies by staff type is shown below:
  - Ward manager – 1 FTE
  - Clinical educator – 0.6 FTE
  - Consultant – 0.8 FTE
  - Speciality doctor – 0.64 FTE
  - Nurse (Band 6) inpatient unit – 0.52 FTE
  - Nurse (Band 6) palliative care hub – 2 FTE
  - Fundraising officer – 2 FTE
- Difficulties in recruiting to senior specialist roles was listed on the risk register. While the service was actively recruiting and had interviews scheduled, managers had acted to minimise the risk from staff vacancies. For example, an interim hospice director was in place to support the running of the service. They were an experienced director from another Sue Ryder hospice who was dividing their time between the two hospice sites. A staff member from the corporate service improvement team was also supporting the service on-site, three days per week. A senior nurse had expressed interest in the clinical educator post and was being supported to fulfil this role. Consultants had increased their clinical sessions to ensure the service was adequately covered.
- Managers used bank, agency and locum staff when needed to ensure staffing establishment was met, and/or to meet patient acuity, and requested staff familiar with the service. Managers told us that wherever possible bank staff would be used in preference to agency staff. Only agency staff experienced in palliative care were used.
- Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff



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completed the same five-day induction and mandatory training programme as substantive staff. Agency staff worked at least one supernumerary shift with an experienced nurse before they commenced duties.

- Nursing handovers took place at the change of each shift, as well as a daily multidisciplinary ward round. We observed the ward round which was well structured and detailed and included a discussion of each patient, with care planned according to patient needs and wishes.
- Student nurses were supernumerary and not included in the nurse-staffing establishment. Every student was assigned a nurse to work with and supervise them on shift.

## Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Patient notes were comprehensive, and all staff could access them easily. The service used an electronic patient record system, with templates designed specifically for the hospice. These included a range of risk assessments as well as individualised care plans. Some paper records were also used, such as intentional rounding forms and assessment of symptoms and comfort measurements for patients with end of life care plans. We reviewed five sets of patient records and found them to be comprehensive and contemporaneous. They contained details of patients emotional, social and spiritual needs, alongside their physical health needs. Patients mental health, dementia, learning disability and behavioural needs were evident, where appropriate. Patient records also reflected their protected characteristics, where relevant.
- Patient records included advanced care plans and DNACPR documentation, where appropriate. The DNACPR forms we reviewed were completed in line with national guidance (Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, Decisions relating to cardiopulmonary resuscitation: 3rd edition (2016)).

They included whether the patient had capacity to make a decision about cardiopulmonary resuscitation and a summary of communications with the patient and family.

- Managers audited the standard of patient records against best practice and identified areas for improvement, where indicated. The documentation audit completed in February 2019 showed overall compliance with best practice standards was 54%. This was significantly below the service target of 90%. Areas of non-compliance included evidence of the staff member's printed name, explanation of abbreviations, preferred place of care recorded, and clear evidence of all required care delivered. We saw evidence that action was taken to improve the standard of records. The registered manager sent an email to all staff with the audit results and improvement action plan. The areas of concern were highlighted and relevant information regarding record keeping standards was included. Monthly documentation audits were instigated until an improvement was seen (Source: Provider Information Request, P24 Local Audits, Documentation Audit). The documentation audit completed in April 2019 showed compliance had improved to 97% (Source: Provider Information Request, P24 Documentation Audit Palliative).
- Staff could share details of hospice care with other professionals and agencies. The electronic patient record system was the same as that used by local GPs, district nurses and Macmillan cancer support nurses. This meant staff had immediate access to up-to-date patient information. However, staff told us obtaining patients' test results was frustrating because they could not access these electronically. Instead, staff had to telephone for test results.
- Staff who cared for patients in the community had laptops. This meant they could up-date patient records at each visit.
- Records were generally stored securely. Staff used key cards to access the electronic patient record system. These were password protected. We did observe a key card left unattended in a computer terminal. We raised this with the nurse-in-charge who dealt with our concern immediately. The computer was locked, which meant the patient record system could not be



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accessed without the staff member's password. Therefore, the risk of unauthorised persons accessing patient records was minimal. Paper records were stored securely in the nurses office. Consent to storing and sharing patient information was obtained.

## 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. As of July 2019, the hospice commissioned pharmaceutical products and clinical pharmacy services from an external provider through a service level agreement. A pharmacist visited the hospice weekly to monitor stock, storage and review patient prescription records. They produced a weekly report which highlighted any prescribing errors. A medicines audit file was maintained daily and included a record of storage temperatures, short-dated stock, disposal of unwanted medicines and safety warnings. Medicine stocks were checked and ordered by the nursing staff as required. Staff could access out of hours pharmacy support from a local NHS hospital when needed.
- 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 for use. Controlled drugs (medicines subject to additional security measures) were stored securely within wall mounted cupboards. Two members of staff were required to check the physical stock against the stock level recorded in the controlled drugs register daily. A weekly check was also completed. We reviewed the controlled drug register and saw stock was reconciled daily and weekly. Controlled drugs brought in by patients were stored securely and there were adequate controls in place to prevent misuse. Patients' own controlled drugs were recorded in a separate controlled drug register on admission and were reconciled daily and every time they were administered. Medicines that needed to be kept below a certain temperature to maintain their efficacy were stored in a locked fridge. The treatment room where medicines were stored was air-conditioned. This meant the temperature was maintained within the

recommended range (below 25°C). We saw storage temperatures were checked daily to ensure medicines were effective and safe for patient use. Temperatures recorded for all days seen were within the recommended range. Staff we spoke with knew what action to take if temperatures were out of the recommended range. Blank prescription pads (FP10 prescriptions) were stored securely and monitoring systems were in place to ensure all prescriptions were accounted for. The audit record detailed each prescription issued and included the name of the doctor who issued the prescription, the date it was issued, the patient name and prescription number. This was in line with national guidance (Department of Health, Security of prescription form guidance (August 2013)).

- We reviewed two patient prescription records and found they were signed, dated, timed and legible. Patient allergies were documented, and medicines were given as prescribed. We saw patient medicines were regularly reviewed, including the use of 'as needed' medicines.
- Discharge medicines were ordered and received in a timely way and qualified staff advised patients and/or those close to them on their safe use. Patients being cared for at home administered their own medicines. Anticipatory medicines and controlled drugs for pain relief were managed by the district nurse service. Palliative care hub staff could arrange a district nurse review if the patient was struggling to manage their pain and/or symptoms effectively.
- Medical staff had access to electronic GP records to ensure patients' medicines were prescribed and continued following admission, where appropriate.
- Some medicines were administered continuously through a patch or intravenous infusion (medicines administered directly into a vein). Nursing staff checked these regularly to ensure patches were in place, syringe drivers were correctly set and working, and intravenous lines were patent.
- Medicines were disposed of safely and records of destruction were maintained. Unwanted or expired medicines were kept secure and separate from other medicines and were disposed of correctly.



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- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff knew how to report medicine errors or incidents and we saw these were investigated and learning was shared with all relevant staff. Managers audited medicines management against best practice and identified areas for improvement, where indicated. According to the integrated quality and performance report for August 2019, the most recent audit showed compliance was 99%. In March 2019, the registered manager completed the Care Quality Commission (CQC) controlled drugs governance self-assessment tool. The results showed the service was compliant with most assurance indicators. The two areas identified for improvement concerned standard operating procedures being in place for dealing with a significant event involving controlled drugs and to formally escalate controlled drug concerns (Source: Provider Information Request, P24 Local Audits, AO Annual Audit (CQC Controlled Drugs Governance Secondary Care) March 2019). We saw the current management of medicines policy had been revised in May 2019 and included what to do if a serious discrepancy in controlled drug stock levels was identified and responsibilities of the accountable officer for controlled drugs (Source: Additional Evidence Request, Management of Medicines Policy and Procedure, Version 12 (May 2019)).
- The service had a named lead for medicines management who was responsible for championing best practice. They attended meetings with other medicine leads within the Sue Ryder organisation to share learning from incidents, audits and safety alerts, for example. They then shared this with appropriate staff at the hospice. They were also available to provide staff with additional support, training and advice as needed.
- Nursing staff were required to undertake annual medicines management e-learning training and practical competency assessment, including drug calculations. As of September 2019, the completion rate for eligible staff was 92%.
- Controlled drugs were frequently used to manage patients pain. The hospice permitted single nurse

administered controlled drugs (SNAD) to ensure patients received them promptly when needed. Staff undertook a bi-annual SNAD competency assessment, which 100% of eligible staff had completed.

## Incidents

- **The service managed patient safety incidents well. Staff recognised and reported most incidents and near misses appropriately. Managers investigated incidents and shared lessons learned with the whole team and wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- Staff knew what incidents to report, how to report them and reported all incidents they should report. The hospice used an electronic reporting system for reporting incidents. All grades of staff could access the incident reporting system and those who worked remotely could access the system through their laptops. Staff we spoke with said they were encouraged to report incidents and felt confident to do so.
- Staff received feedback from investigation of incidents, both internal and external to the service. Staff could indicate if they wanted feedback from incidents they had reported from the electronic reporting system. Feedback from incidents was shared with staff in a variety of ways such as team meetings, email, newsletters and staff noticeboards. Staff told us they felt well informed about incidents. Incidents were a standing agenda item at monthly governance meetings. There was evidence that changes had been made as a result of incident investigations.
- Managers debriefed and supported staff after any serious incident. While the service had not had any serious incidents occur since at least May 2018, staff confirmed managers supported them when they were involved in incidents.
- Managers investigated incidents thoroughly. Incidents reported were reviewed daily and where necessary



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investigations were initiated to identify any actions needed to address the incident and minimise recurrence. Incidents reported were also reviewed by the corporate quality team.

- Managers ensured actions from patient safety alerts were acted upon, where indicated, and were shared with staff. Managers we spoke with were able to provide examples of patient safety alerts they had acted on. The registered manager maintained a record of all Central Alerting System (CAS) alerts received and action taken, where needed. There were no CAS alerts awaiting review and/or action at the time of our inspection.
- From May 2018 to May 2019, the hospice reported no serious incidents or never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. For the same reporting period, the hospice had no serious incidents
- Clinical 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 hospice had a duty of candour policy which staff could access through the trust intranet. The duty of candour is 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. From May 2018 to May 2019, the hospice did not report any incidents which required the duty of candour to be instigated.

## Safety Thermometer (or equivalent)

- Staff monitored safety performance to indicate how safe the service was in providing harm free care. The prevalence of patient harm because of falls, pressure ulcers and healthcare associated infections was monitored and reported monthly. From September 2018 to August 2019, the service reported 10 hospice acquired pressure ulcers, 23 falls and zero healthcare associated infections (MRSA and C. Diff).

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

Good



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

## Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This was evident from our observations of care, review of patient records and hospice guidelines, and discussions with staff. For example, the hospice had a spiritual care and chaplaincy service to ensure people's emotional, spiritual and social needs were identified, assessed and met. Bereavement, emotional and spiritual support was offered to all patients, families and carers which was appropriate to individual needs and preferences. This was in line with national guidance (National Institute for Health and Care Excellence (NICE), end of life care for adults: Quality Standard [QS13], quality statements 6, 7 and 14 (March 2017)).
- Care of patients in the last days and hours of life was delivered in accordance with the five priorities for care of the dying person. We found all five priorities (recognition of dying, sensitive and effective communication, involvement in decisions, support needs being met and individualised care plans) were met. For example, we saw end of life care plans were developed following multidisciplinary review and



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sensitive discussions with the patient and their family or carers. They included evidence of communication with the patient and family, details of discussions with the family support team and spiritual care coordinator, advance care planning, symptom management, continence, nutrition and hydration, and spiritual and psychological support needs. Care plans were individualised, up-to-date and reflected the needs and wishes of patients and those close to them. This was in line with national guidance (Leadership Alliance for the Care of Dying People, One Chance To Get It Right: Improving people's experience of care in the last few days and hours of life (June 2014)) and (NICE, Care of dying adults in the last days of life: [QS144] (March 2017)).

- We saw patients had a recommended summary plan for emergency care and treatment (ReSPECT), where appropriate. These were created through conversations between the patient and their health professionals. The ReSPECT forms we saw included agreed clinical recommendations for the patients' care and treatment in a future emergency, such as whether cardiopulmonary resuscitation should be attempted. This was in line with national recommendations (Resuscitation Council (UK)).
- Policies seen were up-to-date and referenced national guidance and evidence-based practice. Staff could easily access policies, guidelines and pathways through the hospice's intranet, which they demonstrated during the inspection. Staff were informed of updated guidance through a variety of means, such as team meetings, newsletters and emails. We observed staff discussing new guidance regarding when to refer to the coroner during handover.
- Staff routinely referred to the psychological, emotional and spiritual needs of patients, their relatives and carers, at handover meetings. We observed this during the inspection.

## Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.**

- Staff made sure patients had support with nutrition and hydration to meet their needs and wishes. The catering department prepared freshly made meals on-site. Hot and cold food options were available for each meal, including breakfast. The service catered for all types of needs including vegetarian, soft, dairy and gluten free. On admission, the chef spoke with each patient to discuss any special dietary requirements they had, as well as their food preferences.
- Catering staff visited patients daily with the menu options and to take their meal orders. If patients wanted anything different from the menu, staff would endeavour to make whatever they wanted. One patient told us, "The food was as good as that at Buckingham Palace". From May 2018 to April 2019, results from the relatives survey showed 71% of relatives felt the food and menu choice was always a good standard. A further 13% felt it was usually a good standard and 11% felt they did not know (Source: Provider Information Request, P29 Staff surveys and patient feedback; Palliative – Relatives Experience May 2018 to April 2019).
- Families and carers were welcome to order hot and cold food from the menu at a small charge. Food and drinks were available outside of mealtimes. The inpatient unit had a kitchen where patients and those close to them could help themselves to hot and cold drinks, as well as snacks such as cereals and toast. Families and carers could also bring in their own food or order takeaways to be delivered to the hospice if they wished.
- Staff used a nationally recognised screening tool to assess and monitor patients' nutritional needs. Patients' nutritional needs were assessed on admission using the malnutrition universal screening tool (MUST). This was reviewed weekly or when there was any change in the patients' condition. The GULP assessment tool was used to assess patient risk of dehydration. We observed patients' nutritional and hydration needs were discussed daily at handover and the multidisciplinary ward round. The documentation audit completed in April 2019 showed compliance with nutrition and hydration quality indicators was 100% (Source: Provider Information Request, P24 Documentation Audit Palliative).



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- We saw palliative care hub staff provided support and advice to families of patients nearing the end of life with limited or no oral intake, this included oral health. They undertook daily oral care assessments to ensure patient comfort.
- Specialist support from staff, such as dietitians, was available for patients who needed it. This was provided by the local NHS trust. Staff told us they could refer patients to the dietetic service for assessment when required.
- Catering staff did all they could to support patient choice and fulfilled catering requests for special events and celebrations, such as birthdays and weddings. They frequently made cakes, which we observed patients and visitors enjoy during the inspection. The hospice had a selection of alcoholic beverages for patients if they wished.
- Glucose preparations were available for patients with diabetes, when needed. These enable a person to increase their blood glucose level rapidly when needed.

## 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' using recognised tools and gave pain relief in line with individual needs and best practice. We saw patients' pain levels were regularly assessed using a numerical pain scale. Other recognised tools were used to help identify distress cues in patients who because of cognitive impairment, or physical illness, had limited communication. Staff also regularly assessed patients ability to tolerate oral medicines and alternative administration routes would be prescribed when indicated, such as intravenous infusion or pain relief patches.
- Patient records we reviewed showed care plans included an appropriate pain assessment and management plan. Anticipatory medicines with individualised indications for use, dosage and route of administration were prescribed for patients identified as being in the last days of life. These included

medicines for pain, agitation, respiratory tract secretions, nausea/vomiting and dyspnoea (difficult or laboured breathing). This was in line with national guidance (NICE, Care of dying adults in the last days of life: [QS144], quality statement 3 (March 2017)).

Prescribing medicines in anticipation can prevent a lapse in symptom control, which could cause distress for the person who is dying and those close to them.

- Patients received pain relief soon after requesting it. The hospice permitted single nurse administered controlled drugs to ensure patients received pain relief promptly when needed. Patients' we spoke with told us they were regularly offered pain relief and were given it promptly when they needed it. From May 2018 to April 2019, results from the relatives survey showed 82% of relatives felt their relative was always comfortable and their symptoms were well controlled. A further 13% felt their relative was usually comfortable (Source: Provider Information Request, P29 Staff surveys and patient feedback; Palliative – Relatives Experience May 2018 to April 2019).
- Patients being cared for at home had their pain managed by GPs, district nurses and specialist nurses. Palliative care hub staff monitored patients' comfort levels during their visits and would escalate to the district nurse service for review 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.**
- There was a clear approach to monitoring, auditing and benchmarking the quality of the services and outcomes for patients receiving care and treatment. The hospice used patient and relatives feedback tools to measure patient outcomes. Quality and outcome information showed the needs of patients were mostly being met. Feedback was sought on a range of quality indicators and the findings were used to make improvements where indicated. For example, from April to June 2019, feedback from the relatives survey showed 91% felt their relative was referred to the hospice service at the right time for them, while 9% felt it was not soon enough. Similarly, when asked if the patient felt staff made an effort to meet their



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individual needs and priorities, 91% responded “yes, completely” and 9% responded “yes, to some extent”. From May 2018 to April 2019, 100% of patients using the day therapy service felt the hospice team made an effort to meet their individual needs and priorities.

- The service had introduced tools to improve patient outcome measurement. We observed Outcome Assessment and Complexity Collaborative (OACC) scores were discussed at the multidisciplinary handover and ward round. The OACC is a suite of measures used to assess the care that matters most to people and their families at the end of life, such as control of their pain, breathlessness and fatigue, the opportunity to discuss worries, or to achieve one more personal goal before they die. This information was used by the multidisciplinary team to plan care, treatment and support, to best meet the needs of each individual patient. Staff also used the Integrated Palliative care Outcome Scale (IPOS) to capture patients most important concerns, both in relation to physical symptoms, but also extending to information needs, practical concerns, anxiety or low mood, family and friends anxieties and overall feeling of being at peace. The patient records we reviewed and conversations we had with staff demonstrated they understood outcomes for individuals and responded to individual need. We were told the hospice was introducing the HOPE tool for the assessment of patients spiritual needs. The HOPE questions provide a formal tool to assess a patient’s spiritual needs: H – sources of hope, strength, comfort, meaning, peace, love and connection; O – the role of organised religion for the patient; P – personal spirituality and practices; E – effect on medical care and end of life decisions.
- The service participated in quality improvement initiatives, such as the Sue Ryder clinical audit programme. The programme included audits of documentation, medicines management, Mental Capacity Act compliance, manual handling, infection control, falls risk management and medical equipment. There was evidence of action taken in response to any areas of concern identified. Managers shared and made sure staff understood information from the audits. For example, in response to the

results of the documentation audit carried out in February 2019, the head of clinical services emailed all relevant staff with the audit results and improvement action plan.

## 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. We reviewed 10 staff files and found they contained relevant information to demonstrate staff suitability and competence for their roles, such as up-to-date Disclosure and Barring Service (DBS) check, references, full employment history, evidence of qualifications and professional registration, where applicable. Managers checked qualified staff had professional registration and we saw 100% of eligible staff had completed revalidation with their professional body. Clinical staff were required to complete training and competency workbooks to ensure they had the appropriate skills and knowledge to manage patients safely and effectively. The competency workbooks had been designed in line with national guidance and best practice. The competency workbook for community nursing assistants included assessment of their communication skills, catheter care, oral care, pressure care, and moving and handling, for example. Registered nurses underwent annual medicines management e-learning training and practical competency assessment, including drug calculations.
- Managers gave all new staff a full induction tailored to their role before they started work. This included bank staff and volunteers. All staff underwent the Sue Ryder five-day induction programme, which included mandatory and role specific training. Staff told us they had received a good induction. Nurses and nursing assistants worked in a supernumerary capacity alongside an experienced staff member until they were competent to work alone.
- Managers supported staff to develop through regular development meetings and yearly, constructive appraisals of their work. As of April 2019, 99% of staff



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had completed an annual appraisal (Source: Provider Information Request, Staff Registration tab). At the beginning of each appraisal year, managers met with staff to agree their performance and development objectives for the coming year. These were linked to the service's strategic objectives and priorities and the Sue Ryder behavioural standards. Staff had regular one-to-one meetings with their manager to monitor their performance. They had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. For example, two staff members had recently commenced a palliative care course. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported to improve their practice where indicated. Staff received regular clinical supervision. This was provided on a one-to-one or group basis. Ad hoc supervision sessions were arranged to support staff following any significant events or incidents.

- Trainee doctors had a clinical supervisor who they worked with regularly during their placement. Medical staff we spoke with told us they felt well supported from senior medical staff and could approach them for advice at any time.
- According to the service's risk register, the clinical educator and practice educator posts were vacant and had been difficult to recruit to. We were told a senior nurse had expressed interest in the clinical educator post and was being supported to fulfil this role.
- Volunteers were used by the service and were trained and supported for the roles they undertook. They were provided with training, such as the trust's mandatory training programme.
- The service's resuscitation policy detailed staff resuscitation training requirements. Annual basic life support training was mandatory for all clinical staff.

## Multidisciplinary working

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

- Staff held regular and effective multidisciplinary meetings to plan and deliver holistic patient care. All necessary staff were involved in assessing, planning and delivering patient care and treatment. We observed the multidisciplinary handover and ward round. This was attended by the medical team, nursing staff, bereavement coordinator, spiritual care coordinator, physiotherapist and palliative social worker. Each patient was discussed in detail, with care and treatment planned in accordance with their physical, psychological, emotional, spiritual and social needs, as well as their wishes.
- There was a clear process for the transfer of care from hospital to hospice, and from the hospice to home or other place of care.
- Staff participated in relevant external meetings and shared information appropriately. Managers attended Gold Standard Framework (GSF) meetings with local GPs where they discussed each patient on the end of life register and how they could best support them. The GSF is a framework which promotes best-practice in end of life care. It is used by many GPs, hospices and hospitals to enable earlier recognition of patients with life-limiting conditions, helping them to plan ahead to live as well as possible. Managers also attended weekly multidisciplinary meetings at the local NHS hospital to identify what the service could do to help, and support patients identified for palliative and/or end of life care.
- Throughout our inspection, we observed positive interactions between all staff and volunteers. Staff we spoke with confirmed there was effective multidisciplinary team working. They told us they worked together to provide the best care and support they could for patients and their families or carers.
- Staff worked with colleagues in other services to deliver effective care, treatment and support. For example, the lead nurse for pressure ulcers met regularly with district nurses to share best practice. The palliative social worker liaised with local authorities and schools to ensure children and young people facing the loss of a parent received appropriate support, when needed.



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- Staff supported colleagues working in end of life care in other services in their community. For example, medical staff held regular study days for GPs to promote best practice in end of life care.

## 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. Family, friends and carers were welcome to visit their loved one any time of the day or night.
- A consultant or specialty doctor led a daily ward round, Monday to Friday. Staff were able to contact the doctor and consultant on-call for advice and support, 24 hours a day, seven days a week.
- The palliative care hub team were available to provide support and advice over the phone 24 hours a day, seven days a week. The fast track service provided up to three visits at home per day from 7am to 9.30pm. A member of staff was also available each night to provide one patient and their carer with a night sit service from 9pm to 7am.

## Health promotion

- **Staff gave patients practical support to help them live well until they died.**
- Staff assessed each patient's health when admitted and provided support to help them live well until they died. The patient records we reviewed and observations we made confirmed this. Emotional, spiritual, psychological and practical support was routinely provided.
- The day therapy service provided a nine-week rolling programme aimed at empowering patients to live well by supporting them to manage their condition, maintain independence and make new friendships. The programme was provided by a multidisciplinary team, including a physiotherapist, occupational therapist, palliative social worker, spiritual care coordinator, complementary therapist and trained volunteers. Therapy programmes were tailored to individual needs and goals. A variety of methods were used to help patients, such as mindfulness and

relaxation techniques, exercise sessions, complementary therapies, such as massage, reflexology and reiki, and techniques to deal with breathlessness and fatigue.

- The service had relevant information to help patients live well until they died, and to help families and carers cope following the death of their loved one. This included financial and practical advice. Staff signposted patients and those close to them to other support agencies and community services, such as local psychological wellbeing services and carers organisations. Families and carers were offered bereavement counselling after a loved one had died.

## 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.**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and they knew who to contact for advice. The service had up-to-date policies regarding consent and the MCA 2005 which staff could easily access through the hospice intranet. Staff understood their roles and responsibilities regarding consent and the MCA. They understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions and following discussion with their family or carers. In April 2019, 100% of records audited showed key information regarding mental capacity had been completed. We saw DNACPR decisions were made appropriately and in line with national guidance.
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. The patient records we reviewed confirmed this. We also observed staff gaining verbal consent from patients' before they undertook interventions, such as personal care. In April 2019, 100% of records audited showed appropriate consent to treatment was obtained and recorded.



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- Eligible staff completed training on the MCA and DoLS. As of September 2019, 95% of staff had completed MCA and DoLS training, which exceeded the hospice target of 90%.

## Are hospice services for adults caring?

Outstanding



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

### Compassionate care

- **Staff treated patients and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond expectations to meet their individual needs and wishes. Patients and their families were truly respected and valued as individuals by an exceptional service.**
- Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interact and treat patients and their families in a friendly, warm, caring and compassionate manner. It was evident staff built strong and trusted relationships with patients and those close to them. There was a strong, visible patient-centred culture. Staff were highly motivated and inspired to provide care that was compassionate, kind and promoted dignity. One staff member told us, “The patient always comes first, that’s what I’m here for.” This sentiment was echoed by all staff we spoke with.
- Feedback from patients, those close to them and stakeholders was overwhelmingly positive about the way staff treated people. They thought staff were “outstanding” and often went above and beyond what was expected when providing care and support. One patient told us, “Can’t fault the nurses, when you ring they’re here, they’re brilliant”. Another patient told us, “I’m more than happy with the service. We would be in great difficulty without it. They give a first-class service”. We read many thank you messages from patients and relatives who frequently likened staff to “angels”, and many that spoke of the compassion, care and support staff gave them when they needed it most. For example, one relative wrote, “Thanks for the exemplary care that my mother received. The care not only for Mum but for us as a family was exceptional, a real example of how end of life treatment should be. Particular mention to all the carers, the time they took with Mum each day to make sure she was comfortable was outstanding...” Another wrote, “There are not the words to say how grateful we are for the care you gave. Every person we met worked tirelessly to ensure that she was calm and comfortable in her last days and hours. You treated her with such dignity, respect and love and we absolutely know without a doubt that it was the best possible place and care she could have experienced.” A prison officer who had been attending the hospice with patients for several years wrote, “. . . I wanted to let you know how much I think of your staff. Nothing is too much trouble for them. They all have a wonderful manner with the patients, and all take the time to talk to them and let them know what they are doing, even for those who do not know where or why they are there... They are wonderful with the visiting relatives and again do all they can to help. I realise that due to the nature of [the hospice] one would expect all this, but to be there and see it in action really makes me feel all the staff, from the cleaners, cooks and nursing staff, should be aware of what I and many other officers who attend there think...”
- Staff ensured that care after death included honouring the spiritual and cultural wishes of the deceased person and those close to them. Family members and carers were asked if they wished to assist with the personal care of the body after death, such as bathing and dressing.
- Staff made sure patient’s privacy and dignity needs were understood and always respected. ‘Please do not enter’ signs were used when patients and those close to them did not want to be disturbed. We observed these were respected by staff. Staff spoke with compassion and sensitivity when they described care for patients’ who had died, and how they ensured the privacy and dignity of the deceased person was maintained. We observed access to parts of the hospice was restricted when the deceased person was transferred from the inpatient unit to the mortuary. Patients we spoke with told us their privacy and dignity were always respected and protected. Feedback we read also confirmed this. For example, one relative wrote, “Our greatest thanks for the



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excellent care that you gave to...and for allowing him to die in comfort and peace and with dignity..."

Another wrote, "Mum has been treated with the utmost respect and dignity..." From May 2018 to April 2019, feedback from the relatives survey showed 96% of respondents felt their relative was always treated with respect and dignity by staff, and 4% felt they usually were (Source: Provider Information Request, P29 Staff Surveys and Patient Feedback, P29 Palliative – Relatives Experience May 2018 to April 2019).

- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patient records we reviewed and observations we made demonstrated the totality of people's needs were recognised and respected, including spiritual, religious and cultural needs. The hospice had a spiritual care coordinator who provided a listening presence, companionship and one-to-one pastoral support for patients and those close to them, irrespective of their beliefs. They spent time getting to know patients and what was important to them, their interests and what lifted their spirits, be that connected to a particular faith, or things like family, sport or music.
- Staff consistently endeavoured to provide compassionate care tailored to patients' individual needs and wishes, particularly for those approaching the end of life. Staff wanted to make end of life care as good as it could be for the patient and their family or carers and went above and beyond to achieve this. For example, one patient told staff they wanted to see their classic car one last time and so staff arranged for the car to be brought to the hospice, so the patient could see it from their window. Another patient wanted to see their horse again and so staff arranged for their horse to be brought to the hospice. Another asked if they could have a beach party in their room for their children and so staff decorated the room with beach bunting and a sandpit with bucket and spades, so they could have a fun family beach party. When hearing of a patient's love of a well-known singer, a staff member arranged a personal video message to be sent to the patient by the singer. The hospice had facilitated many weddings and blessings for patients and those close to them, often at very short notice. Staff did not just facilitate special events for patients, they also did all they could to make them feel special,

such as hair, make-up and dress. Staff had created a 'selfie box' with props for patients and families to use to help them create fun, lasting memories captured in a photograph. We also observed that families and carers often revisited the hospice after the death of their loved one, with some still visiting 10 years or more later. Many of the volunteers at the hospice had been family members of patients who had been cared for at the hospice. This was testament to how warmly people felt about the hospice, that they wanted to return to the place where their loved one had died.

- Patient requests and wishes were always acted on by staff to make them feel at home, wherever possible. Patients were encouraged to bring personal belongings with them to make them feel at home, such as photographs and bedding.
- Staff displayed an understanding and non-judgmental attitude when caring for, or talking about, patients with mental health needs and those from marginalised groups, such as prisoners.

## Emotional support

- **Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. People's emotional and social needs were seen as being as important as their physical needs.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and those close to them, and consistently took account of this when providing care and treatment. We observed staff members spending time talking and joking with patients and those close to them, to help alleviate distress and sadness. Feedback from relatives often mentioned how staff had helped them cope with the death of a loved one. For example, one relative said, "...you were the shining light in the darkness for us all." Another wrote, "[Staff] have cared for my [...] in the last couple of weeks with dignity, care and kindness... You are all angels, dedicated to help others. On entering [the hospice] one feels a burden lifted as everything possible is done to ease the stress and all the staff are wonderful. When your world is falling apart they pick you up and



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nothing is too much trouble for them. They do it with compassion, smiles and yes, laughter! We thank every single one of you..." Another relative wrote, "Thank you for being alongside us at the most difficult time of our lives... Just being able to come and talk and cry and be listened to in a safe place was a very welcome retreat from the outside world."

- Bereavement support workers and trained counsellors were available to help families and friends emotionally in coming to terms with a life-limiting diagnosis or the loss of a loved one. Bereavement support included one-to-one counselling, informal drop in sessions and bereavement groups. One family member wrote, "My [relative] had grief counselling for some months with you and I can honestly say it helped [them] tremendously."
- The hospice worked with voluntary agencies to support families. For example, in partnership with Carers in Bedfordshire, the hospice had established a monthly drop-in group for carers, the person they care for and former carers of all ages and circumstances. 'Carers' Thursday' aimed to give carers a 'listening ear' and the chance to chat with others in a similar situation. It was started to make sure local carers had the support they needed to help them cope with the demands of caring for a family member or friend. The monthly sessions gave attendees the opportunity to share their experiences over a cup of tea and a homemade cake, as well as participating in a range of activities and talks from guest speakers. The hospice also had Pets as Therapy dogs who visited the hospice regularly to bring joy and comfort to patients and those close to them. We observed the delight "Mabel" brought to patients, relatives and staff during the inspection.
- Staff ensured patients who did not have family, friends or carers were cared for and supported, particularly when approaching the end of life. For example, volunteers would sit and chat with patients and staff would wash the clothes of any patient who had no family, friends or carers to do this for them.

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

- **Staff supported and involved patients, families and carers to understand their condition and ensure they were active partners in their care and treatment. Staff helped patients live every day to the fullest.**
- Staff made sure patients and those close to them understood their care and treatment and supported patients to make advanced decisions about their care, where possible. Patients we spoke with felt they had received the information they needed to understand their condition and make informed decisions about their care which met their emotional, cultural, spiritual and personal needs, as well as their physical health needs.
- It was evident staff did all they could to support patients' and those close to them through the most difficult times of their lives and helped them live the best life they possibly could. When asked about their job, one member of the palliative care hub team had said, "Every day is important and that's what we do; we try to make sure patients live every day to the fullest." Feedback showed how much the care and support of staff had meant to patients and how much it had benefitted them. For example, one patient wrote, "The carers and nurses have treated me with so much care and kindness that they have changed me from someone in so much despair that I wanted to go to sleep and not wake up, to someone who could smile and live again...". Another patient wrote, "I would like to thank you from the bottom of my heart for the loving care you gave me, that brought me back from the death of despair, to wanting to live my life to the full again, without you that wouldn't have been possible...".
- Patients' whose preferred place of death was home, were referred to the palliative care hub team for daily support and symptom control where possible. We read many thank you messages from family members expressing their gratitude to staff for the care and support they had provided. For example, one relative wrote, "With the help of the palliative team my husband's wishes were granted to die at home, looking at his garden, surrounded by his family."
- Staff talked with patients, families and carers in a way they could understand. Patients and relatives we spoke with told us they never felt rushed when they



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were speaking to doctors and nurses and were encouraged to ask questions if they were unsure about any information given. Feedback from patients and families we read confirmed this. From May 2018 to April 2019, feedback from the relatives survey showed 91% of respondents felt their questions were always answered in a way they could understand and 7% felt they usually were (Source: Provider Information Request, P29 Staff Surveys and Patient Feedback, P29 Palliative – Relatives Experience May 2018 to April 2019). Staff supported patients with delivering bad news to their loved ones and gave us examples of when they had done so. For example, one staff member described how they had supported a father who was struggling to tell his children he was dying. Staff helped prepare the father for this difficult conversation by advising him on appropriate language to use. They also devised codewords which the father could use if he needed staff to step in and help him at any point.

- Patients and their families were encouraged to give feedback on the service and their care and staff supported them to do this. Staff recognised how important the time patients had left was and sought to gain and act on feedback promptly. Inpatient unit staff used tablets to obtain patient feedback, which was reviewed daily. This meant they could take immediate action to address any concerns when indicated. During the inspection, when asked if anything could be improved, a patient said they would like their bed closer to the window. On reading this, staff repositioned the bed where the patient wanted it. Feedback from patients and those close to them was continually positive about the service. From January to June 2019, 98% of people who used the fast track palliative care hub service were extremely likely/likely to recommend the service to friends or family.
- Patients were supported to keep in touch with their friends and family. Staff welcomed relatives, friends and pets, and recognised the emotional support and comfort they provided. The hospice had an open visiting policy, so family and friends could spend precious time with their loved one whenever they wished. Beds were available to enable loved ones uninterrupted time together. Pets were also allowed to stay with patients.

- Staff ensured patients and those close to them could access the information they needed, including from other services.

## 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

- **Services were delivered in a way to ensure flexibility, choice and continuity of care. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.**
- The services provided reflected the needs of the population served and promoted flexibility, choice and continuity of care. The hospice provided inpatient and 'at home' palliative and end of life care services. This meant patients could choose their preferred place of care and death, where possible. The hospice also had day therapy services for patients living with long term conditions. This provided some treatments which patients would otherwise have to access at the local hospital. For example, there was a lymphoedema clinic for patients with secondary lymphoedema because of cancer or cancer related treatment. Lymphoedema is a long term (chronic) condition that causes swelling in the body's tissues. It can affect any part of the body but usually develops in the arms or legs. The clinic was also available to patients with chronic oedema secondary to limb dependency and/or immobility in patients with advanced progressive diseases, such as multiple sclerosis or motor neurone disease. Patients were seen by a specialist nurse. The aim of the clinic was to help patients maintain their independence by showing patients how to take care of their swelling and prevent infection. The day therapy unit also offered a nine-week rolling programme that gave patients, families and carers the necessary



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education, skills and advice to manage symptoms and promote wellbeing. This included exercise sessions and techniques to deal with breathlessness and fatigue. Complementary therapies were also offered, such as reiki, massage and reflexology.

- The hospice worked collaboratively with others in the wider system and local stakeholders to design and plan palliative and end of life care services. The palliative care hub (PCH) involved organisations across Bedfordshire working together to ensure people at the end of life received the care they needed to enable them to remain in their own homes, such as district nurses, GPs and specialist Macmillan nurses. It offered short term nursing care, personal care and emotional support for individuals with a life-limiting condition and their families. Services provided by the PCH included a fast track service. This was designed to enable patients who were deemed to be in the last few weeks or days of life, to remain at home in their preferred place of death. The service provided up to three visits per day by palliative care nursing assistants. They supported patients with repositioning and personal, continence and mouth care, as well as providing emotional support and advice. A night sitting service was available for patients who needed support between 9pm and 7am to enable them to remain in their own homes. At the time of inspection, the hospice was commissioned to provide one night sit per night across the whole of Bedfordshire. This meant only one patient and their carer had the night sit service each night. Managers had identified current service capacity was not enough to meet increasing demand for the night sitting service and had raised this with the commissioners. We were told they were hoping this provision would be increased to meet patient demand. The PCH also offered a crisis visiting service. This was designed to prevent hospital admission and to keep a patient at home until appropriate support in the community could be provided. Feedback from partner organisations was positive and confirmed services were planned collaboratively to ensure the needs of the local community were met.
- The hospice had identified where people's needs and choices were not being met and used this to improve and develop services. Since our last inspection, the hospice had established a monthly drop-in service for

carers, the person they cared for and former carers of all ages and circumstances, known as 'Carers Thursday'. This service was set up in partnership with a local organisation, Carers in Bedfordshire. The group was set up for two reasons; to offer support to carers, which the hospice did not previously have any structure in place for doing so, and to introduce people to St John's should they require the service in the future. As well as providing practical advice and bereavement support, the service provided an informal, friendly forum where people could meet others in similar circumstances and participate in fun and relaxing activities. We saw staff sought feedback from attendees of the group and used their feedback to improve the service, such as activities and guest speakers. Feedback about the service was positive and it was evident attendees found it beneficial. One carer said, "Very good to mix with people who are in a similar situation to yourself and also meet up with the professionals who can help if needed".

- Arrangements were in place to help address inequalities and to meet the diverse needs of local people. For example, the hospice had an arrangement with the local prison for prisoners who needed symptom control or end of life care and who chose the hospice as their preferred place of care. Staff also gave us examples where they had supported homeless people to access the hospice and ensure they received the end of life care and support they needed. In partnership with a national charity, the service provided night wear, socks and toiletries to patients who needed them.
- Facilities and premises were appropriate for the services being delivered and met the needs of a range of people who used the service. The hospice was situated in a peaceful, rural location which offered free parking. The car park had recently been relayed following complaints about pot holes and managers told us they were hoping to extend the car park. Volunteer drivers were available to pick up patients and carers from home to the hospice when needed. The garden and patio areas promoted a peaceful environment and provided patients and their friends and family with the opportunity to sit, walk or play outside, with various outdoor games available. The patient bedrooms we saw were large and light, with views of the garden and surrounding countryside. All



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areas of the hospice were made to look as homely as possible. Patients were encouraged to bring personal items with them to make them feel as comfortable as possible, such as photographs and their own bedding.

- Facilities were available for families. There were communal areas within the hospice including a conservatory and kitchens in the day therapy and inpatient units, where patients and visitors could store and make their own food and drinks when they wished. There was a large lounge, with comfortable seating and patio doors which opened into the garden. It had magazines and books, a television and table and chairs for children, with a small selection of toys, books and activity equipment for them to use. There was also a vending machine and hot drinks machine with biscuits available for patients and visitors at any time of the day or night. There was a multi-faith and spiritual room where people could pray or just be on their own if they wished. A quiet room was also available on the inpatient unit. Many of the patient bedrooms were large and visitors could stay overnight if they wished. Toilet and shower facilities were available to those staying with their loved ones. All patients and visitors could use the hospice's free Wi-Fi. This meant they could easily keep in touch with their friends and family.
- Sue Ryder had an on-line community service. This was available to anyone. It provided information and advice about a range of topics, such as going on holiday, making a will and what to expect when someone is dying. It also provided an opportunity for people to chat on-line with people in similar circumstances, so they could share and help each other with valuable emotional support.

## Meeting people's individual needs

- **Services were tailored to meet patients' individual needs and preferences. 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. However, patients' preferred place of death was not always documented.**
- The hospice was committed to providing equal access to services for patients and visitors. Staff told us they

had rarely needed to use interpreters, but they could access translation services for patients' for whom English was not their first language when needed. A digital listening device was available to help patients and visitors who had hearing difficulties.

- The hospice was accessible to patients and visitors with mobility difficulties and wheelchair users. There was a lift to the first floor, where the inpatient unit was situated. There were bathroom and toilet facilities for patients and visitors with mobility difficulties and specialist equipment was available, such as hoists.
- Staff spoke sensitively and confidently about the differing needs of patients with learning disabilities, mental health concerns and dementia. Sue Ryder had introduced 'What Matters To Me' training for staff. This training workshop had been developed with the British Institute of Human Rights. It was designed to help practitioners use human rights as a practical framework for ethical decision-making and for ensuring compassion and dignity in end of life care. As of September 2019, 38% of eligible staff had completed this training. However, a workshop was being held at the service in November 2019 to enable more staff to attend.
- Care after death was managed sensitively and in a way which respected the wishes of families while following appropriate process. This was evident from the conversations we had with staff and observations we made. Staff ensured families understood the practical arrangements needed after the death of their family member. Staff were available to provide practical advice and helped patients and families to arrange funerals in accordance with their wishes. Leaflets were also available to guide people through what they needed to do after the death of a loved one. Additionally, the hospice provided a free will service.
- Staff endeavoured to provide care that was not limited in terms of diversity, ethnicity, culture or aimed at any particular community group. They demonstrated a holistic, patient-centred approach to care planning and delivery of care. Patients' spiritual, religious, psychological, emotional and social needs were taken into account. This was evident from the patient records we reviewed and observations we made during the inspection. We heard many examples where staff had fulfilled individual wishes to ensure



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the time patients had left with their loved ones was memorable and positive. These included arranging for patients to see their pets, arranging parties for them and their children, and arranging weddings and blessings. For example, staff arranged for a patient and their family to celebrate Christmas in the summer. The family stayed overnight on 'Christmas Eve' and were given new pyjamas and hot chocolate. They had presents in the morning and catering staff cooked them a Christmas dinner. The hospice catered for patients' individual spiritual and religious needs. There was a multi-faith and spiritual room which had religious texts from different faiths, including Christianity, Buddhism, Sikhism and Islam. The hospice had arrangements with local Church of England, Methodist and Catholic chaplains who would visit patients when requested. At the time of our inspection, the spiritual coordinator was liaising with other religious leaders in the local community to promote the hospice and establish links with different faiths to help support patients.

- Patients were given a choice of food and drink to meet their cultural and religious preferences. Visitors could bring their own food for them, which could be stored and warmed in the kitchen facilities.
- Staff involved in care were informed of a person's advance care plan and preferred place of care and death. Patients were supported to develop an advance care plan, including a recommended summary plan for emergency care and treatment (ReSPECT), where appropriate. This was evident from the patient records we reviewed and our observations of the multidisciplinary handover and ward round.
- Staff understood the needs of people in vulnerable circumstances and planned care to meet their individual needs. We heard examples where staff had supported patients' who were homeless access the care and treatment they needed. If patients had little or no appropriate clothing, staff would get items for them from the on-site Sue Ryder charity shop.
- Information regarding patients preferred place of death (PPD) was not always documented. From October 2018 to October 2019, the inpatient unit (IPU) reported 209 deaths; of these, 87 patients' had expressed a PPD (42%). For the remaining 122 patients', either no preference was recorded, the

patient was undecided, or it was deemed inappropriate to ask. We saw action was being taken to improve this. For example, we were told new referral forms were being introduced which included questions about preferred place of care (PPC) and death. Managers were also working jointly with partner organisations to discuss who was best placed to have these conversations with patients, when they should take place and how this data should be captured.

## 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. Where preferred place of death was known, this was achieved for most patients.**
- The hospice 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. All referrals for the inpatient unit were assessed at the daily handover and patients were prioritised for admission according to need, where necessary. The service aimed to admit patients on the same day as referral wherever possible. In August 2019, data showed inpatient bed occupancy was 60%. This was below the hospice target of 75%. We were told managers were prioritising plans to increase referrals and admissions. For the same period, over 60% of patients were admitted the same day they were referred. Data collected from March to August 2019, showed the percentage of patients admitted on the same day as referral was generally increasing month-on-month (Source: Integrated Quality and Performance Report, August 2019). Most admissions occurred during the day, but the service would admit out of hours and at weekends when necessary, to meet patients care needs and preferences. At the time of inspection, no patients were awaiting admission to the inpatient unit.
- Managers monitored referrals to the palliative care register and took action to ensure more patients could access the specialist palliative care service when they needed it. The PCH manager had undertaken visits to



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various GP surgeries and care homes to raise awareness of the service and encourage early referral to the palliative care register so appropriate support could be put in place. Data showed this had had a positive impact on the number of referrals received (Source: Bedfordshire Palliative Care Hub, Monthly Reporting August 2019). The PCH manager had completed a review of GP surgeries and identified those with low referral rates. These were contacted to ensure they were aware of the service and how and when to refer. They also attended weekly multidisciplinary meetings at the local acute NHS hospital to identify patients who would benefit from the service.

- Staff made sure patients could access the hospice when needed and achieved their preferred place of death (PPD) wherever possible. From October 2018 to October 2019 where PPD was known, 95.3% of patients admitted to the inpatient unit achieved this. For the 4.7% of patients who did not achieve their PPD this was because their presentation had changed, or their condition had rapidly changed prior to admission and/or discharge. From April 2018 to March 2019, 77% of patients' who received care from the palliative care hub service achieved their PPD. Data for the current financial year, from April to August 2019, showed the percentage of patients' who received care from the palliative care hub service and who achieved their PPD had increased to 82%.
- The hospice was able to meet the needs of patients who would benefit from the service at the point they needed it. The palliative care hub (PCH) provided a single point of access to patients on the palliative end of life care register. Once referred to the PCH, patients and carers could access support and advice over the phone 24 hours a day, seven days a week. From April to August 2019, the service had an average of 2,304 inbound and 1,985 outbound calls per month. This was an increase on the previous year (2018/19) when the service reported an average of 2,174 in bound and 1,497 outbound calls per month. Within this period, from April 2018 to May 2019, an average of 400 calls were abandoned each month. Abandoned calls occurred when the registered nurse and nursing assistant were already on calls and were unable to answer. Managers recognised this could be improved and since June 2019, all unanswered calls were redirected to the PCH manager to answer. We saw the abandoned telephone call rate had significantly improved and since June 2019, 99% of calls were answered (Source: Bedfordshire Palliative Care Hub, Monthly Reporting August 2019).
- The PCH also provided crisis, planned visiting, fast track and night sitting services. These were designed to prevent unnecessary and unwanted hospital admissions and to enable patients to be in their preferred place at the end of their life. Since April 2018, data showed the number of patients' requiring the crisis visiting service had declined; from around 250 crisis visits in April 2018, to less than 100 in August 2019. This was because since March 2019, the service was extended to the whole of Bedfordshire and the increase in staffing meant planned visits could be commenced on the same day as referral, thereby reducing the need for 'crisis' visits.
- Fast track referrals were received through the NHS continuing healthcare service. The PCH updated them daily with capacity to ensure as many patients as possible could benefit from the fast track service. From March 2018 to August 2019, the fast track service received 303 referrals, of which 100% of patients were reviewed within two weeks of referral. This was in line with the target (Source: Bedfordshire Palliative Care Hub, Monthly Reporting August 2019). We were told the referral process was changing from October 2019, when all fast track referrals would be sent directly to the PCH to process.
- The PCH was not always able to fulfil night sit requests. Since April 2018, 40% of night sit referrals were not fulfilled and of those, most (82%) were due to multiple referrals for the same night. At the time of inspection, the service was only commissioned to provide one night sit per night. This meant only one patient and their carer had the night sit service each night. Managers told us they were hoping this would be increased.
- There were discharge processes in place so that patients could be safely discharged home to their preferred place of death, wherever possible. These included liaising with the PCH and district nursing service to ensure an appropriate care package was in place. Crisis visits could be arranged so that patients' could be discharged promptly.



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## 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 hospice had processes to ensure complaints were dealt with effectively, including prompt acknowledgement of the complaint, a written response to the complaint and whether changes had been made because of the complaint. Face-to-face meetings with the complainant were also offered, when indicated. Staff understood the policy on complaints and knew how to handle them. They told us that where possible complaints were resolved immediately. Emphasis was placed on listening to the patient or relative to identify their needs and to address their concerns in a manner that improved outcomes for them, wherever possible. If concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint. Staff told us the service received very few formal complaints, which was validated by the number received within the inspection reporting period.
- Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints and feedback was shared with staff through a variety of means such as newsletters, team meetings and noticeboards. Staff confirmed they received feedback on complaints. Action was taken in response to complaints and feedback received to improve patient experience and care provision. We saw 'you said, we did' boards displayed in the hospice with examples of improvements made in response to patient feedback. For example, one day therapy patient asked for comfy chairs and so the hospice purchased two reclining chairs for the day therapy suite. Another asked if they could spend time outside during day therapy, and so staff introduced a new walking group session. Where individual members of staff were the cause of the complaint, managers discussed the concerns raised with them, so they could reflect and make changes to their practice accordingly.

- The hospice clearly displayed information about how to raise a complaint in all areas, including the lounge and patient rooms. Leaflets regarding the complaints process were available for patients and families.
- From May 2018 to April 2019, the hospice received zero complaints. They did however, receive a complaint in June 2019 from relatives regarding the care of their loved one. We saw a thorough investigation of the concerns raised had been conducted which involved the family. The response letter was sensitively written and included the staff's sincerest apologies for any distress caused. A clear response to the concerns raised was provided including the learning and actions taken to improve. The complaint was investigated and responded to in line with hospice policy, which states complaints should be dealt with within 20 working days.
- For the same reporting period, the hospice received 105 written compliments. However, we saw many more expressions of gratitude during the inspection. Common themes from compliments included the unfailing care and kindness of staff and the difference this had made to families in their time of need. The respect and dignity staff gave to patients was also a recurring theme.

## Are hospice services for adults well-led?

Outstanding



Our rating of well-led improved. We rated it as **outstanding**.

### Leadership

- **There had been some instability in the leadership team, with numerous changes in management over several years. However, 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 had been some instability in the leadership team for several years. One staff member told us there



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had been five hospice directors in the four years they had worked at the hospice. The lack of stability was the only concern staff raised with us. Managers recognised this and had acted to address this concern. To create some stability, the corporate leadership team had appointed an experienced hospice director as the interim hospice director for St John's. They were a director from another Sue Ryder hospice who was dividing their time between the two hospice sites. We saw regular listening events and engagement champion meetings were being held to keep staff informed of what was happening at the hospice and to provide a forum where they could raise any issues or concerns they had. The interim hospice director also produced a regular newsletter for staff, where they shared important information about the hospice and Sue Ryder organisation and celebrated staff success.

- Difficulties in recruiting to senior specialist roles was listed on the risk register. While the service was actively recruiting, managers had acted to minimise the risk from staff vacancies. For example, an interim hospice director was in place to support the running of the service. A staff member from the corporate service improvement team was also supporting the service on-site, three days per week. A senior nurse had expressed interest in the clinical educator post and was being supported to fulfil this role.
- Leaders understood the issues, challenges and priorities in the service, and beyond, and proactively sought to address them. They worked collaboratively with partner organisations, stakeholders and other agencies to deliver high-quality, patient and family-centred palliative and end of life care services.
- There was a clear management structure with defining lines of responsibility and accountability. The day to day management of the hospice was undertaken by the senior leadership team. This included the interim hospice director, head of clinical services, head of support services and head of hospice fundraising. They were supported by the medical team, managers and leads of each department. The senior leadership team was accountable to the Sue Ryder executive leadership team, who in turn were responsible to the council of trustees. The interim hospice director reported directly to the director of nursing, who they said was very visible and supportive.
- We spoke with one of the Sue Ryder trustees, who told us they were kept well informed of what was happening within the hospice. This was evident from their knowledge about the service, such as the lack of consistency in leadership. They spoke with pride about the care the service provided, which they heard received from relatives they had spoken with. Members of the council of trustees chaired various governance sub-committees and met bi-monthly as a board. This ensured they met their governance responsibilities and maintained oversight of the quality and safety of care. There were 13 trustees on the council from a variety of backgrounds, all of who had or still held senior executive positions, including within the NHS. Two of the trustees were practising consultants; one in palliative medicine and one in neurology.
- Staff we spoke with were generally positive about their leaders and were hopeful there would be greater consistency in leadership. They told us they were very visible, approachable and they felt well supported. We observed this during the inspection.
- Staff working in the community told us they felt better connected to teams based at the hospice since the palliative care hub (PCH) was relocated on the hospice site. Prior to this they said the teams were disconnected, but this had vastly improved and PCH staff liaised more with inpatient staff for the benefit of patients.
- The service provided development opportunities for staff that supported them to develop leadership and management skills. For example, the head of support services was being supported to complete a degree in leadership and management at the time of inspection. Two members of the nursing team were being supported to take on more senior roles within the inpatient unit.

## 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.**



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- There was a clear vision, mission and set of values, with quality and sustainability as the top priorities. The hospice vision, mission and values were those of Sue Ryder, and were focused on providing high-quality palliative care for patients and those close to them living with life-limiting conditions. The Sue Ryder vision was, “We see a future where our palliative and neurological care reaches more communities; where we can help more people begin to cope with bereavement; and where everyone can access the quality of care they deserve.” The mission was, “Sue Ryder supports people through the most difficult times of their lives. Whether that’s a terminal illness, the loss of a loved one or a neurological condition – we’re there when it matters. Our doctors, nurses and carers give people the compassion and expert care they need to help them live the best life they possibly can.”
- There was an established set of values, which were:
  - Make the future together – sharing our knowledge with each other and collaborating with our volunteers, supporters and people who use our services to deliver positive outcomes.
  - Do the right thing – working with honesty and integrity, having courage and resilience to face the challenges in delivering our goals.
  - Push the boundaries – constantly looking at ways to improve what we do and how we do it, with creativity and innovation.
- The values were underpinned by Sue Ryder ‘behaviours’ which staff were expected to demonstrate at all times. These included emotional awareness, honesty and integrity, resilience, delivering outcomes and working together. The appraisal process incorporated the Sue Ryder values and behaviours, whereby staff had to evidence how they demonstrated them at work. We saw the Sue Ryder vision, mission and values were publicly displayed throughout the hospice. Most staff we spoke with could articulate the Sue Ryder vision and mission.
- Sue Ryder had developed a five-year strategy for 2018 to 2023. This had been developed in collaboration with staff, service users and external partners, and was aligned to national recommendations for palliative and end of life care. The strategy recognised the

challenges presented by a growing and ageing population, with more people being diagnosed with complex conditions, and outlined how the organisation planned to deliver services which met the needs of more people and enabled them to access personalised, life-enhancing care. There were two strategic aims: provide care and support for more people; influence new models of care across the UK. In partnership with relevant stakeholders, the hospice had developed services in line with the strategy, such as the palliative care hub. Since April 2018, this service had grown and was now providing community-based palliative and end of life care to people across the whole of Bedfordshire. Progress against delivering the strategy and local plans were monitored and reviewed.

## Culture

- **Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people’s experiences. Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- We observed a culture of commitment, collaboration, support and respect across all departments and teams within the service. It was evident staff were passionate about the care they provided and were proud to work at the hospice. Staff told us they loved their jobs and were committed to providing the best possible care for patients and those close to them. They felt it was a “privilege” to care for people at the end of their life. Throughout our inspection, we observed positive and respectful interactions between staff at all levels. Staff told us they all worked well together, they supported and cared for each other and treated each other with respect. Every staff member we spoke with remarked on the real sense of team working throughout the hospice.
- Staff told us they felt supported, respected and valued. They described the culture within the service as open and positive. Leaders were visible, accessible and supportive. The senior management team promoted an ‘open door’ culture and it was evident staff felt



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confident to voice any concerns or issues they had. None of the staff we spoke with raised any concerns about bullying or inappropriate behaviours from colleagues. Arrangements were in place to ensure staff could raise concerns safely and without fear of reprisal, including a whistleblowing policy which staff could easily access from the hospice intranet.

- The culture of the service was centred on the needs of patients and those close to them. We heard many examples where staff exemplified this during the inspection, such as the lengths staff went to, to meet the individual needs and wishes of patients and to help them live each day to the fullest. Many of the volunteers who worked at the hospice were relatives of patients who had been cared for at St John's. This was testament to how positively former service users felt about the hospice and the care they provided.
- Leaders spoke with pride about the work and care their staff delivered daily. They celebrated staff success by sharing positive feedback received and positive contributions made by staff. Staff were invited to nominate colleagues who had been particularly helpful and exemplified the Sue Ryder behaviours. The interim hospice director sent thank you 'spotlight cards' to nominated staff. Sue Ryder held an annual 'Incredible Colleagues Awards' event which recognised staff and volunteers who had gone the extra mile. Three staff members from the hospice had been shortlisted for the unsung hero, long-time achievement and compassionate carer award categories.
- There was a strong emphasis on the safety and wellbeing of staff. Measures were in place to protect the safety of staff who worked alone and within teams in the local community. The service had recently installed additional CCTV equipment so staff working on the inpatient unit at night could see who was entering the hospice. This was in response to concerns raised by some staff members. A confidential telephone-based counselling service was available to staff. Sue Ryder was also acting to improve how the organisation and staff understood and managed mental health. This was in response to staff feedback. For example, the executive leadership team were attending training on leading a mentally healthy

organisation in the new year. This training would then be available to senior leadership team members. They also planned to introduce in-house mental health first aiders.

- The culture encouraged openness and honesty. The service had processes to ensure the duty of candour was met, including training for staff. Staff understood the duty of candour and confirmed they were encouraged to be open and honest with patients, families and carers.
- There were mechanisms for providing staff at every level with the development they needed, such as appraisals and one-to-one discussions. Staff spoke positively about development and training opportunities. Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. We were given examples of when this had occurred.

## 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 safeguard high standards of care. Monthly quality improvement group meetings were held. These followed a standing agenda which was aligned to the Care Quality Commission (CQC) domains, namely; safe, effective, caring, responsive and well-led. We reviewed six sets of meeting minutes which confirmed governance matters, such as incidents, risks, complaints, feedback, audits, and training compliance, were discussed. A quality improvement plan was also in place to ensure actions arising from governance meetings were monitored and completed (Source: Provider Information Request, P25 Local Meetings).
- Quality and risk information about the service was reviewed at hospice through to board level, such as staffing metrics, incidents, complaints and activity. The governance and risk structure for Sue Ryder



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showed information discussed at quality improvement group meetings fed into relevant corporate groups, such as the research governance group and medical devices group. These groups fed into the health governance committee, which fed into the health and social care sub-committee, which fed into the council of trustees (board) meetings (Source: Provider Information Request, P2 Risk and Governance Structure). This meant there was oversight of the service at hospice to board level. The trustee we spoke with and minutes of the health and social care sub-committee meetings we reviewed confirmed this (Source: Provider Information Request, P12 Minutes).

- Effective governance processes were established at shop-floor level. The nurse-in-charge of the inpatient unit checked all daily checks had been completed, such as emergency equipment and medicine storage temperatures.
- Staff at all levels were clear about their roles and had a clear understanding of their accountabilities and who they reported to. Staff were committed to improving the quality of service provision and safeguarding high standards of care. Staff knew how to report incidents and were encouraged to do so.
- Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

## 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.**
- There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospice had an up-to-date risk management policy and related policies in place, such as the complaints policy and incident and near miss policy. The aim of the risk management policy was: to promote a risk aware culture; ensure appropriate systems were in place for identifying, assessing and

controlling key risks; to maintain effective structure for risk management so that a consistent approach was applied, and; to provide practical instruction and tools for risk management.

- The hospice had a local risk register which included a description of each risk, the potential impact of the risk and the risk owner, alongside mitigating actions and controls in place to minimise the risk. Each risk was scored according to the likelihood of the risk occurring and its potential impact. At the time of our inspection, five risks were detailed on the risk register; two of which were related to staffing and difficulties with recruiting to senior and specialist roles. We saw the risk register had been recently reviewed and action had been taken to minimise each risk. Risks were reviewed regularly at weekly senior management team and monthly governance meetings. There was alignment between the recorded risks and what staff identified as risks within the service, such as staffing.
- Individual risk assessments were carried out for each patient on admission to the service. These were reviewed regularly. When a risk was identified, we saw actions were taken to minimise any potential harm to the patient, such as from falls or pressure ulcers.
- External companies were employed to undertake specialist risk assessments where appropriate. For example, a fire risk assessment was carried out in June 2019 which identified some areas of non-compliance. We saw there was an action plan for areas of non-compliance, most of which had been completed by the time of our inspection, with other work scheduled. In the interim, the lack of fire resistance compartmentalisation in some areas of the building had been added to the risk register. Controls were in place to minimise the risk.
- Incidents reported were reviewed regularly by senior staff and where necessary, investigations were initiated to identify any themes and actions needed to minimise recurrence. We saw there were three incidents under review at the time of our inspection. The corporate quality team and chief executive for Sue Ryder had oversight of all incidents reported.



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- There was a programme of clinical and internal audit. This was used to monitor quality and operational processes, and results were used to identify where improvement action should be taken. Staff confirmed they received feedback from audits.
- The service had an up-to-date business continuity plan which was accessible to staff and detailed what action should be taken and by who, in the event of a critical incident involving loss of building, information technology or staff. Emergency contact numbers for managers and services, such as electricity, gas and water providers, was included.
- Staff confirmed they received feedback on risks, incidents, issues and performance in a variety of ways, such as team meetings, noticeboards, newsletters and email.
- The head of clinical services, data analyst and department leaders met monthly to review all data collected and ensure it was accurate, valid, reliable, timely and relevant.
- There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance. For example, the palliative care hub produced a monthly report for the local clinical commissioning groups and community NHS provider. The report was detailed and included a range of performance and quality indicators.
- Staff had access to up-to-date and comprehensive information regarding patients' care and treatment. The electronic patient record system was the same as that used by local GPs, district nurses and Macmillan nurses. There were arrangements to ensure confidentiality of patient information held electronically and staff were aware of how to use and store confidential information. Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information.

## Managing information

- **The service invested in best practice information systems and 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.**
  - There was a holistic understanding of performance which sufficiently covered and integrated people's views with information on quality, operations and finances. Clear and robust service performance measures were reported and monitored. Staff had access to quality and performance data through the monthly integrated quality and performance report. We saw these reports were detailed and included data on a range of performance and quality indicators, such as incidents, staffing, service user feedback, complaints and activity. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements, where indicated. Statistical process control (SPC) charts were used to track performance over a period of time, where relevant, and to highlight unexpected variations in performance which warranted investigation. This meant staff could identify at a glance, performance trends and areas that required investigation and improvement.
- ## Engagement
- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, the patient feedback response rate was significantly below the target.**
  - People's views and experiences were gathered and acted on to shape and improve the service and culture. Patients, families and carers were encouraged to share their views to help improve services. Feedback was reviewed by staff and used to inform improvements and learning, where possible. The inpatient unit gathered real-time feedback through tablet devices, which generated a daily feedback report. Patients were asked about their experience of care at the hospice, such as mealtimes and how their health had changed since using the service. By asking for feedback in this way, staff hoped issues would be



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raised soon after they arose and meant they could be acted upon quickly. We saw evidence of this during the inspection. For example, one patient had said they would like their bed closer to the window. This was highlighted on the daily feedback report and staff promptly repositioned the patient's bed by the window. In response to a complaint received, a service user was involved in designing the patient leaflet about the palliative care hub service. However, from April 2018 to March 2019, the response rate for the service was the lowest in the organisation, at 11%; the highest reported response rate was 20%. This was significantly below the response target of 65%, from patients admitted to an inpatient unit (Source: Provider Information Request, P12 Minutes, Patient Safety and Experience Report April 2019). We were told there had been technical issues with the tablet device used to collect real-time feedback, which had now been resolved. We were told managers were hoping to source additional volunteers to improve the response rate. Furthermore, response rates were being monitored at quality improvement group meetings. Managers had a meeting planned with their counterparts from another Sue Ryder hospice to share best practice.

- The hospice undertook a survey of bereaved relatives and friends. This was sent out six weeks after the patient had died. Relatives were asked to rate and comment on their experience of their loved one's care and treatment. From May 2018 to April 2019, the feedback showed most respondents rated the service highly. In August 2019, the service installed 'you said, we did' boards so people could see what improvements had been made in response to feedback received.
- There were high levels of engagement with patients, families and carers, partner organisations and the public. For example, the hospice held many fundraising events across the local community to raise public awareness and support for the hospice. These included an annual curry and quiz night, the country fayre and starlight hike. Families and carers were invited to attend the hospice for an annual day of remembrance, known as the 'Lights of Love' event, where people could come together to reflect and remember their loved ones. In partnership with Carers in Bedfordshire, the hospice had established a

monthly drop-in group for carers, the person they care for and former carers of all ages and circumstances. The service engaged with organisations representing people from equality and vulnerable groups, to shape and improve services, such as the local prison. At the time of our inspection, the spiritual care coordinator was contacting religious leaders in the local community to educate them on the services provided by the hospice. Palliative care hub staff were engaging with local learning disability providers to promote the service and help improve end of life care for people with learning disabilities.

- The hospice worked in partnership with other services providing end of life care to ensure patients' individual needs were effectively met. For example, managers and department leaders attended weekly end of life care multidisciplinary meetings at the local NHS hospital. Senior staff attended monthly gold standard framework meetings with local GPs. Palliative care hub staff were actively promoting their services amongst partner organisations, such as the local NHS community provider, ambulance providers and GPs. We were given examples of how engagement with other services involved in end of life care had helped patients achieve a 'better death'. Paramedics responding to a 999 call, for example, checked if the patient was on the end of life care register and arranged for them to be transferred to the hospice instead of the local NHS emergency department. This was in accordance with the patient and relatives wishes and national recommendations (Department of Health, Our Commitment to you for end of life care: The Government Response to the Review of Choice in End of Life Care (July 2016)).
- The views of staff were sought and acted on. Staff were invited to participate in the annual Sue Ryder staff survey. In the 2019 survey, the hospice scored 7.1 (out of 10) for an overall indicator of staff engagement. This was lower (worse) than the national Sue Ryder average of 7.5, and indicated staff were reasonably well engaged. We saw action had been taken to address issues raised by staff and improve staff engagement. For example, staff engagement champions had been appointed with representation from each department and monthly engagement champion meetings were held. The aim of these meetings was to ensure staff felt they had a voice and



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could raise concerns and share ideas for improvement. We attended an engagement champion meeting and saw staff were listened to. Requests or issues raised were responded to promptly by the senior management team. The interim hospice director had introduced a weekly newsletter for staff, which included updates and news about the hospice and Sue Ryder organisation. They also held regular 'Let's Talk' sessions for staff and volunteers, where they provided an update on the hospice and invited open questions from staff.

- From the conversations we had with staff and observations we made during the inspection, it was evident that staff were engaged in the service. They told us they felt confident to raise concerns and were encouraged to come up with ways in which services could be improved. Information was shared with staff in a variety of ways, such as handovers, email, noticeboards and staff events. Staff told us they had regular team meetings. Meeting minutes reviewed showed staff engagement at all levels.

## Learning, continuous improvement and innovation

- **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 improvements since we last inspected in April 2016. Most notably was the introduction of the palliative care hub fast track service. This was an 18-month pilot which commenced in March 2018 and would run until October 2019, from when it was hoped the contract would stay with the hospice. The fast track service had commenced in Central Bedfordshire and since March 2019, had been rolled out across the whole of Bedfordshire. We were told feedback from stakeholders had been positive and the contract had been extended until at least April 2020.
- Staff were involved in an innovative project to support patients to choose their own care home. The palliative social worker recognised that patients discharged from a hospice to a care home often had their choice

and control compromised because they had to rely on others to choose a home on their behalf. While patients were often unable to view care homes themselves, staff wanted to empower patients to make an informed choice and to make choosing a home a dignified reality for them. Staff looked at the brochures of 28 nursing homes in the local area and found they rarely showed pictures of bedrooms, which was where patients requiring end of life care often spent most, if not all, of their time. To address this, staff visited all nursing homes who agreed to participate in the project and photographed the bedrooms. This meant patients who were not able to view nursing homes themselves were given more choice and control regarding where they would like to go. The photograph folders were also used by staff to open up discussions with patients about what to expect in a nursing home. The palliative social worker showcased this project at a national Association of Palliative Care Social Workers event.

- Staff and volunteers were committed to improving service provision and the patient experience. Staff and volunteers actively fundraised for the hospice and Sue Ryder organisation to ensure the charity could continue to provide care and treatment to those in the local community who needed it. We saw many examples of fundraising events held, such as the starlight hike, curry and quiz nights, the country fayre and Summer festival, Christmas tree light festival and afternoon teas.
- The service was committed to training and staff development. Staff told us they were encouraged and supported to complete additional training. For example, the support services manager had received funding to undertake a degree in business management.
- In June 2019, one of the volunteers had been awarded 'Volunteer of the Year' at the Central Bedfordshire Cheering Volunteering Awards. The annual event was held to thank and recognise the many volunteers and voluntary organisations across Central Bedfordshire for the work they did to help others in their community.

# Outstanding practice and areas for improvement

## Outstanding practice

- The palliative care hub service worked collaboratively with partner organisations to ensure patients received the best care possible at the end of their life, in their own homes. Feedback from relatives and carers who had been supported by the palliative care hub was overwhelmingly positive, and staff were often described as “angels” and having gone above and beyond expectations.
- Staff were involved in an innovative project to support patients to choose their own care home. The palliative social worker recognised that patients discharged from a hospice to a care home often had

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## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that patients preferred place of care and preferred place of death are documented.
- The provider should make efforts to improve the real-time patient feedback response rate.
- The provider should ensure all ‘aroma steam’ machines are safety tested in accordance with the service’s maintenance schedule.