St Michael's Hospice (North Hampshire)

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Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff with key skills to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- People were truly respected and valued as individuals and were empowered as partners in their care. Staff fully involved people and treated them with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service tailored planned care to meet the needs of individual people, took account of patients' individual needs, and made it easy for people to give feedback. People received care in a way that was flexible, offered choice and continuity. People could access the service when they needed it and did not have to wait too long for treatment.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in their daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However:

- The medicines in the drug fridge was not maintained securely at the time of the inspection.
- The staff records were not maintained securely.
- The clinical room where medicines were kept did not have any facility to monitor the room temperature.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good	

Summary of findings

Contents

Summary of this inspection

Background to St Michael's Hospice (North Hampshire)

The St Michael's Hospice (North Hampshire) is operated by St Michael's Hospice (North Hampshire). The hospice is situated in Basingstoke and supports people living in Basingstoke and the surrounding area. The service provides specialist palliative care, advice and support for adults with life limiting illness and their families. They deliver physical, emotional, spiritual and holistic care through a multi- disciplinary team of palliative care nurses, doctors, healthcare assistants, counsellors, physio and occupational therapists and an inhouse chaplain. The hospice has an eight bedded inpatient unit with en suite facilities and a community care service known as Hospital at Home to support patients in their own home.

The hospice has a day care service that provides support and therapy to individuals and groups. This has been closed due to restrictions caused by the pandemic. This is currently used by the local NHS trust to provide Oncology care to patients. However; the hospice plans to resume the day service in October 2021.

In the reporting period of April 2020 - March 2021, the service had 225 bed days and an occupancy of 72%.

Track record on safety

- No Never events
- One serious injury
- No incidents of hospital acquired *Meticillin-resistant Staphylococcus aureus* (MRSA),
- No incidents of hospital acquired *Meticillin-sensitive staphylococcus aureus* (MSSA)
- No incidents of hospital acquired *Clostridioides difficile (C. Diff)*
- No incidents of hospital acquired *E. coli*
- *No clinical complaints*
- 134 compliments.

The hospice is registered to provide the following regulated activities:

- Diagnostic and Screening Procedures
- Treatment of disease, disorder or injury

Services provided at the hospital under service level agreement:

- Pathology and histology
- Pharmacy
- IT
- Maintenance of medical equipment
- Clinical and or non-clinical waste removal
- Emergency maintenance out of hours from the local Trust.

St Michael's Hospice had a registered manager. This is a person who has registered with the Care Quality Commission to manage the regulated activities. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations.

Summary of this inspection

We last inspected this service in July 2016 when we rated it as Good overall and found no breaches of regulations.

How we carried out this inspection

The team that inspected the hospice comprised a CQC lead inspector, and a specialist advisor with expertise in end of life care. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

During the inspection we looked at care provided on the ward, in the community and spoke to staff about care provided in the hospital. We spoke to four patients and two relatives. We spoke to 14 members of staff. This included consultants, medical director, the chief executive officer, registered manager, doctors, nurses, health care assistants and domestic staff.

We also reviewed six patient records, incident reports, staff records, feedback/compliments, risk register, data, and other information that we hold about the service.

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

Outstanding practice

We found the following outstanding practice:

- Patients and their caregivers were supported in a caring, compassionate way, staff treated patients with care and involved patients as partners in their care.
- Staff, patients and their relatives shared stories and examples of exemplary care and staff going above and beyond to care for their patients. This included celebrating special events and achieving their preferred place of death.
- The service had acquired an electronic record system which will impact positively on patients. Staff will be able to access and share real-time information to support effective decision-making, enhance co-ordinated care at the right time and place for patients and family caregivers.
- The hospice had developed and worked cohesively with the local trust in sharing information and linked with the palliative care team at the local trust to facilitate effective patient transfers and discharges.

Areas for improvement

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

Action the service SHOULD take to improve:

Core/additional service [amend as appropriate – if there is only one service, delete this heading]

- The service should ensure that medicines in the drug fridge is kept safely and securely. Regulation 12(2)(g)
- The service should consider monitoring the clinical room temperature where medicines were kept. Regulation 12(2)(g).

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Are Hospice services for adults safe?

Good

Mandatory training

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

The mandatory training schedule was monitored which staff said they completed when they joined the service and was relevant to their roles. The registered manager was responsible for monitoring compliance and reminded staff when they were due a refresher course. Mandatory training data showed staff were 92% compliant with training requirements, as set by the hospice.

Staff had completed training in modules including but not limited to, basic life support and advanced life support, health and safety, infection control including refresher training for COVID -19 management. Other mandatory training was fire safety and moving and handling.

Staff were positive about the training and support they received. Staff had access to two computers in a quiet room to complete on line training. Managers told us that most training had been completed online due to COVID-19 and there was a gradual move to reinstate some face to face training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff and allied healthcare professionals received safeguarding training specific for their role on how to recognise and report abuse. Staff could give examples of what constituted as abuse and how to raise any concerns. They knew how to protect patients from poor care and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff including senior managers were supported to undertake regular updates in safeguarding to maintain their skills and followed procedures aimed at safeguarding children and adults. Staff received training appropriate to their roles which included volunteers working at the service. Staff followed safe procedures for children visiting the service.

Doctors and palliative care consultants received training specific for their role on how to recognise and report abuse. The service had a safeguarding lead and doctors knew how to make a safeguarding referral and who to inform if they had concerns.

Safeguarding was discussed as part of the handover and discharge planning into the community to ensure people were not put at risk and referrals were followed up with the relevant authorities. Safeguarding was discussed at head of department meetings as well as at the senior leadership meeting to ensure that there was learning from any incident and that there was dissemination of information and at team meetings. The service had not made any safeguarding referrals in the last 12 months.

The safeguarding policy included recruitment practice to protect patients from the risks of abuse. There were clear arrangements to support staff and ensuring they had an up to date enhanced Disclosure and Barring Service (DBS) checks prior to them starting work. We requested further evidence of checks following the inspection which the provider submitted. This showed safe recruitment practices were followed which included DBS. There was an internal process for checks once completed, these were recorded on the HR database. Records showed that volunteers also had a DBS check completed before they started work at the service.

Cleanliness, infection control and hygiene

Staff used infection control measures on the wards and when transporting patients after death.

Staff followed infection control principles including the use of personal protective equipment (PPE). They adhered to effective hand hygiene policies and procedures to prevent the spread of infection. staff used hand sanitiser and washed their hands at appropriate times. All staff adhered to the 'bare below the elbows' best practice when delivering care. Staff adhered the five moments of hand washing in line with the world health organisation (WHO) protocols to prevent the spread of infection.

Staff cleaned equipment after every patient contact and labelled equipment to show when it was last cleaned and safe to use. Staff followed their infection control procedure; patients were all accommodated in single rooms and staff told us this enhanced their ability to isolate patients, if suspected of having an infectious condition.

The service had developed new measures during the pandemic to manage the flow of visitors whilst maintaining effective infection control processes during the pandemic and information was shared with patient's family.

The service had infection prevention and control measures to prevent the spread of COVID-19. All staff completed twice weekly lateral flow testing and records of these were maintained. The service had supported staff through the vaccination programme and vaccination status of staff was recorded in their personnel records.

There were clear procedures for looking after a patient after death and staff followed this. Last offices were managed safely in the chapel of rest and infection control procedures were followed. This ensured the health and safety of staff and family who may come into contact with a patient's body after death including the undertakers.

Staff worked effectively to prevent infections. The hospice had reported no incidents of Clostridioides difficile (C. difficile), MRSA, vomiting or diarrhoea outbreaks in the past 12 months.

There was a programme of continuous audits to monitor infection prevention and action plans were developed to mitigate any risks identified and learning from audits were shared including change in practice. The most recent infection control audit showed the service had achieved 100% compliance. Leaders told us that infection control was high on the agenda and this was achieved as a team approach.

The hospice completed regular water testing for legionella and bacteriological infections and prioritised high-risk areas to have more regular checks. This included notifying the relevant external agencies as required. The most recent legionella test was completed in April 2021 and found no concerns.

Environment and equipment

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

The design of the environment followed national guidance. The premises were bright, well ventilated, clean and well maintained. Consideration was given for people with limited mobility and wheelchair users with ramps and level access available to people.

There were adequate and suitable seating in the reception area and a large conservatory. All patients' suite were for single occupancy with en-suite facilities and easy access for people with limited mobility. The service had suitable facilities to meet the needs of patients' families as there was room for extra bed if needed.

There was also a family room with facility for hot and cold drinks. This was currently used by staff due to the pandemic and the manager told us this would be reinstated as family room soon. Patients and their family benefitted from a well-designed garden which they said provided a' sanctuary and was peaceful'. It had various sections with level access, seating areas and a pond which the volunteers at the hospice beautifully maintained.

Patients could reach call bells as were refreshments and we were told staff responded quickly when called. Patients told us that staff came in within a couple of minutes when they requested help. Patients said the staff always made sure they could reach their call bells before leaving the room.

The service had enough suitable equipment to help them to safely care for patients. There was a ceiling track hoist which was used to enable the patient to be transferred to the en suite shower room. The bedroom was clean and bright and there was a white board with the names of staff caring for the patient on that day. There was adequate PPE outside the room to support effective infection control practice.

The service managed substances that were hazardous to health safely and in line with Control of Substances Hazardous to Health (COSHH) Regulation 2002, these were locked securely to prevent access by unauthorised persons.

Staff carried out daily safety checks of specialist equipment and detailed records were maintained. The service had a process to test electrical equipment providing assurance that they were safe for use. We randomly checked several pieces of equipment, these had label indicating the devices had been recently tested and were fit for use.

Staff disposed of clinical waste safely. The service had appropriate arrangements in place for the management of clinical waste and sharps. Arrangements for storing, classifying and labelling clinical waste kept patients and staff safe.

Good

Hospice services for adults

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service had developed and used an adapted version of the Early Warning Score (EWS). This supported staff in the early detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Information included numerical scoring for low, medium , high and clear action that staff should take. A medium score would require an urgent review by ward-based doctor to decide on escalation, further investigations and management. A high score would require a review by doctors and consultants. Consider SEPSIS, change frequency of observations, patient wishes, or escalation to the acute setting if this is reflected in Advanced Care Planning or ReSPECT form discussions.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Assessments included venous thromboembolism (risks of blood clots) falls, malnutrition and pressure ulcers. Staff had knowledge of specific risk issues related to their patients and knew how to deal with them. Following assessments patients were provided with equipment such as fall monitoring mats and pressure relieving equipment in response to patients' risks. Care plans were developed and reviewed to manage risks such as pressure ulcers and pressure relieving equipment were provided.

The Hospice at Home team proactively managed risks and supported people to live at home and respected their wishes. The physiotherapist and occupational therapist team ensured following assessments that people had the necessary equipment in their homes to live safely.

Managers monitored hospice acquired pressure ulcers, staff recorded these as incidents which were investigated to identify any learning. They had five acquired pressure ulcers in the past 12 months and these were investigated.

Staff completed psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health support if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others. We observed two multi-disciplinary team handovers which were comprehensive and all necessary information to keep patients were shared. This included diagnosis, any physical or psychological concerns, pain management, family concerns, discharge planning.

There were well developed procedures with undertakers which worked effectively for transfers of deceased patients from the service.

Nurse staffing

The service had enough medical, nursing, support staff and volunteers 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. Leaders assessed and reviewed their staffing and ensured there were adequate staff to meet the needs of patients. The hospice had recognised staffing issues and had two open days at the hospice as part of their recruitment drive.

Managers took a proactive approach and assessed their skill mix in the inpatient unit and the hospice at home team. They were working on a joint approach on staffing and looked at healthcare assistant roles with the appropriate training in supplementing the service. Two Band 4 HCAs had subsequently been appointed. The service had also secured two registered nurses on a year secondment from the trust.

The newly appointed bereavement lead and the chaplain were also providing support to patients and caregivers. Patients and relatives told us there were always enough staff and they felt safe, and staff spent time providing care and support in a calm manner.

The managers adjusted staffing levels according to the needs of patients and the number of nurses and healthcare assistants met the planned numbers. Bank and agency staff were given a full induction and used regular agency staff to maintain continuity in care.

The service was in the process of recruiting a director of nursing who would be responsible for the clinical management of the service and would work across the inpatient unit and hospice @home teams.

Medical staffing

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

The service had enough medical staff including palliative care consultants to keep patients safe. All care and treatment at the service was consultant led. There were four consultants including the medical director. The medical team establishment included two community based doctors, two speciality doctors who were on maternity leave. One doctor was providing maternity cover for a year, a GP trainee and two trust grades seconded for a year from the local trust. There were effective arrangements for out of hours and weekend cover.

The service had palliative care consultants on call 24 hours seven days a week and staff said were responsive and would attend as required.

Records

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

The service was currently using a paper based system with the aim of introducing electronic patient record (EPR) towards the end of September 2021.

We reviewed six patient records and found they were comprehensive and contained good details about patients' assessments and measures to meet their needs. Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients who were transferred out had copies of their records sent with them as needed to provide up to date information and maintain continuity in patient's care.

Staff had completed training on the EPR system and leaders were confident that EPR system will be beneficial for staff and patients as the multi- disciplinary team in the community will be able to access patient's records.

Medicines

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

Staff reviewed patients' medicines regularly and provided specific advice to patients and caregivers about their medicines. The pharmacist from the local trust provided support to patients in managing their medicines under a service level agreement. The undertook daily visits to review medicines chart and prescriptions. Patients told us they were provided with information about their medicines and discussed their medicines with the doctors, nurses and the pharmacist.

Staff followed their policy and processes when prescribing, administering, recording and storing medicines. Medicines were stored in a locked room, with restricted access to authorised clinical staff. We reviewed the storage of medicines during the inspection and medicines were locked securely. However, the lock to the medicines fridge was missing which meant the service could not be assured fridge medicines were stored safely. We brought this to the attention of the nurse in charge who said that the lock was broken; and action was taken.

There was an effective system for obtaining medicines including those required in an emergency. Prescribing was undertaken on dedicated treatment charts and records of administration were clearly documented. There was a separate chart for the administration of medicines through a syringe driver. This is a portable device used to administer a continuous dose of medicine usually pain medicine.

People were provided with comprehensive information about medicines being used outside the terms of their UK product licence, or medicines that may not be licensed in the UK. The use of such medicines is widely used as pain medicine in palliative care. Patients told us that they had received information about their medicines. Information included the possible side effects which patients said enabled them to make an informed choice about their treatment.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drugs were dispensed from obtaining them on an individual prescription. This was in line with the Misuse of Drugs Regulations 2001. Controlled drugs (CDs) were stored securely in line with the Misuse of Drugs (Safe Custody) Regulations (1973) and managed in line with the hospital-controlled drug policy. The service provided mandatory controlled drugs submissions to NHS England, and this was up to date.

A review of the controlled drug register on the ward showed staff adhered to the medicines management policy and the register was completed. The service had introduced single nurse administration and dispensing of controlled drug (SNAD). Staff followed their policy for the safe management of CD. The CD register was stored securely to minimise the risks of access by unauthorised persons.

The service had appointed a controlled drug accountable officer (CDAO) who had overall responsibility for the safe management of controlled medicines. The service undertook a CD audit in August 2021, and they achieved compliance.

Good

Hospice services for adults

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The manager reviewed all safety alerts and cascaded this information to the staff and records were kept for reference.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff followed their internal process to report, record and sought advice as needed. We reviewed records of two incidents which were fully investigated, and action plans developed to mitigate risks of re occurrence. Actions taken included reviewing procedures and staff training and lessons learnt were shared with the staff.

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

Staff understood the duty of candour. They described how they would be open and transparent. Staff would give patients and families a full explanation if things went wrong.

Are Hospice services for adults effective?

Good

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service had care plans to support staff delivering care to patients in the last days and hours of life. The care plans demonstrated best practice in relation to planning end of life care, including a holistic approach to the needs of patients and their family. This was in line with the 'Every Moment Matters' narrative from The National Council for Palliative Care, March 2015.

We saw anticipatory medicines prescribed for pain management, breathlessness, nausea, distress and agitation. These were given in line with the National Institute of Health and Care Excellence (NICE) guidelines for care of the dying adult in the last days of life and palliative care for adults.

The hospice collected information so that family caregivers needs were also considered and met. Following a bereavement, the hospice ran a bereavement support group and invited family caregivers to provide support through the bereavement process.

The hospice used recognised quantity measures to identify whether patient goals and outcomes were being met and potentially improving. The hospice used Achieving Priority of Care (APOC) which was a tool to identify patient priorities of care and changes in patient symptoms. The APOC was designed to create a standardised set of outcome measures for use in palliative care and was focussed on promoting a holistic and patient-centred care approach.

The hospice used the Karnofsky Performance Status Scale (KPS) to standardise its measure of a patient's status. KPS is a standardised tool used to measure the ability of a patient to perform daily tasks. A higher score means that a patient is better able to carry out daily activities. All staff were knowledgeable about the different points on the scale.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. All staff we spoke with had a good understanding of the Mental Health Act and could explain how they would ensure a patient's rights were protected. The service had a social worker and provided psychological support and guidance to patients and their relatives, to ensure patient's rights under the MHA were protected.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and caregivers. This was followed up by further actions/ support and discussion with people.

Guidance was discussed at the governance meeting. The clinical management team working on the end of life NICE guidelines and have identified areas they could improve. The team met monthly and would include NICE guidelines in their discussions to identify any changes.

Nutrition and hydration

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

Patients were assessed for their nutrition and hydration assessment on admission. Staff used a nationally recognised a nutrition screening tool to assess the dietary needs of patients. The nutritional assessments were completed in full in all the patient records we reviewed. Staff maintained accurate records of patient's fluid and nutrition charts where needed.

Patient's nutrition and hydration was assessed and monitored as part of patients personalised care for the last days of life plan. This also included a mouthcare and oral hygiene care plan.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered a choice of meals from a menu each day and provided snacks and drinks throughout the day. Meal choices included adjustments made for patients' religious, cultural and other needs. Staff were aware of patients' cultural needs and said that halal or Kosher meals would be sourced locally and were available to patients.

Staff discussed and considered the views of the patient and of those close to them and explained the issues to be considered, including the benefits, and risks of providing clinically assisted nutrition and hydration at the end of life. Patients' nutritional needs were discussed at handovers, and staff had access to dietician, offering advice and support to patients to meet their nutritional requirements.

Patients were overwhelmingly positive about the quality, and food choices which was available to them. Comments included' the staff will prepare you something even if it's not on the menu'. Other people commented that the food was 'wonderful and always looked appetising.'

Good

Hospice services for adults

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They worked closely with the patient and family caregiver to understand and support those unable to communicate and gave additional pain relief to ease pain.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. There was an individualised and patient driven approach to pain relief. Staff routinely assessed patients' pain level during routine observations, and as required. We spoke with four patients, and they told us that their pain was well managed, and staff regularly checked if they required any pain relief medicines. All patients told us staff had managed their pain and comfort as best as possible.

The serviced used Palliative Care Formulary 6 and "Managing symptoms for an adult in the last days of life" NICE pathway, November 2020 for pain and symptom control. These guidelines are evidence-based approaches to managing pain and symptoms in patients at the end of life.

Palliative care consultants prescribed anticipatory medicines for pain relief in patients approaching the end of life. Anticipatory medicines are prescribed before a patient requires them to ensure they are available once a patient does require them. Staff had access to current references to ensure the correct and safe administration of medicines.

Patients were supported to manage their pain when living in the community. Patients were provided with syringe drivers; this is a portable device used to administer a continuous dose of medicine usually pain medicine. A patient told us that this worked effectively, and they had received good information and leaflets which enabled them to make an informed choice. The hospice at home team visited the patients daily to ensure that the syringe driver was working and renewed the pain medicines as needed. Patients were able to seek support 24 hrs a day if they had any issue with their pain control and would call the hospice team.

Patient outcomes

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

The service had an effective approach to monitoring and recording patient outcomes, using a variety of audit techniques. The service used patient and family caregiver feedback to establish when they had provided care that met people's needs. To support this feedback, the service used patient reported outcome measures (PROMS). Managers and staff used the information to improve patients' experience of care and treatment.

The outcomes for patients were positive, consistent and met expectations. The service used Achieving Priority of Care (APOC) to assess their effectiveness for individual patients. These scores were also looked at on a hospice wide level to ensure patients benefitted from inpatient care. These were scrutinised at the quarterly quality and governance meetings and were used as indicators to ensure the changes to the model of care was not negatively impacting on the quality of care and the outcomes for patients

The service participated in relevant national clinical audits. The hospice participated in Hospice UK benchmarking for falls and used data to monitor themes and trends and were pro -active in taking actions to address any identified issues and share learning. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Good

Hospice services for adults

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were supported to complete further training relevant to their role and specific to the needs of the people they supported, for example, Intravenous therapy and devices, venepuncture (inserting a needle into a vein, usually to obtain blood) and cannulation (inserting a tube into a patient's vein so that infusions can be inserted directly into the patient's bloodstream).
The service was setting up an education calendar about training that was available, and the calendar will also be printed on monthly basis and put up in the staff room. Staff were also creating a database to record all training that staff had attended.

Staff completed annual mandatory training in key skills which included resuscitation, symptom management, discharge planning, tissue viability and bereavement interviews. This ensured staff had the appropriate knowledge and skills to support people effectively and were enabled to retain and update them. Records demonstrated that the registered manager and management team had completed courses relevant to their role and responsibilities.

Managers gave all new staff a full induction tailored to their role before they started work. The service had volunteer leads who supported the volunteers with a full induction to the service and training for them to perform their roles and this included safeguarding training

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisals rates were also discussed at their governance and team meetings. The human resources team monitored professional registration and revalidation for staff and sent reminders to staff when their registration and revalidation to professional bodies was due to be renewed.

Multidisciplinary working

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

The hospice had a cohesive approach to multidisciplinary working to ensure a holistic approach to the care delivery. Staff held daily multidisciplinary meetings which included doctors, nurses and therapy staff.

Multidisciplinary meetings were well structured and were coordinated to ensure that all professionals had equal opportunity to express their view to discuss patient's needs, developed plans and improve their care needs. The service undertook daily multidisciplinary team (MDT) meetings. All team decisions were clearly documented in patients' records, ensuring all staff involved in the care of the patient understood the goals, plan and desired outcomes.

We found a multidisciplinary approach to all aspects of care delivery. The service had developed a joint working with the local hospital palliative care team and attended their handover. This provided an opportunity to plan any imminent discharges or transfers.

Staff worked across health care disciplines and with other agencies when required to care for patients. The clinical staff communicated with the community team such as district nursing team and GP as needed prior to patients discharge to ensure they receive continued support. We saw detailed records of discharge planning which was based on a multidisciplinary team approach and assessments of needs.

Good

Hospice services for adults

The hospice at home team provided care to patients in the community and discharged them to the district nursing team once the patients were stabilised. The service ensured that discharge letters were sent to the GPS which provided detailed information about the care and treatment and maintain continuity in patients' care.

Seven-day services

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

The hospice was open 24 hours a day, seven-days a week to support patients and family caregivers who required help with their care. Nursing and healthcare staff provided care to patients 24 hours a day.

Consultants were available for advice and support seven-days a week. Consultants were available overnight and at weekends via telephone for escalation when a patient's condition changed.

Staff could call for support from other disciplines such as chaplaincy and mental health services, 24 hours a day and seven days a week. Staff told us they found access to support easy and always available.

The hospice had access to a team of support staff to escalate building and equipment failures. The team were available Monday to Friday and the service had a service level agreement with the local trust for emergency equipment failure.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in the inpatient unit and available to the hospice at home patients.

People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.

Staff were focussed on enhancing quality of life for all patients using the service. The day therapy service identified patients in need of extra support and provided emotional support in addition to physiotherapy and care planning.

The service ran healthy lifestyle workshops for patients and their families which included topics such as physical activity.

The service had a gym with specialised equipment to allow patients to alleviate common palliative symptoms such as breathlessness and to support patients to maintain their own health and wellbeing.

There were rooms in the hospice dedicated to complimentary therapies and art therapies.

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Good

Hospice services for adults

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Doctors implementing the do not attempt cardiopulmonary resuscitation (DNACPR) orders discussed this with the patient concerned and, where consent was given, with their family.

The service had adopted the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) at the service. This is a national patient held document, which was completed following an advance care planning conversation between a patient and a healthcare professional. Patients' records contained the ReSPECT document with evidence of discussion with the patients and their family and recent reviews to ensure they remained current and valid.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

We reviewed eight DNACPR and ReSPECT documents with contained clear evidence that patients and their family had been fully involved in the decision. For the patients who lacked capacity, all reasonable efforts were made to contact those close to the patient or others with responsibility to make decisions on their behalf.

Minutes of governance meetings showed that leaders discussed following the CQC report on DNACPR they wanted to be assured that blanket decisions were not being made during the pandemic. All agreed that each patient was involved in these discussions, and they were appropriately used. No further action was required.

Are Hospice services for adults caring?

Outstanding ☆

Compassionate care

Staff consistently treated patients with compassion and kindness. There was a strong and visible person-centred culture. Staff were highly motivated to offer care that promoted and respected people's privacy and dignity. Staff provided care in a holistic way considering the whole person.

People and those close to them continually provided positive feedback about how staff treated them, with compassion and kindness. Their feedback showed a strong sense of a person-centred culture. Patient commented' compassionate and caring of my personal needs from when I arrived, through every step until I was ready to go home.'

Staff were discreet and respected the totality of a patient's needs, including when a patient or those close to them may be afraid or feeling anxious. Staff took time to interact with them in a respectful and considerate way. Staff gave various examples of treating patients and family caregivers with compassion and those in distress and reaching out to them.

Patients were given the opportunity to talk about what they wanted to happen after they die. This could include discussing their wishes in relation to the handling of their body, and their beliefs or values about organ donation. Information was shared with care and compassion about their care, ability to undertake activities of living and overall care wishes.

Patients were supported at the end of their life to have a comfortable, dignified and pain free death. Staff worked closely with people's family to manage, respect and follow people's choices and wishes for their end of life care as their needs changed.

Staff shared stories and examples of exemplary care and going above and beyond to care for their patients. We saw thank you cards which include people saying hope grateful their loves ones spent their last days with the support of the hospice staff.

Staff were responsive and went the extra miles to fulfil patients' wishes. Three staff members told us about a patient who loved Christmas and had a very short life expectancy and was not expected to see Christmas. They made Christmas preparations and decorated the patient's suite and brought forward Christmas celebration for the patient to enjoy with their family with their family. Other examples included staff arranging a wedding ceremony in the conservatory and blessings. Staff told us about wheeling patients outside in their beds during the good weather to enjoy the garden.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to their care needs. Staff referred to patient records and conversations about a patient's wishes when providing care.

The dignity of deceased patients was maintained through the services processes for performing last offices and the deceased person remained in the chapel of rest which was always temperature controlled and ready. Patients were transferred with dignity from the chapel of rest to the undertakers as the door opened directly to the waiting hearse.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff recognised the impact of small gestures in supporting patients and those close to them. The service went above and beyond to ensure patients and those close to them had the emotional support throughout the final days of their life.

Staff consistently provided emotional support and advice to patients and those close to them. We saw the service had a culture where all staff provided emotional support to patients and those close to them regardless of role or seniority. Staff embodied this culture in their daily work routine

The service had a dedicated inhouse chaplain to support the spiritual and religious needs of patients and their family. The chaplain was available during working hours, Monday, Wednesday and Friday from 8am to 5pm. The chaplain supported people to bring in religious leaders from other faiths in the local community. The chaplain provided regular support to patients and their relatives and was being asked to conduct funerals by families.

The service had appointed a new bereavement lead in April this year and had started providing support to relatives with monthly bereavement evenings. There was complimentary therapy sessions which had been reinstated as this was paused during COVID -19. Patients said they enjoyed the hand and foot massages

Staff undertook training on providing emotional support and having difficult conversations. Patients and family caregivers said staff were sensitive when they discussed their wishes and preferred place of care or death. The service

monitored and worked pro- actively to meet the patient preferred place of death 96%. Arrangements could be made within hours and staff were committed in doing everything possible to fulfil people's wishes. Comments from patients included' this is the most caring, peaceful and yet efficient place' and 'care given by all staff is so good, considerate, gentle and kind'

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service continually emphasised a family caregiver's emotional needs were equally important to that of a patient. The service put both patients and their family at the centre of their care and made sure people received the support they needed. They promoted support for patients as well as the needs of family caregivers. A person told us that the hospice had given her a 'lifeline' and kept in regular contact during her early bereavement. Attending the bereavement coffee mornings had allowed them to understand what they were feeling was normal, meeting other people and sharing their stories was all part of the healing.

The hospice had trained counsellors and provided a confidential counselling service to patients and family caregivers which continued for weeks post discharge and bereavement. The hospice had set up a bereavement coffee morning which had been a success with good attendance and had received positive feedback. Family could contact the service and attend the service any time after bereavement and had a bereavement lead. Patients living in the community told us that they felt totally reassured that the staff were there 24 hrs and could call the hospice for advice and support.

Understanding and involvement of patients and those close to them

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

Staff supported patients to make advanced decisions about their care. The service had reviewed their Achieving Priority of Care (APOC) document during COVID-19. This is a specific document has been designed to guide care for people identified as being in their last days and hours of life, to ensure they achieved the national five priorities of care, which included-

Recognise the possibility the person is likely to be dying.

Communicate with person and those important to them.

Involve them in decision-making about treatment and care.

Support the needs of the person and those important to them.

Plan and Do with an individual plan of care.

Patients' records contained details of their care and how patients would achieve this. Staff supported to access other professionals such as legal advice as needed. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

The service offered bereavement support to families and caregivers. They offered a face to face session, and this consisted of between three to five sessions to begin with. Bereavement support for children was also available and dealt with sensitivity.

Good

Hospice services for adults

The latest friend and family test showed that 98% of patents and their family would recommend the service. Staff made sure patients and those close to them understood their care and treatment. Patients and relatives told us staff kept them informed about the care and treatment being provided. They also said they were involved in the decision about making care choices. Comments included that their spouse 'worries about me, the staff are wonderful and involve me in the discussion about care and what's going to happen". Another patient told us 'It's the little things, nothing seems like too much trouble'. 'My family feel so much better because they know I am in good hands'.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service used different methods to help them communicate effectively with patients with communication difficulties and sought support as needed.

Staff supported patients to make informed decisions about their care. This included discussion a do not attempt cardiopulmonary resuscitation (DNACPR) order. All inpatients in the hospice had a completed DNACPR order fully completed including a record of discussion with the patient and family or advocates and legal appointee as appropriate.

Patients gave positive feedback about the service. All patients we spoke to were overwhelmingly positive about the staff and the care and support that the hospice had provided. Comments from patients – 'the hospice at home team were very caring, friendly, helpful and supported my husband and me throughout the illness'. A patient commented' the 'doctors come round every day and they will ask if you have any questions'.

Are Hospice services for adults responsive?

Good

Service delivery to meet the needs of local people

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

Leaders planned and organised services, so they met the changing needs of the local population. They tailored services to meet the needs of individual people and delivered the services in a way to ensure flexibility, choice and continuity of care. The hospice worked closely with the local trust palliative care team and accepted referrals from GPs, the hospice care team, local hospitals and other health and social care providers.

They operated an urgent access pathway and rapid discharge pathways which were responsive to patient's needs and prioritising risks. The hospice at home team would provide care on the same day.

The environment was well designed, welcoming and well maintained. Facilities and premises were designed with the needs of the patients and family.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff had access to mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Good

Hospice services for adults

The Hospice at Home team visited and provided palliative care to people in their own homes. The hospice provided a holistic approach to care and supported people with their family support team, physio and occupational therapy team, chaplain, psychologist, counselling team and dedicated social worker.

The hospice at home nurses worked as “shared care” with the district nurses, supporting patients with syringe drivers until their symptoms are settled and patients were handed back to the district nursing team Meeting people’s individual needs.

The hospice consultants and doctors worked in all the services provided and visited people in the in-patient unit, and specialist out-patient clinics, such as people living with Motor Neurones Disease and heart failure clinics.

Meeting people’s individual needs

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

Staff used admission documentation that involved a full holistic assessment of a patient’s individual needs. We reviewed six patients’ records and found staff had completed detailed information and clearly documented it.

The environment was designed to meet the diverse needs of needs of patients. Patients were encouraged to bring in items from home to personalise the suites and help reduce anxiety.

People with limited mobility and wheelchair users could easily access all areas as accommodation was all on the ground floor. Contingency plans were in place and had consultants support for any urgent care and transfer to the local trust.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. Patients told us that staff took time to explain their care and treatment. The service could access information and leaflets in other languages, different formats such as large prints to meet the needs of the community they served. Patients and their family had access to interpreters and signers if needed.

People using wheelchairs could easily access all areas of the hospice, all patient services were on the ground floor with step free access at all entrances and out to the terrace area and garden.

The hospice had developed an effective process and flow chart to support staff in making referrals for tissue and organ donations

Access and flow.

In the reporting period from April 2020 to March 2021, there were 225 inpatient episodes of care recorded at the hospice. The hospice at home team undertook 526 home visits.

The hospice was 16 % NHS-funded and 84% were from charities and donations.

Good

Hospice services for adults

The hospice received referrals from GPs, the wider hospice care team, local hospitals and other health and social care provider. The hospice worked closely with the local acute NHS hospital trust and their palliative care team. This allowed for early identification of patients in need of palliative care on discharge from hospital and provided a seamless approach to transfers from the hospital to inpatient care in the hospice.

Urgent access pathway- rapid discharge pathway were in place, needs were assessed and allocated to the appropriate service such as inpatient unit or the hospice at home team. Hospice at home would provide a same day service.

The hospice reviewed their length of care / stay that was not directly linked with COVID-19 cases which showed a pattern of late referrals during the pandemic.

The service kept patients informed of the service they offered, and limitation placed on them by restrictions related to the pandemic. Some people chose to have care at home due to the restrictions on visiting in care settings during the pandemic. The service had developed new infection control procedures to allow for safe visiting, and information leaflets were made available to patients and their family.

Learning from complaints and concerns

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

The service had a complaint policy and procedure, and staff knew how to access this. Information on how to raise a concern or complaint was available to patients and their relatives.

During the 12 months prior to inspection, the service had received no complaint and five concerns which were investigated and responded to. The hospice received 134 compliments during the same reporting period. Patients and relatives told us they had no complaints about the service and staff 'were wonderful'

The registered manager was responsible for looking at all complaints at the service and escalated them as necessary. Staff told us they received few complaints and would always try and resolve any concerns as soon as possible.

The service had a clear process in place for capturing and learning from any concerns and senior staff felt that there were learning opportunities behind each patient/relative feedback.

Are Hospice services for adults well-led?

Good

Leadership

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

Good

Hospice services for adults

There was a clear leadership structure from service level to senior management level. The senior leadership team had recently reviewed the composition of the leadership team and had concluded that there was under representation from a clinical team perspective. The leadership team consisted of the chief executive officer, medical director, director of finance, and commercial director. The service had recruited to a director of nursing role who will be part of the leadership team. They will be responsible for the 'one clinical team approach' deploying staff between the inpatient unit and the hospice at home team.

The board of trustees had the overall responsibility of overseeing the hospice business. There were various committees which made up the board which included the fundraising committee, finance committee, clinical governance, and human resource committees.

The senior leadership team met monthly and had a rotating focus for their meetings. There was a four-weekly cycle of focus that revolved through finances, business development, quality and facilities joined with personnel. There was an ongoing action plan that meant that action was decided for each issue raised and the actions were allocated to a designated person. The action plan was then reviewed and updated at each meeting and progress against action plans were assessed.

Leaders were keen to build on the structure with equal representation on the leadership team, keeping patients and families at forefront of their care. The changes were an opportunity and ensure staff could thrive in an environment to develop their skill and for clinical staff to thrive in palliative care. Staff felt that the new structure was a positive step and the reshuffle of the leadership team had gone from 'strength to strength'.

Vision and Strategy

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

The service had a clear vision and values which was displayed- Vision-

- To influence and lead all aspects of care provision in North Hampshire. This would be delivered by working in partnerships with all stakeholders, particularly service users with active participation to develop and deliver services which, as far as possible will be user led.

The vision and values were developed from the 'ground up' with involvement of patients, relatives, staff and stakeholder and worked up through the senior leadership team. All staff knew about their vision and values known as PRIDE (People. Respect. Integrity. Diversity. Excellence)

The hospice values underpinned the work that all their staff and volunteers-

- Value each other caring for people and treating people with compassion.
- Judging every issue by considering the outcome for people and promoting their wellbeing and safety.
- Providing a supportive working environment aligned to best employment practice.
- Supporting and collaborating with colleagues, showing commitment to working together.

The service had a strategic plan which was launched in April 2020 and aligned the plan with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care.

Leaders were committed in developing their strategy, and part of the strategy was to develop sustainable partnerships with the local trusts

The senior leadership team and the board of trustees had the experience, capacity and capability to ensure that the strategy could be delivered. Strategic objectives were supported by measurable outcomes, which were cascaded throughout the organisation. Leaders understood the challenges and had an action plan to achieving the strategy, including effects of the pandemic and local health economy factors.

The relevant leadership experience and skills were maintained through effective selection, development and succession planning. An appraisal programme for trustees had been developed to provide support and development.

Culture

Staff felt respected, supported and valued. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There was a strong culture of teamwork and support across all levels of the service. The service had an open culture where patients, their families and staff could freely raise concerns. Staff were focused on the needs of patients receiving care and shared a common goal to improve the quality and safety of care and people's experiences.

The hospice had an open and inclusive culture where people were valued and treated with integrity and compassion. Staff were positive about working for the hospice and the open door policy and were confident in raising any concerns and felt valued and well supported in their roles. Staff who worked remotely said they felt connected to the team and to the organisation. The service valued the contribution of its volunteers.

Staff described how they were very proud to work for the hospice and spoke highly of the culture. Staff felt valued and supported, and said they were proud of the care they delivered.

The clinical governance committee feedback in April 2021 highlighted that there was an open, honest meeting which highlighted the positive work that was done within the hospice. The confidence, resilience, and energy coming from the teams was recognised and praised.

The service had a whistleblowing policy which was available to all staff and staff we spoke to knew how to raise concerns.

There was an emphasis on the safety and wellbeing of staff. During the COVID-19 staff had completed a risk assessment to establish any risk. Staff completed lateral flow tests twice weekly. Staff who tested positive for COVID-19 were asked to isolate and not to attend work. Staff who were clinically vulnerable were supported to work remotely if possible and maintained their safety.

There was a very strong emphasis on equality and diversity within the service and staff felt they were treated well. The organisational culture was to understand that each individual was unique and can contribute to the success of the organisation.

Teams worked collaboratively, and we saw examples of positive cross-team working to provide joined up care for patients. There were particularly strong links between those working in the hospice at home and inpatient unit. They worked cohesively supporting each other which positively impacted on patients and their families.

The service had an in date lone working policy. Staff and volunteers working in the community had a system of checking in to ensure they were safe. Leaders were planning on the next stage to develop and celebrate success, from colleagues' nominations, patients and family feedback.

Governance

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

There was well developed and effective governance structure. The committee consisted of the CEO, clinical management team, trustees, palliative care consultants and medical directors. The meetings were structured around the clinical dashboard and discussions were focussed on this. All meetings within the governance framework were well attended with clear lines of accountability throughout the hospice structure. Staff at all levels clearly understood their roles and responsibilities and fed back to the meetings.

The trustees acknowledged the positive impact of the local trust was using the day centre until September demonstrating the hospice's continued strong links with the local hospital trust. The clinical governance committee had had clear remit and was effective in monitoring and improving quality and forging strong links with healthcare partners was vital for the sustainability of the Hospice.

Governance meeting has continued, every quarter as planned during the pandemic. The chair was keen to have space on the agenda for topical discussion and assessing the effectiveness of the meetings. Assurance was sought for example regarding CQC report and blanket decisions on DNACPR.

Reviews of policies were standard items on the agenda where policies were approved, and a list of policies was shared for review at the next meeting. Policies were shared out between specialist committees in accordance with their relevance, with a master list which showed who owned each policy. It was down to those committees to review and sign off policies once ratified.

Recent policies reviewed included-

- Deprivation of Liberty safeguards
- Mental Capacity
- Patient Falls
- Patient Property
- Discharge and Transfer of Care
- Nasogastric Tube Insertion of Adults

The board and senior leadership team made sure they proactively reviewed governance and performance arrangements and reflected best practice. They welcomed constructive challenges from people who use services, the trustees, and stakeholders and used this to develop the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The hospice had a comprehensive process to identify, monitor and address current and future risks. The hospice held a risk register and our review showed comprehensive information about the issues and actions they needed to take to help minimise the risks. All risks clearly had a staff responsible for overseeing the actions and clear timescales for review. Senior staff could tell us their top risks and actions taken to mitigate this. An example was staffing and the recruitment drive which had been recently completed and they had secured two staff on a year placement from the local trust.

The hospice had nominated leads for areas such as infection control, safeguarding and finance. These leads reported on their areas at meetings and answered to the interim chief executive and trustees on the quality of the information they presented.

Performance issues were escalated to the relevant committees and the board through clear structures and processes. The leadership team was knowledgeable about quality issues and priorities, understood what the challenges were and took action to address them. Performance information was used to made improvement and assured safe care delivery.

The provider effectively used data to monitor quality, drive improvements and this was aligned to their strategy and business plans.

Mortality reviews occurred periodically with the trust and two other hospices. All admissions where the patient died within 24 hours or stayed longer than 21 days were deemed appropriate for the review. They worked as multi-disciplinary team to review deaths and shared learning. The latest mortality review highlighted good documentation of care received at the hospice.

The hospice had business continuity plans such as power loss, floods and had mitigation in place which included a service level agreement with the local for equipment maintenance out of hours and major incidents.

Information Management

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

The hospice was moving on e -system for medical prescribing and electronic patient records (EPR). Staff had received training to enable them to use the systems safely. This would have positive impact for patients as staff would be able to access records for the hospital palliative team and community. The hospice at home team were already using EPR.

Leaders used information in reporting, performance management and delivering quality care. Staff undertook audits to make sure information they used was accurate, valid and reliable.

Leaders proactively collected information and analysed it to drive improvements in care such as patient Information governance training formed part of the mandatory training programme for the service, and staff we spoke with understood their responsibilities regarding information management.

The service had appointed a Caldicott Guardian who had clear understanding of the Caldicott principles and had undertaken further training to support them in their role. Caldicott principles are fundamental rules and regulations that guide a patient's confidentiality. They are the basic rules every healthcare personnel must follow to ensure there is no breach of confidentiality. Staff spoke about sharing information only in the best interest of the patient and as disclosures to protect patients.

Good

Hospice services for adults

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.

The hospice had a joint up approach to gather feedback from people who used their services. All this feedback was reviewed; themes and trends were identified to improve the future service the hospice provided. Feedback was overwhelmingly positive and included feedback within the governance papers regarding a recent wedding that took place at the hospice.

Leaders were developing hospice user groups to gain feedback and look at how they need to enhance services to meet local needs.

The hospice priorities were to focus on patient engagement and becoming partners in their care through patients and carers committee. The hospice ran a joint staff and volunteer forum, that was chaired by a member of staff. They felt a joint forum provided integrated learning and support and provided volunteers a formal way of speaking and voicing their opinions with the organisation.

The hospice worked collaboratively with the local health and social care groups to deliver services needed in the areas they covered. An example was the service worked collaboratively with the local NHS hospital to identify suitable patients for referral to the hospice as early as possible. This reduced the burden on frontline hospital staff and aimed to reduce hospital admissions for people near or at the end of life.

The service actively engaged staff, so their views are reflected in the planning and delivery of services and in the shaping of the culture.

Learning, continuous improvement and innovation

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

Leaders supported safe innovation and staff had objectives focused on improvement and learning. Managers encouraged staff to use information and regularly take time out to review performance and make improvements.

The hospice had received funding from a local company to a new training/ development role for a nurse which would be completed over three years leading to become a non- medical prescriber. This role offered career development and would also release a medical staff from some of the work they currently do.

Two registered nurses from the local trust will be joining the hospice for a year on a new foundation in palliative care with an educational and self-directed learning element to it. The hospice will support these nurses through this programme and competency assessments, and they will achieve a diploma in palliative care at the end of it.

The service was continuing to develop community and inpatient team working together as equal partners in healthcare systems.

The service was planning to launch a Hospice User Group (HUG) and circulated information to the committee. The group would meet 4 times a year to review services provided and how these could be further developed. Recruitment can sometimes be an issue, but there could be an option for members to attend virtually. A staff member was attending a HUG meeting at another hospice to learn more about this service.

Good

Hospice services for adults

The hospice had reviewed their clinical audits framework in July 2021 renamed as the 'Quality Improvement Committee', champions had been identified to drive clinical audits and quality improvement plans at the service.