St Barnabas Hospice - Specialist Palliative Care Unit

Quality Report

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

Ratings

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

Overall summary

St Barnabas Hospice is operated by St Barnabas Hospice Trust (Lincolnshire).

St Barnabas Hospice is a Specialist Palliative Care Unit which provides a wide range of services for adults who have advanced, progressive illnesses and where the focus is on palliative and end of life care. The services are provided within four settings; an eleven-bed in-patient unit, day therapy centres, hospice at home services and a palliative care co-ordination centre. Holistic services are delivered by a team of medical, nursing and social work staff, occupational and physiotherapists, counsellors, volunteers and chaplains.

Summary of findings

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had been in post at St Barnabas Hospice since 2015.

The service was registered to provide the one regulated activity of Treatment of disease, disorder or injury (TDDI) to people over the age of 18 years.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on the 08 August 2019.

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

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

Services we rate

Our rating of this hospice improved. We rated it as **Outstanding** overall because:

We found outstanding practice in relation to the hospice:

- There was a very strong, patient-centred culture from all staff. Staff were motivated and inspired to offer care for patients with kindness, compassion, dignity and respect through supportive relationships with patients and their families, care givers and loved ones.
- We observed all staff members speaking to patients and their relatives and care givers with compassion and we observed sensitivity being shown during those conversations.
- We heard patients being offered food and drinks in an encouraging and caring way and observed staff and volunteers to always be doing as much as they could to help patients.
- One of the patients told us, "The staff are all fantastic". another patient told us. "I simply cannot fault them". Another patient told us, "The care here is second to none"
- Staff ensured that patients and those close to them were partners in decisions about their care and treatment. People's individual needs and preferences are central to the delivery of tailored services.
- There are innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for patients with multiple and complex needs. For example, at the time of our inspection, the hospice was delivering two projects to reach out to the homeless community and to a local prison, offering bereavement care to both communities. The projects included education to support staff to provide palliative care to those who do not normally have access hospice care counselling and provide bereavement counselling to the inmates of a local prison
- The Hospice hosts the PCCC, a commissioned service, with a single point of access. The PCCC was available to health professionals, patients, their families and care givers who need advice and support regarding palliative and or end-of-life care
- The PCCC centre facilitated referrals, organised care packages and worked in partnership with the clinical teams and the wider health community to enable care delivery within that community.

We found **Good** practice in relation to the hospice:

- The service provides mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understand how to protect patients from abuse and the service works well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Summary of findings

- The service-controls infection risk well. Staff keep equipment and the premises clean and used control measures to prevent the spread of infection.
- The service has suitable premises and equipment and looks after them well.
- Staff complete and update risk assessments for each patient. The records are clear and updated regularly
- The service has 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.
- Staff keep detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service follows best practice when prescribing and giving medications and patients receive the right medication at the right dose at the right time
- The service manages patient safety incidents well. Staff recognise incidents and reported them appropriately. Managers investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff apologise and give patients honest information and suitable support.
- The service provides care and treatment based on national guidance and evidence of its effectiveness. Managers check to make sure staff follow guidance.
- Staff give patients enough food and drink to meet their needs and improve their health. They use special feeding and hydration techniques when necessary. The service adjusts for patients' religious, cultural and other preferences.
- Staff assess and monitor patients regularly to see if they were in pain. They support those unable to communicate using suitable assessment tools and give additional pain relief to ease pain.
- Managers monitor the effectiveness of care and treatment and use the findings to improve them. They compare local results with those of other services to learn from them.
- The service make sure staff are competent for their roles. Managers appraise staff's work performance and hold supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds work together as a team to benefit patients. Doctors, nurses and other healthcare professionals support each other to provide good care.
- The service delivers a full inpatient service for patients receiving palliative care seven days a week.
- Staff understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They know how to support patients experiencing mental ill health and those who lack capacity to make decisions about their care.
- The service plan provides services in a way that meet the needs of local people.
- The service takes account of patients' individual needs.
- People can access the service when they need it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line with good practice.
- The service treats concerns and complaints seriously, investigates them and learns lessons from the results, and shares these with all staff.
- Managers at all levels have the right skills and abilities to run a service providing high-quality sustainable care.
- The service has a vision for what it wants to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promote a positive culture that supports and values staff, creating a sense of common purpose based on shared values.
- The service has effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected risks

Summary of findings

- The service collects, analyses, manages and uses information well to support all its activities, using secure electronic systems with security safeguards.
- The service engages well with patients, staff, the public and local organisations to plan and manage appropriate services as well as collaborating with partner organisations effectively.
- The service is committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Services we rate

Our rating of this. We rated it as outstanding overall

- Staff cared for patients with compassion, empathy and respect. Feedback from all patients confirmed that staff treated them exceptionally well and with kindness and told us that staff went over and above what was expected of them. People were truly respected and valued as individuals and empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.
- The trust responded to people's individual needs and preferences which were central to the delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The services were flexible, provided informed choice and ensured continuity of care.
- There was an embedded and extensive team of volunteers who helped support the service. There was a separate volunteer induction and training programme. Volunteers were valued members of the service who were provided with support and who felt part of the hospice team.

We also found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink. 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.
- Staff treated patients with great compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided exceptional emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	The hospice had an 11 bedded inpatient unit providing care for complex symptom management and terminal care. This was the main activity for this service. The hospice also provided a Hospice at Home Service community service providing specialist palliative care to patients in their usual place of residence, as well as day therapy centres, hospice at home services and a palliative care co-ordination centre. We rated this service as outstanding overall because we rated caring and responsive as outstanding, but safe, effective and well led as good.

Summary of findings

Contents

Outstanding ☆

Location name here

Services we looked at
Hospice services for adults

Summary of this inspection

Background to St Barnabas Hospice - Specialist Palliative Care Unit

St Barnabas Hospice (Lincolnshire) is operated by St Barnabas Hospice Trust. The service opened in 1989.

St Barnabas Hospice is a local independent charity offering palliative care to people with life limiting conditions living in Lincolnshire. The service is situated in Lincoln

The hospice has had the same registered manager in post since 2015.

We inspected the provider at short notice on Thursday 08 August May 2019.

The hospice primarily serves the communities of Lincolnshire and the local area.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and a specialist advisor with expertise in hospice care.

Information about St Barnabas Hospice - Specialist Palliative Care Unit

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St Barnabas Hospice is a Specialist Palliative Care Unit which provides a wide range of services for people who have advanced, progressive illnesses and where the focus is on palliative and end of life care. The services are provided within four settings; an in-patient unit, day therapy centres, hospice at home services and a palliative care co-ordination centre. Holistic services are delivered by a team of medical, nursing and social work staff, occupational and physiotherapists, counsellors, volunteers and chaplains.

The Inpatient Unit has eleven specialist beds and referral to this service is made by a healthcare professional such as GP's, specialist nurses, community nurses or by a local hospital. The unit comprises of a single ward with two bays of four beds each three and individual single rooms. The hospice takes both male and female patients and provides end of life care and palliative services for adults.

The hospice is registered to provide the following regulated activities:

Treatment of disease, disorder or injury (TDDI).

Before we inspected St Barnabas Hospice, we reviewed the information we held about the service. For example, the statement of purpose for the service and notifications we had received from the provider. A notification is information concerning significant events which the service is required to notify us of.

We also asked the provider to complete a Provider Information Return (PIR) before the inspection. This is a form which asks the provider to supply certain key information concerning the service, what the service does well and improvements they plan to make. We used this information to inform our planning.

During our inspection we spent time observing how staff provided care for patients so that we gained a better understanding of their how they experienced care. We spoke with six patients who used hospice services and eight family members, care givers and loved ones. We reviewed 10 patients care records which included medication administration charts. We reviewed 10 Do not resuscitate forms (DNACPR) orders

We spoke with the Chief Executive Officer for the provider organisation, the registered manager, the data protection officer, team manager and a team co-ordinator, hospice and the home from hospice nursing staff, administrative staff, two chefs, a housekeeper, three volunteers, five patients and eight relatives.

Summary of this inspection

Track record on safety 4 April 2018 to 31 March 2019

- Zero Never Events
- One serious incident (moderate harm)

One incidence of a healthcare acquired infection

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe stayed the same. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service managed patient safety incidents well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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. The service followed best practice when prescribing and giving medications and patients received the right medication at the right dose at the right time.

Are services effective?

Good

Our rating of effective stayed the same.We rated it as **Good** because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain, and supported pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles. Managers
- All those responsible for delivering care worked together as a team to benefit patients.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment.

Are services caring?

Outstanding ☆

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

- Staff cared for patients with compassion. Feedback from patients' families, loved ones and care givers, without exception confirmed that staff treated them very well and with kindness that went above and beyond. There was a strong, patient-centred culture on the unit from all staff.
- Staff were motivated and inspired to offer care for patients with kindness, compassion, dignity and respect through supportive relationships with patients and their families.
- Staff provided emotional support to patients to minimise their distress. Staff understood that patients' emotional needs were as important as their physical needs.
- Staff went the extra mile in their care and support of patients to enable dying patients' involvement at chosen celebrations and momentous occasions in their final days of life.
- Staff ensured that patients and those close to them were partners in decisions about their care and treatment. All the relatives and care givers spoke highly of the care their loved one had received and reported that had felt fully involved in all aspects of care and had also had their opinions considered.
- Patients always received a high level of emotional support to minimise their distress. Staff fully understood that patients' emotional needs were as important as their physical needs.

Summary of this inspection

Are services responsive?

Outstanding 

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

- Services were tailored to meet the needs of individual people and delivered in a way to ensure flexibility, choice and continuity of care and they coordinated care with other services and providers.
- 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.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs
- It was easy for people to give feedback and raise concerns about care received.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with all staff.

Are services well-led?

Good 

Our rating of well-led improved.We rated it as **Good** because:

- Managers had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was a systematic approach to continually improving the quality of its services and safeguarding high standards of care.
- The service was committed to improving services by learning from when things went well and when they went wrong.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The collected, analysed, managed and used information well to support all its activities.
- The service engaged with patients, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Hospice services for adults

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

Are hospice services for adults safe?

Good

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

Mandatory training

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

The service had a mandatory training and competency framework, compliance was monitored through the service's training database. All mandatory training and competencies were reviewed on a regular basis to ensure that they met current guidelines and procedures and each competency document had a review date. In key areas such as moving and handling, champions had been identified to monitor the application of training in practice.

Staff undertook annual mandatory training to ensure they remained suitably skilled to undertake their job role. Staff told us that both the mandatory training and induction were comprehensive.

All new members of staff and volunteers underwent a structured and comprehensive induction training programme appropriate to their role. This induction was also followed by all bank staff that the service used. In addition, clinical staff underwent first aid and basic life support training

The hospice specified a suitable mandatory training programme for staff and volunteers which was dependent on their role and staff were alerted when their training was due. For all staff, this included health and safety, infection control, moving and handling, confidentiality and data protection. Staff received awareness training about learning disabilities and dementia. Records we saw demonstrated that all staff were up to date with this training.

The mandatory package, training to support patients with mental health needs, dementia, autism and learning disabilities was provided.

The service set a target of 95% for mandatory training compliance. Data showed for the period April 2018 to April 2019 a mandatory compliance rate of 97%, thereby exceeding the target.

Staff had champions to develop their learning and be a point of reference for other staff. These champions included infection control and safeguarding. Champions enable nurses to undertake extended learning and access resources to cascade to other staff on the ward.

The hospice had guidelines policies and procedures that were up to date and accessible to staff on the trusts electronic intranet based on current guidance relating to end of life care. Equality and diversity training which was part of the mandatory training programme was also easily accessible

We saw records showing that fire training took place for all staff and volunteers and that fire drills took place weekly.

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.

The service had an up to date safeguarding adults and children policy which clearly identified different types of abuse including female genital mutilation and child sexual exploitation and how to recognise these. The policy contained a clear flow chart to direct staff to appropriate actions to take if abuse was suspected, with the contact numbers and addresses for the relevant agencies, including the local authority. This was available for staff to access on the hospice's intranet.

The registered manager was the service's safeguarding lead for the hospice and the hospice at home team, they had completed level three safeguarding adults training, as had other relevant key members of staff. All level three trained staff were on a safeguarding rota and available 24 hours a day, seven days a week for advice and assistance

The service safeguarding lead told us they met regularly with staff to discuss specific case studies and lessons learned. Staff confirmed that this was the case.

Staff had a good understanding of how to protect patients from abuse and could describe what

safeguarding was and the process to refer alerts. For example, one staff member told us of a referral they had made to the local safeguarding authority due to the alleged historical sexual abuse of an end of life care patient.

Data showed for the period of 2018/2019, that level one safeguarding training was at 93%, level two 98% and level three 98% against the service target of 95%.

As part of safeguarding training, all clinical staff underwent a suicide awareness course, which taught staff how to identify patients exhibiting suicidal ideation. The training included a 'Keeping Safe' care plan which was completed for the patient and formed part of the psychiatric referral

All clinical staff underwent regular group safeguarding supervision. There was also 'ad-hoc' or 'in the moment' supervision by the safeguarding lead for staff who needed to discuss any aspect of the safeguarding process that was concerning them.

The safeguarding lead at the hospice, attended regular group supervision with the safeguarding lead at the neighbouring NHS acute trust

All staff and volunteers underwent a Disclosure and Barring Service (DBS) check at the correct level for their role as part of the recruitment process.

Staff undertook chaperone training as part of their mandatory training and there were posters throughout the hospice advising how to request a chaperone.

Staff received a quarterly electronic safeguarding newsletter, which each quarter addresses different aspects of safeguarding. For example, the April newsletter discussed controlling and coercive behaviour and reviewed the five principles of The Mental Capacity Act.

The service had a training matrix for safeguarding adults and children for 2019/2020 which was aligned to the adults and children's intercollegiate documents roles and competencies for healthcare staff and a PREVENT training competency matrix mapped from the PREVENT training and competency framework 2017. Both documents showed the level of training required for each set of clinical and non-clinical staff and the timeline for training renewal.

PREVENT works to stop individuals from becoming involved or supporting terrorism or extremist activity. The PREVENT Programme is designed to safeguard people in a similar way to safeguarding processes to protect people from gang activity, drug abuse, and physical and sexual abuse

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The 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. All areas of the building were observed to be visibly clean and tidy as were the grounds and the gardens.

Patient areas we inspected were visibly clean, including the reception and waiting area. Staff were observed to be following the service's arms 'bare below the elbows' protocol. Hand gels were readily available in all areas of the hospice. There were plenty of handwashing sinks to use and lots of dispensers for aprons and various sized gloves, which were all fully stocked.

We saw staff washing their hands before providing care and treatment to patients. They had access to personal protective equipment such as gloves and aprons and were seen to be using these appropriately.

All the toilets in the unit were well stocked with soap and paper towels and were visibly clean and tidy.

There were infection control link nurses to ensure staff's knowledge and skills were kept up to date and they had access to specific guidance and support.

If a patient had an infection, or required barrier nursing, they were nursed in a side room and a notice was placed on the door. Barrier nursing occurs when a patient who has an infection is placed in a side room and extra precautions are implemented, such as staff wearing gloves, masks and plastic aprons, to prevent spread of the patient's infection to other patients and staff

We saw that all cutlery and plates used by a patient who was barrier nursed were segregated in the kitchen and washed separately in the dish washer. The catering staff wore separate gloves when handling the cutlery and plates to minimise any risks associated with cross infection

Good standards of hygiene were maintained. Housekeeping staff were clear in their responsibilities and there were procedures to reduce the risk of cross-infection.

The laundry was secure, well equipped, clean and organised. Most laundry had been contracted out and was undertaken off site, however, there were systems in place to ensure laundry undertaken on site was segregated and managed safely.

The flooring used enabled staff to carry out appropriate cleaning to maintain a suitable level of hygiene and reduce the risk of cross infection. We saw completed cleaning rotas and we observed housekeeping staff working throughout the day.

Staff used green 'I am clean' labels to identify equipment which had been cleaned and the date this was last completed.

We reviewed the Infection prevention and control annual work plan 2019/20. The work plan was reviewed on an annual basis to support the delivery of the St Barnabas Hospice three-year Infection Prevention and Control Strategy.

The purpose of the work plan was to ensure the hospice delivered a high standard of care to all patients. The work plan had several different items. For example, hand hygiene audits, review of reviews of mandatory training and policy review. The review schedule was six monthly and was up to date at the time of our inspection

The hospice used an annual clinical staff hand hygiene competency sheet for clinical staff observation and assessment.

Hand hygiene audits demonstrated for the period 2017/2018 100% compliance rate with a 98% compliance rate for the period 2018/19 against the trust target of 95%

There were effective infection prevention and control arrangements in place following death. The service had a 'care after death policy', which gave guidance regarding specific infections and how potentially infected bodies should be managed after death to minimise infection risk. This meant, patients left the hospice in a timely and dignified way and any risks of cross-infection were appropriately managed.

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 service was provided from a converted standalone large house which had been converted to a standard and design suitable for the services provided. The building was on three levels with stairs and a lift for access to all levels. All patient care was based on the ground floor, with the chapel of rest situated on the lower ground floor.

There was a reception desk and a waiting area, with comfortable seating and a room called 'The Edwards room' where there was a coffee machine and other vending machines vending light snacks. All coffee was vended free of charge by the hospice.

At the reception desk, there was an emergency call bell to notify other staff if a visitor was being aggressive or other help was needed.

The building had a fire alarm system installed and we saw from records that this and firefighting equipment was regularly maintained and replaced when necessary. We checked a sample of firefighting equipment and they were all within their next service dates.

A fire safety and evacuation procedure was displayed in reception, and staff knew the procedure to follow in the event of fire. Records showed the service had a weekly fire drill.

The inpatient unit was not locked. Visitors signed in at reception during the day or could be buzzed into the unit by staff out of hours. The hospice had an open visiting policy which meant that people could arrive at any hour. Staff checked that all visitors were appropriate before allowing them into the unit.

Medical equipment was checked and serviced in line with manufacturers' guidance. Syringe pumps were serviced annually and when needed. The service used the T34 McKinley syringe pumps for patients who required continuous infusion of medication to control their symptoms and these met the current requirements of the Medicines and Healthcare Regulatory Agency (MHRA) for end of life care patients who required continuous symptom management. This meant that patients were protected from harm when a syringe pump was used to administer a continuous infusion of medication because the syringe pumps used were tamperproof and had the recommended alarm features.

All portable electrical equipment had been serviced and tested within the last year. Daily equipment safety checks were undertaken in line with local policies. These included checks of resuscitation equipment and blood monitoring equipment.

Hoists were available for the safe moving and handling of patients. We saw that when not in use they were cleaned and stored safely. Staff told us they had a good relationship with the local equipment loan store and could access equipment quickly and easily

Rooms were accessible to staff by a secure key pad entry. For example, the rooms which held medicines and cleaning equipment were secured to prevent unauthorised entry and patient harm.

Clinical waste and domestic waste bins were emptied by the cleaning staff on the ward area and disposed of through the trusts waste disposal procedures. Staff adhered to correct principle for managing and disposing of sharps. Sharps bins were correctly assembled and were not overfilled (all bins were observed to be below three quarters filled).

The chapel of rest was visibly clean although quite dated, however, it provided facilities for

relatives such as comfortable seating and privacy. There was a 'cooling blanket' to keep the

deceased cool should there be a delay in transfer to an undertaker or if there was very hot

weather

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 regular risk assessments for patients in receipt of end of life and palliative care. We reviewed 10 sets of patient records. All included up to date care plans and risk assessments.

Staff knew how to recognise a deteriorating patient and how to escalate this. We observed nursing staff asking doctors to review a patient who had deteriorated and saw that doctors reviewed patients promptly when asked to do so.

We saw evidence of staff putting additional safety measure in place to reduce patient risk. For example, patients at risk of skin damage had access to pressure relieving equipment, and patients at risk of falls were monitored closely through a fall's prevention check. These checks were completed on a regular basis dependent on how much of a risk the patient was at falling.

We saw that all patients underwent a skin assessment within six hours of admission and a 'wound booklet' was completed by staff

The service undertook hourly intentional rounding. This is an organised process where nurses carry out regular checks with individual patients at set times. During these checks, the nurses undertake scheduled or required tasks. For example, observations of patients; addressing patients' pain, positioning and personal care needs; assessing and attending to the patient's comfort; and checking the environment for any risks to the patient's comfort or safety. Dependent on the individual patient's level of risk, these checks were conducted between one to four hourly intervals.

Physiotherapists and occupational therapists undertook full functional assessments of patients

within 48 hours of admission to the hospice to assess if patients needed any aids or

assistance with their activities of daily living.

Resuscitation processes for patients were clear for staff and training had been provided. There were ligature cutters available to staff should they need them

Social and complimentary therapy activities were risk assessed for each patient and this was noted in their care plans.

Staffing

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,

There were sufficient numbers of staff employed in appropriate roles to provide care for patients in the inpatient unit, hospice at home services and day therapy services. The roles included nursing, medical, chaplaincy and welfare specialists.

The service used a locally devised acuity tool daily to identify the staffing resources needed and the needs of patients on each day. The acuity tool into account patients need for spiritual, psychosocial and cognitive support as well as their physical care needs. We saw from rotas that the planned medical staffing skill mix matched actual staffing levels,

Staff working within all areas of the service told us staffing levels were appropriate for patient's holistic care needs and told us they had enough time to give compassionate and responsive care.

The service did not use agency staff unless in very unusual circumstances, but had a strong bank of staff, largely their own part time team who filled in as needed.

Patient care was also supported by a wider team including healthcare assistants, therapists, volunteers and domestic staff.

On call doctors were not resident, but were within a 45-minute travel period to the hospice

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.

Medical and nursing notes were stored securely, they were kept in trolleys outside the relevant bays they held information for. The trolleys were locked but readily available for staff members on the in-patient unit

We reviewed the medical and nursing notes of 10 patients who were receiving palliative or end of life care. Notes were accurate, complete, legible and up to date. We saw risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.

All the records we viewed included detailed information about the management of symptoms,

discussions and interventions.

The end of life care medical documentation contained detailed discussion and decision making with the patient and/or family and outlined the professionals involved in the care. The document also provided guidance and flowcharts for clinicians on symptom control such as management of pain, nausea, agitation and breathlessness.

Staff told us that consent was gained before any sharing of patient information, both internally and with primary care services would occur. As the hospice used electronic records, if consent was obtained, the summary of care record would be shared with the patients G.P.

The hospice had access to an electronic records system used across the community and in primary care. Staff could use this to see at a glance other providers' recent input into any patient's care had been.

Medicines

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

The service followed best practice and local policy when prescribing, dispensing, delivering and monitoring medicines given to end of life care patients which included medications used in anticipatory prescribing. Anticipatory medicines are medicines which prescribed for key symptoms associated with last days of life (for example, pain, agitation, excessive respiratory secretions, nausea and vomiting and breathlessness) and are prescribed in advance for rapid symptom relief.

Staff told us all patients who were admitted into the hospice, regardless of whether they were in the last days of life or not were prescribed anticipatory medicines as they were usually admitted for some form of pain and symptom control. Patients who were new to the in-patient unit would always be discussed with medical staff prior to administering any anticipatory medicine. We saw evidence of staff administering anticipatory medicines for a patient who was admitted for pain management.

Medicines were stored correctly. Controlled drugs were appropriately stored in line with current legislation. We saw the temperature of areas used to store medicines was recorded daily and was within safe limits. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. They are medicines that are subject to stricter legal controls to prevent them being misused, being obtained illegally or causing harm

Some patients required continuous medication administration through a syringe pump to control their symptoms. At the time of our inspection, six patients required a syringe pump. Staff were knowledgeable about syringe pumps and the medicines that were administered through them. Staff told us some patients required more than one pump due to incompatibilities between some medicines. All staff were required to undergo specific competency training for managing a syringe pump, with a duration of supervised practice prior to being able to lead on this.

Administration of medicines and intravenous fluids to patients was managed safely. All intravenous fluids, medicines and syringe drivers were checked and administered by two registered nurses.

The hospice had a detailed medicines management policy which was regularly reviewed, understood by relevant staff and specific to this service. Prescribers had access to local, regional and national prescribing guidelines relating to medicines used in the hospice.

Medicines and medicines related stationery were managed appropriately. They were ordered, transported, stored, and disposed of safely and securely. A pharmacist was employed by the hospice, and other support services and supplies were obtained through a service level agreement with the local hospital trust. There was a system in place to ensure that medicines alert or recalls were actioned appropriately.

The hospice had nurses who were non-medical prescribers and one nurse who was commencing their training. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional's field of expertise.

If day care patients wanted to self-administer their own medicines independently, they were supported to do this. A risk assessment was undertaken for all patients who wanted to self-administer.

Disposal of medicines was managed safely. All medicines were kept for seven days after death and then disposed of by the pharmacist. Controlled drugs were neutralised correctly before disposal. Destruction records were well maintained.

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.

Systems were in place to monitor and manage accidents and incidents to maintain patients safety. Staff were aware of the process to report any incidents and accidents and all were recorded.

The hospice incident management policy was in date. The policy gave clear guidelines about the

process for reporting and categorising incidents and encouraged an open culture of incident reporting.

Staff reported incidents through the hospice electronic reporting system. Nursing and medical staff understood their responsibilities to raise concerns and report incidents and near misses.

Managers investigated incidents and shared lessons learned with the whole team and the wider service at regular team meetings, electronic communications and training sessions. When things went wrong, staff apologised and gave patients honest information and suitable support. The registered manager audited incidents and accidents to analyse any trends or to identify where improvements could be made to minimise their reoccurrence.

Managers ensured that actions from patient safety alerts were implemented and monitored.

For example, significant improvements were made to reduce risks, incidents and accidents relating to a serious incident the hospice had during the past 12 months. A small oxygen flash fire incident occurred at the hospice due to a patient's visitor smoking. This incident was investigated using root cause analyses and changes made, which included no smoking by patients' relatives and friends anywhere in the hospice. No smoking signs were also placed in and around the hospice and the no smoking policy and procedure reviewed.

The hospice had never reported any never events. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The hospice had a pressure ulcer prevention policy and procedure, which was mapped to the new NHS improvement revised definitions NHS improvement pressure ulcers revised definition and measurement June 2018.The hospice had a team of tissue viability link nurses and had recently seconded a specialist nurse to deliver training and support best practice.

Staff had a clear understanding of the duty of candour. 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. The hospice had applied duty of candour to the incident that occurred in the past 12 months

The hospice had a comprehensive policy and procedure to support the duty of candour. In addition, the director of patient care and governance lead had undertaken training to support effective management of this process.

To ensure staff were informed of their organisational and professional responsibilities the 2019/2020 mandatory training programme included a refresher session on the principles of duty of candour

To support patients and families with this process the hospice had a supporting leaflet to provide information on the process and legislation.

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 services based on national guidance

The service provided care and treatment based on national guidance and evidence of its effectiveness. The hospice completed a range of audits, including audits of medicines management, patient safety, infection prevention controls, National Institute for Health and Care Excellence (NICE) guidance and symptom control. All the on-going work and updates were fed back to the clinical governance meeting. Audit results were shared

with staff by email and at team meetings. Recommendations from the audits were incorporated into the action plan and monitored through the clinical governance monthly team meeting.

Policies and procedures were readily available for all staff. Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. The documents contained flow charts and contact details of relevant agencies, as well as clear guidance for staff. We reviewed eight policies and found them to all be current and in date. In 2014, The Department of Health launched a new approach to the care of people who were dying based on the needs and wishes of the person and those close to them. Five New Priorities for Care replaced the Liverpool Care Pathway creating the basis for caring for someone at the end of their life. During our inspection, we reviewed patient records and the five priorities of care. We found that all five priorities (recognition of dying, sensitive and effective communication, involvement in decisions, emotional needs being met and individualised care plans) had been addressed and met. We also saw that patients had a clear personalised care plan that reflected their needs and was up to date.

In 2018, the service had introduced the use of the Recommended Summary Plan for Emergency Care and Treatment process (ReSPECT) for every patient. ReSPECT is a process that creates personalised recommendations for a patient's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. The plan is created through conversations between a person and their health professionals. The plan is recorded on a form and included in their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome they would want, that would not help, or that they would not want. If a patient has a do not resuscitate order, this is also included as part of ReSPECT

The hospice had devised a ReSPECT video to support training, raising awareness and developing staff confidence to the process

Nutrition and hydration

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

The hospice had a suitably equipped kitchen. The head chef visited patient's twice a day to ask about their meal choices.

The kitchen had provisions for patients who did not want regular meals or who did not want to eat at set times. Staff told us they always kept a selection of sandwiches, soups and cereals for patients and they would always try to ensure whatever patients wanted for their meals, this was provided. One catering staff member told us how they had gone to the local fish and chip shop to buy fish and chips for a patient who specifically wanted that as their dinner choice

Patients had access to a coffee area within the Edwards room which also stocked items which they could snack on.

Staff were aware of allergies and intolerances, and there was a board in the kitchen which staff recorded any specific dietary information.

Protected meals times were in place. We observed that patients had access to drinks, which were within their reach. All the care records we reviewed, showed staff had supported and advised patients who were identified as being at nutritional risk. Where patients were unable to eat due to their ill health, we saw that care plans were in place for staff to monitor their food and nutrition.

We saw the malnutrition universal screening tool (MUST) being used in addition to the national screening tool. This is a universal five-step tool to identify adults who are malnourished, at risk of malnutrition or obese. It also included management guidelines, which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

We saw as part of the nurses intentional rounding, they regularly offered patients drinks and asked if they wanted anything to eat.

Relatives told us the nurses were regularly asking them if they would like a drink or a snack and that the food was very good and that there were plenty of drinks available.

One patient told us when they were admitted to the hospice they had not eaten in seven days as they had no appetite, however, the food was so delicious and so well presented at the hospice they had been eating very well which they never thought they would do again.

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.

We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality

Standard CG140. This quality standard defines clinical best practice in the safe and effective

prescribing of strong opioids for pain in palliative care of adults.

Staff assessed and monitored patients regularly to see if they were in pain. They supported those

unable to communicate using a 'This is how I feel' pictorial assessment tool and gave additional pain relief to ease pain as required.

We saw evidence of patients regularly being assessed for pain and given medication in a timely

manner. For example, a patient on the ward we inspected, had

undergone an assessment of their pain level which resulted in having their medication changed to

control this.

We saw patients had been prescribed pain relief medication as and when required (PRN) so

that breakthrough pain could be managed. Breakthrough pain can occur in between regular

planned pain relief. Staff confirmed syringe pumps were accessible if a patient was receiving end

of life care and required subcutaneous medication for pain relief.

Patients told us staff had discussed pain relief with them and they understood what they were

taking and the effect the medicine would have.

If day patients wanted to self-administer their medicines, there was a risk assessment process to allow them to do this safely and effectively.

Patient outcomes

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

The hospice had processes aimed at identifying how well it met patient's needs, and the scope of the services provided. The hospice was monitored through team dashboards and had an audit schedule for clinical services which was reviewed at the monthly clinical governance meeting. The audit schedule covered a number of subjects, for example a documentation audits, the management of blood transfusions and management of waste audit

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. These surveys and audits were analysed, and changes and improvements were made as a result. For example, the vending of coffee in the Edwards room was changed to a no charge service, due to previous patient survey feedback.

Patients were admitted to hospice services with a diverse range of life limiting illnesses of both cancer and on-cancer related illnesses

Data showed the cancer to non-cancer ratio of treatment for the period April to – September 2019 was 31% non-cancer and 69% cancer diagnosis. For the same six -month period in 2018 the split was cancer 73% and non-cancer 27%.

Patients and families completed a discharge questionnaire for comments. Staff sent out questionnaires upon discharge. All questionnaires were returned to the quality and audit manager who compiled a report based on feedback for learning purposes

The latest friends and family test showed that 93% of patients would be likely to recommend the hospice service to a friend with 7% stating they would be extremely likely to do so. The friends and family test was displayed on the ward

All of the patients had an individualised care plan in place as part of their ReSPECT treatment plan that set out their advanced care preferences. It covered activities of daily living, family and care giver support, infection control, mental capacity, tissue viability, advance care planning and symptom management. There was provision for recording preferred place of care and death within the treatment plan. The plans were regularly reviewed and audited. Data showed for 2019 that in April 93.2% May 92% and June 93.3% of patients both in the in-patient unit and cared for in the community achieved their preferred place of care and death

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.

The hospice had a mandatory training programme and in addition to this there was a clinical training and competency framework for all clinical staff.

Staff told us they could access a variety of training relevant to their role. Volunteers recruited to the hospice undertook the mandatory training and induction programme within the hospice

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 monitor the effectiveness of the service.

Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. All qualified nursing, medical and health care support workers we spoke with confirmed they had received a meaningful appraisal within the past year.

All staff told us they felt very well supported and competent to fulfil their role.

Data showed that in the past 12 months, 87% of nurses had received their appraisal, against the hospice target of 95%. With 100% of both allied health and 100% medical staff receiving their appraisal during the same period.

All clinical staff received re-validation reminders 12 weeks in advance, data showed that for the period April 2018 to April 2019 100% of staff had revalidated their registration as needed.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients.

All members of the multidisciplinary team worked and interacted well with each other to enable a coordinated approach to the way in which care was delivered. We saw evidence of regular input from the dietitian, occupational therapist, physiotherapist, and social worker involved in the care and treatment of end of life and palliative care patients. Staff and volunteers worked closely and effectively together with a culture of respect for each other's roles.

Staff also worked in partnership with external providers of end of life care in assessing, planning and delivering care and treatment. This included GP's, primary care nursing teams, allied health professionals, social care providers, secondary care and other voluntary sector workers. All relevant teams, services and organisations were informed in writing, over the telephone or by email if people were discharged from the service. Discharges were undertaken at an appropriate time of day and only done when any necessary ongoing care is in place. We saw these recorded in-patient records, in discussions with staff and those who used the service.

All referrals were discussed at the twice daily triage meetings, Monday – Friday, at 9am and 2pm, after which, the referrer would be contacted. Admissions took place to the hospice Monday to Friday preferably be before 2.30pm each day

Outstanding ☆

Hospice services for adults

The hospice was using The Electronic Palliative Care Coordination Systems (EPaCCS). This is

an electronic computerised information system regarding patients who were known to be dying

that could be accessed by all staff.

In accordance with the Gold Standards Framework, MDT meetings took place weekly to ensure any changes to patients needs could be addressed promptly.

The Gold Standards Framework (GSF) is a framework used by many GP practices, care homes, hospices and hospitals to enable earlier recognition of patients with life-limiting conditions, helping them to plan ahead to live as well as possible right to the end

Board rounds took place on the ward daily where patients who required a fast track or rapid discharge pathway were discussed.

Nursing staff had a daily 10 at two meeting, to identify any patient issues that had arisen since the nursing handover or any other aspects which needed attention.

Health promotion

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

Staff supported patients who were end of life or palliative to maintain healthy choices and healthy lifestyles. Patients were given advice on how they could be involved in monitoring their own health and wellbeing to maximise their independence and comfort.

A healthy diet was promoted, and wellbeing sessions were part of the provision including various forms of relaxation and alternative therapies.

Leaflets were available in the hospice on subjects such as living positively with cancer and managing breathlessness.

As well as supporting patients the hospice worked to identify the needs of families and care givers and part of this was to ensure they were supported to remain healthy.

Consent and Mental Capacity Act

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

Relatives and patients, we spoke with told us staff did not provide any care without first asking their permission. We looked at 10 set of patient care records and saw consent was appropriately obtained and, consent forms had been signed.

Mental capacity assessments were included as part of the ReSPECT paperwork. The Mental Capacity Act (2005) is legislation designed to protect patients who may lack capacity to make certain decisions about their care and treatment. The Mental Capacity Act (2005) allows a certain level of restraint and restriction to be used if they are in a person's best interest. Deprivation of Liberty Safeguards (DoLS), are needed if the restriction and restraint used will deprive a person of their liberty. Staff we spoke with could describe the process of assessing capacity and the requirements for obtaining consent if the patient was assessed as lacking capacity.

During our inspection, we looked at 10 'Do Not Attempt Cardio Pulmonary Resuscitation'

(DNACPR) orders (ReSPECT forms) and found that all 10 were completed correctly

Staff understood how and when to assess whether a patient had capacity to make decisions about their care and treatment. They followed the policy and procedure when a patient was unable to give informed consent.

We reviewed three sets of patient records and saw that in all three mental capacity assessments had been carried out appropriately.

Are hospice services for adults caring?

Outstanding ☆

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

Compassionate care

Patients were at the centre of everything the staff and hospice did. Patients were cared for with total

compassion. Feedback from patients confirmed that staff treated them well and with kindness and went above and beyond. There was a strong, patient-centred culture on from all levels of staff.

Throughout our inspection and without exception we observed that patients and families were at the heart of everything staff did. Staff responded compassionately when patients or their relatives and loved ones needed help. Support was always given by caring staff, to meet the needs of the patients and their families and feedback from people who used the service was continually positive about the way staff treated them. Staff identified patients who needed extra support and discussed changes to patients' care and treatment with patients, their families and their care givers.

The service provided support to families and care givers to maintain their own health and wellbeing. We spoke with patients and relatives in the hospice and observed their care and treatment

There was a strong, patient-centred culture from all staff. Staff were motivated and inspired to offer care for patients with kindness, compassion, dignity and respect through supportive relationships with patients and their families, care givers and loved ones.

We observed all staff members speaking to patients and their relatives and care givers with compassion and we observed sensitivity being shown during those conversations.

We heard patients being offered food and drinks in an encouraging and caring way and observed staff and volunteers to always be doing as much as they could to help patients.

One of the patients told us, "The staff are all fantastic". another patient told us. "I simply cannot fault them". Another patient told us, "The care here is second to none"

All the staff at the hospice were passionate about delivering compassionate care, with the patient at the centre of everything they did, and they went above and beyond the call of duty to achieve this. We were told about how a patients last wish was to see their horse, and how the hospice had arranged for a horsebox to bring the horse to the hospice and the patient was taken outside on their bed to say their last goodbye.

Another patient had been encouraged to bring their dogs to come and stay with them and another patient had their cat brought in from home, who would sleep on the end of their bed.

Staff did all they could to facilitate any requests from takeaway pizza to a gin and tonic or a sherry before dinner.

The hospice had a dedicated well-being team which provided spiritual care and counselling support for patients and families which extended after death.

Emotional support

Staff provided a high level of emotional support to patients, families and care givers to minimise their distress. They understood patients' personal, cultural, physical and religious needs.

Patients who used services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. For example, beds could be ordered for couples wanting to be together and one of the larger rooms was sufficient in size to allow families to remain together, in the privacy of the one room for an extended amount of time

Staff empowered patients who used the service to actively contribute to it, to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. Patients individual preferences and needs were always reflected in how care was delivered. For example, staff told us about a patient who was approaching their last days of life and who had previously lived mainly outside in the rural community. As the weather was mild, the patient had requested to have their last days of life nursed on a bed outside. The hospice arranged for their bed to be placed outside in the hospice grounds and all care was delivered as per the patients request.

The service recognised that people needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. For example, through the service's collaborative working with other services and professionals, patients only had to tell

'their story' once. This meant individualised care, which was easily accessed and coordinated, and helped improve symptom management

The service provided person centred care with patients placed at the heart of the service at all times. Patients were given every opportunity to express their views and be involved in making decisions about their care.

Staff understood that patients' emotional needs were as important as their physical needs. Feedback from patients about how they were cared for was consistently positive. Staff showed a profound awareness of the emotional impact of conditions on patients and took account of this during assessments.

Patients told us they had opportunities to discuss any bad news with staff and they were given appropriate support when receiving bad news. Patients told us that staff provided comfort when they were upset and often sat with them talking and holding their hand when they were distressed

We saw all staff offering encouragement to patients in a reassuring manner, to alleviate anxiety. All discussions concerning aspects of patient care involved family members opinions being heard and valued

Staff welcomed relatives and friends to visit, as this provided the patient with emotional support. The hospice had an open visiting policy, so relatives and loved ones could spend time with the patient.

Understanding and involvement of patients and those close to them

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

Patients and those close to them were partners in decisions about their care and treatment. Relatives and care givers unanimously spoke highly of the care their loved one had received and reported they had felt fully involved in all aspects of care and had also had their opinions considered.

Staff were always aware of patients who were end of life or in need of palliative care and were reliant on having their relatives and loved ones close to them, and how involved the families and friends of patients when planning and providing care. They ensured that those close to the patients were present when advising of any updates to the patient.

All the staff we spoke with showed an awareness of the importance of treating patients and them

representatives in a sensitive manner.

We saw staff discuss care issues with patients and relatives where possible and these were

clearly documented in patient's notes. An example of this was when we saw a doctor

explain to a patient and their relatives some of the side effects of their medication. This was done

concisely and in plain English.

We saw evidence in patient care records that relatives were involved decisions about patients' care and treatment and in developing their care plans. Relatives told us that staff answered questions about care and treatment openly and in plain English.

Consideration of patient privacy and dignity was consistently embedded in everything the staff did and staff ensured that sensitive communication took place between staff and the dying person in an atmosphere of dignity and respect.

All the patients and relatives we spoke with told us their privacy and dignity was always maintained by staff. We observed, staff speaking in hushed tones near sleeping patients, using eye contact and where the curtains were drawn around the bed, asking if it was OK to enter.

Documentation showed that privacy and dignity was referenced in key policies for example care after death, and urinary catheterisation

Relatives and patients told us that nothing was too much trouble for staff, they took time to listen and would go that 'extra mile' to ensure they were cared for and that whatever they needed was provided. Patients told us, they felt they really mattered to staff, with one patient telling us, they felt 'like family'

Outstanding ☆

Hospice services for adults

The hospice, which offered a range of emotional, practical and psychological support to patients and their families and loved ones affected by a life limiting illness. The family support team was based at the hospice and allowed relatives to be involved in the patient's journey.

The service also provided a comprehensive information pack for patient's relatives and friends,

this included a care givers support assessment which contained several questions designed to assess whether the patient's care giver may need help with and to ascertain how much they wanted to be involved, with the patients consent

We saw evidence in patient records that care plans were developed collaboratively with patients and families. Relatives were encouraged to help with the nutritional needs of their loved one at mealtimes if this was appropriate, and could bring in special foods, treats or alcohol for patients.

Patients were encouraged where appropriate to dress in their day clothes and to take part in the activities provided by the in-patient unit

Are hospice services for adults responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

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

Service delivery to meet the needs of local people

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

The hospice is situated near the centre of Lincoln and easily accessible by car with a major bus route nearby. There was a small car park at the front and the side of the hospice, where all visitors to the hospice could park for free

The entrance to the hospice was through automatic glass doors, making it accessible for those people with prams or wheelchairs.

On entering the hospice, there was a room called the Edwards room, which provided drinks and snacks. There was a family room with comfortable seating and a chapel of rest available should relatives wish to visit their loved one between them leaving the ward and transferring to the undertakers.

The hospice ran several events throughout the year from raffles, to themed events that everyone in the community could attend. The hospice website under the event section had the message "there for the whole family"

Special remembrance days were well attended by local people, thereby strengthening the relationship between the hospice and the local community.

The garden and lawn areas were well kept, thereby offering patients and their relatives or care givers the opportunity to sit in the garden, with many of the rooms having views across the gardens and the grounds.

The services provided by the hospice reflected the needs of the population they served, and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered. There was one ward with two bays of four beds and three specialist single side rooms. All the single rooms were spacious enough to accommodate a put-up bed. A separate family suite that could accommodate two families was available for overnight stay or for as long as the family required it. There was a basic kitchen as part of the family unit. The family unit was free of charge

People's individual needs and preferences are central to the delivery of tailored services.

There are innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. For example, at the time of our inspection, the hospice was delivering two projects to reach out to the homeless community and to a local prison, offering bereavement and support care sessions to both communities. The projects included education to

support staff to provide palliative care to those who do not normally have access hospice care counselling and provide bereavement counselling to the inmates of a local prison

The homeless project commenced in April of 2019 and at the time of our inspection, had received referrals for fifteen people in Lincoln. Each bereavement support session is for approximately one hour. The team provide a specialist bereavement counselling service for the homeless community in Lincoln.

At a local prison, the bereavement support team have supported 35 people since June 2018. Each one to one session is for one hour. The team spend one day in the prison each week and provide seven bereavement support sessions. An average of seven sessions is provided to each client.

In addition, thirteen peer listeners, which are prisoners, have been trained by the hospice wellbeing team in models of grief and loss, coping strategies and advanced listening skills.

As a result of the work by the hospice with the prison, a two weekly bereavement group which focusses on the impact of coping with loss and grief within a prison has recently commenced.

Data showed the hospice wellbeing team have supported thirteen prisoners to date through the group. During 2018 a prisoner attended the hospice board meeting to share their experiences of support and care from the wellbeing team.

The Hospice hosts the PCCC (palliative care coordination centre) a commissioned service, with a single point of access to Hospice services.

The PCCC was available to health professionals, patients, their families and care givers who need advice and support regarding palliative and or end-of-life care.

The PCCC facilitated referrals, organised care packages and worked in partnership with the clinical teams and the wider health community to enable care delivery within that community.

The PCCC is open 365 days a year, operating from 9am to 6pm Monday to Friday and 9am to 5pm on Weekends and Bank Holidays. Calls are initially taken by the administration team who forward the referral to the relevant area however, the team is overseen by a registered nurse at all times.

The PCCC used a 'responsive needs tool', to triage all calls. This was a numeric and four level

assessment tool, level one being the lowest with score range from one to 20 up to level four, the

most serious level and a score range 31 to 44 where the patient's condition is deteriorating rapidly

towards the end of their life. The responsive needs tool was devised by the hospice and, supports timely referral to the correct clinical service. The tool is currently used widely within Lincolnshire wide and is incorporated into the template of the palliative care electronic communication system used by both the acute and community health services.

We sat in with one of the administration team members at the PCCC and observed them take three different phone calls. All of the calls were answered promptly, triaged appropriately and the team member undertook the appropriate referrals and made follow up phone calls.

The hospice had developed a 'create a cuddle bear' for patients and their families to make in the hospice. They were given all the materials to make a teddy bear together. The patient could then take the bear home when discharged from the hospice to keep and give cuddles to

Meeting people's individual needs

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

The service took account of patients' individual needs and placed high importance on spiritual care which was provided by the spiritual care champions, volunteers by visiting ministers of different faiths. Patient's pets were also actively encouraged to visit.

Care plans were person-centred and signed by the patient and their main care giver. We reviewed 10 care plans and saw that services were coordinated with other

agencies to provide care to patients with more complex needs. For example, we saw evidence that the local psychiatric team had assessed a patient. The assessment and mental health care plan were clearly documented in the patient care record along with evidence of staff following the care.

The hospice had policies to ensure the services offered did not discriminate against people on the basis of protected characteristics and was able to support people with various faith needs. For example, there was a very small chapel in the hospice, which could be adapted to accommodate various religious, or non-religious ceremonies.

The hospice recognised, respected and supported individual's rights to make decisions about themselves. For example, they facilitated patients' smoking in an area of the garden which was not to the detriment of other patients and staff.

The hospice attempted to meet the needs of different patient groups in a number of different ways, for example, there was a disabled access to the building, we saw signage appropriate for people living with dementia to support inclusivity. The hospice had access to a translation service to meet the needs of those whose first language was not English. Information leaflets could be adapted to braille and other languages and formats as required.

The hospice had access to bariatric equipment for example air mattresses, bed frames commodes, cushions and chairs. These could be accessed within four hours from a local direct healthcare provider.

Patients could access a range of therapies, including complementary therapies. There was also day therapy which offered to a range of clinical, emotional and spiritual support services in a friendly and relaxed atmosphere. Day therapy was attended by nurses, occupational therapists, physiotherapists, health and rehabilitation support workers, chaplains and volunteers.

People who used the hospice services were supported to develop and engage in meaningful social activities and interests of their choice. The hospice day therapy centre co-ordinated an activity programme and many of the activities were supported by occupational and physiotherapy services and volunteers. Activities relating to well-being were offered such as Tai Chi, Reiki, reflexology, therapy dogs and mindfulness sessions. Other activities such as art therapy, knit and natter groups, flower arranging and craft groups were also provided.

The hospice had regular visits from Pets as therapy dogs (PAT) to support patients. On the staff notice board the hospice had a picture of all the staff members with their names and designations, including a picture of a ginger cat with a white coat and a stethoscope superimposed over the top of him. His name underneath said 'Oliver Hospice cat (locum). Staff told us Oliver lived nearby and regularly visited to undertake his cat duties with regard to emotional support for both patients and staff.

Care after death was managed sensitively and, in a way, which respected the wishes of families while following the appropriate process. For example, relatives wishing to view their deceased loved one could stay with them for an extended amount of time. The hospice had a cooling machine to facilitate this for the deceased. The hospice always placed a posy of flowers beside the deceased who was due to have a viewing.

Families were asked what they wanted to follow the death of a loved one as part of the advanced care planning. We also saw evidence that staff took account of patients' spiritual needs within end of life care plans. We saw staff supported bereaved families with practical arrangements such as liaising with funeral directors and registering deaths.

Staff encouraged patients to maintain relationships with people that were close to them. We saw evidence of discussion at handover of staff liaising with relatives and friends of patients to ensure they could do activities together such as attending bingo.

There were numerous leaflets and practical help guides available for patients and their families. These included subjects such as what to say to someone who is dying and how to support relatives who have suffered a bereavement. Each leaflet contained details of useful contacts.

The hospice had signed up to the 'Dying to talk' campaign which is a discussion that guides people through talking with their loved ones.

The hospice had an equality and diversity inclusion and human rights policy which included the privacy

and dignity expectations of staff, for example encouraging practices that took into account the rights of individuals to be treated with dignity and respect. The hospice was committed to meeting the individual needs of its patients in respect of cultural, religious, non-religious needs and equality and diversity.

The hospice was working with Lincolnshire learning disabilities team to raise awareness of the specific needs of individuals with a learning disability and autism.

The Hospice worked actively with the Lincolnshire lesbian, gay, bisexual, transgender, questioning (LGBTQ) network. The hospice nurse consultant was the Lincolnshire LBGTQ "visible ally" and attended the Lincolnshire LBGTQ conference which supported the hospice to develop their equality diversity and inclusion forum. The Hospice chief executive officer is an equality diversity and Inclusion champion for Lincolnshire.

The Hospice was working with the Charity "Enlighten" to develop a train the trainer package to enable champions to strengthen the equality, diversity and inclusion education offer within St Barnabas Hospice, this will also be delivered to the trustees, and executive teams

At the time of our inspection, the hospice was working with care homes to support equitable access to palliative and end of life care by upskilling the staff through the use of technology. The purpose is that this will establish a community of knowledge and learning and address any health unmet need.

To meet the needs of those with dementia at end of life, the trust was supporting a countywide Admiral Nursing development. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia. The project was not exclusively for people using hospice services but is intended to reach the wider community through neighbourhood team working.

The hospice had a number of memory boxes. All were made up individually with families to remember their loved ones and contained items special to the deceased including letters, photographs and whatever else was a special memory

Access to the right care at the right time

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.

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

The service had an admission policy. This was in line with other hospice care providers in the area and met the needs of local people with life-limiting illness.

Patients accessed the service through self-referral, families or professionals. The palliative care coordination centre (PCCC) was the hub of the service and where all referrals are received, care packages organised and partnership working with the clinical teams and the wider health community undertaken to enable a responsive care delivery.

All referrals to the hospice were triaged by a clinician at the PCCC from the information provided to identify the most appropriate service to support the patient and family and the level of urgency.

Telephone contact was made with the patient or their care givers as soon as possible after referral to arrange first appointment or visit, and to seek further information if required, to support effective triage. Contact was maintained with the patient or their care giver until their first appointment or visit if this was not within 24 hours.

Data showed that for the period April 2018 to March 2019 the PCCC received 25,344 phone calls from both professionals and members of the public

Arrangements to admit and treat patients were in line with good practice. The twice daily triage meeting managed access and flow. The multi-professional team assessed all the referrals, advice line calls, and waiting lists. The hospice had a clear admissions criterion in place and all referrals were assessed against this as far as possible, patients were admitted to the hospice before 2.30pm. Admissions were arranged for the patients identified as most in need, using the scoring system on the responsive needs tool. If patients were appropriate for admission but could not be allocated a bed they were

placed on the waiting list until a bed become available. If the patients were in their own homes, then the inpatient unit would liaise daily with the referrer and the community teams to optimise the interim support.

For the hospice at home community services. All referrals were triaged by a clinician from the information provided to identify the most appropriate service to support the patient and family and the level of urgency. Telephone contact was made with the patient or their care givers as soon as possible after referral to arrange first appointment or visit.

The Hospice had developed a triage tool to support multidisciplinary team working. Contact was maintained with the patient or their care giver until their first appointment or visit if this was not within the following 24 hours. The tool was in the process of being embedded extensively across Hospice Services during 2019 as part of the integration work to ensure patients have access to the right clinician at the right time from the point of referral.

For all services, where referrals were received late and patients died before the first visit or appointment, a report was submitted and investigated, to identify any learning for triage processes or to escalate late referral patterns. The service had 214 admissions to the in-patient unit in the past 12 months

At the time of our inspection, teleconference facilities were being made available by the hospice to support maximum access to a specialist MDT for professionals

Data showed the average wait time for a bed on inpatient unit for the period of April to September 2019 was one day.

The registered manager told us the hospice often received late or untimely referrals which impacted on patient access and choice of care. In response to this, the lead nurse was working with senior clinical managers and key individuals externally to identify the cause, with the service being committed to implementing measures to promote earlier recognition and best use of hospice services.

People with a range of disabilities could access and use services on an equal basis to others. There was wheelchair and access to those with disabilities, including those with sight and hearing loss.

The estates strategy was undertaking a full review of hospice premises with a view to a significant upgrade of the inpatient unit to reflect and be responsive to the needs of the services users.

Documentation showed the service had been instrumental in the implementation of ReSPECT process across Lincolnshire, championed by the consultant physicians, this included a training podcast for the entire health community.

The service was working with local nursing homes to support equitable access to palliative and end of life care and to support upskill the nursing home staff

Spiritual and person-centred care was integral to the care, including care after death. Staff worked closely with families and faith leaders to ensure individual beliefs and wishes were met.

The hospice had an urgent counselling referral pathway for both patients and relatives. The response time from the counselling team was 24 hours, however staff told us they had never known anyone who had been referred for urgent counselling wait for longer than 12 hours

For all services, where referrals were received late and patients die before the first visit or appointment, an incident report was raised and investigated to identify any learning for triage processes or to escalate late referral themes.

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**.**

Complaints recognition was part of staff mandatory training. Staff told us the session included active listening, the importance of taking concerns seriously and the escalation process.

We reviewed the complaints policy and saw it was relevant, up-to-date and clearly outlined the complaints process and steps people could take if unhappy with the outcome of a complaint.

Hospice services for adults

We saw posters and information booklets on how to make a complaint were displayed around the unit. Patients and relatives, we spoke with told us they knew how to make a complaint and would be confident to do so if necessary.

Staff understood the complaints system and had access to policy and procedures on the staff intranet.

The trust received 27 complaints between April 2018 and March 2019. Out of the 27 complaints received 21, were upheld. The target for resolving complaints was 14 days and all 21 complaints were resolved within the set timescale.

None of the complaints were concerning the hospice in-patient unit or the hospice at home team, but concerned the other services the trust provided, for example the retail outlets. For the same timeframe, the service received 520 compliments. The common theme from compliments was the acknowledgement that the services provided by the hospice were consistently compassionate, caring and effective.

All concerns and complaints were collated by the governance team to identify any themes or trends. Staff told us that at team meetings learning from complaints was undertaken and implemented accordingly, however, none of the staff with could remember a recent complaint.

Are hospice services for adults well-led?

Good

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

Leadership

Managers had the right skills and abilities to run a service providing high-quality sustainable care.

The leadership structure within the organisation was clear and staff were aware of who they reported to. Staff were familiar with the organisation's strategy, vision and values and were provided with the opportunity to be involved in the development of these.

There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

All leaders had a clear understanding of the challenges to quality and sustainability of the service. They could identify actions to address these such as investing in staff pay, terms and conditions.

The executive team ensured there were comprehensive and successful leadership strategies in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.

The executive team and trustees undertook a plan of quality and safety walkabouts to provide an opportunity for staff feedback and to provide an assessment of the quality of the services and premises. Communication between the senior leadership team and staff was further enabled through well-established manager and staff forums.

There was a clear commitment to the development of leadership at all levels, thereby recognising the importance of developing the rights skills, behaviours and values that are central in developing compassionate collaborate high performance. Anonymous feedback to the leadership team was available to staff via regular surveys. One staff member told us they had fed back this way about an issue which was later remedied.

Community staff told us they felt connected to other teams within their service and to the organisation through regular meetings, staff events and feedback opportunities

Staff told us that leaders were visible and approachable. All staff told us leaders were accessible and responsive. Staff at all levels told us they felt valued and could openly discuss issues or concerns

The service operated a recognition scheme which encouraged staff to nominate individuals, colleagues or teams to be rewarded for work that has been "above and beyond". The nominations were linked to the organisational values, resulting in an annual staff awards presentation evening.

Hospice services for adults

The hospice recognised that a highly effective board was one of the fundamental drivers of organisational performance, and the leadership team were committed to that.

The hospice planned to undertake a review of Board development during 2019.

Vision and strategy

The hospice had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and other stakeholders.

Organisational strategies were in place to guide each directorate in the delivery of innovation, evidence based best practice and research. In addition, the strategies supported sustainability and drive improvement.

The strategy was fully aligned with plans in the wider health economy and the vision and strategy provided the foundation of the organisations strategic direction and guidance for delivering their goals. These goals were developed by staff, patients and people in the local community. This meant there was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

The hospice had recently been involved within the Lincolnshire sustainability and transformation partnership (STP) and was supporting key work streams within that

At the time of our inspection, a core standards behaviour framework was being developed to support staff and managers to fulfil respective roles and support improved working practices, culture and relationships, in order to enhance job satisfaction and underpin the vision and values of the organisation.

The leadership team were well-respected by staff for their collaborative working and influence to improve patient care outcomes within Lincolnshire. Staff and volunteer development were also highly valued.

There was systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The culture within the organisation was completely focussed on the needs of patients, their care givers, families and loved ones. This shared vision was demonstrated in the caring and compassionate way that care was delivered. Individual staff reported that they were respected and valued and there were no negative comments about their experiences working or volunteering for the service.

Staff felt supported, respected, valued positive and proud to work in the organisation. Staff told us they felt pride in the work they carried out to ensure patients received good quality care.

Staff at all levels received regular meaningful appraisals, which provided them with development and career opportunities as well as their own wellbeing and safety was supported.

Staff told us they 'wouldn't work anywhere else' and were proud to support the people who used services.

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 community and inpatient staff, meaning that patients received a seamless service.

Staff had access to occupational health for emotional support when necessary and there were mental health first aiders to support staff with any mental health issues they may experience

The service had a whistleblowing policy which was available to all staff and information on how to raise whistleblowing concerns formed part of mandatory training. Staff we spoke to knew how to raise concerns.

The caring ethos and philosophy of the hospice extended to staff well-being. Staff were supported where necessary to cope with difficult working situations. Regular de-briefs were held to enable staff to reflect and discuss what went well and what they do differently. Counselling opportunities, and access to complementary therapies and employee assistance services were provided to support staff. All staff, without exception told us how much they enjoyed their work at the hospice.

All senior staff were knowledgeable about the duty of candour, there was a standard operating procedure that provided guidance to the requirements of duty of candour. The complaints policy and procedure had clear guidelines on duty of candour for all staff to follow.

Governance

There was a systematic approach to continually improving the quality of its services and safeguarding high standards.

The service had managers at all levels with the right skills and abilities to run a service which provided high quality sustainable care. The senior management team met regularly with the board of trustees.

There were clear lines of governance and accountability from the board of trustees through sub-committees to the chief executive, senior managers and to all staff. Staff were clear about their roles and responsibilities. Staff knew what they were accountable for and who they reported to.

All levels of governance and management performed effectively and interacted with each other appropriately. The leadership team attended governance meetings and information was fed in to local teams at team meetings, in the form of minutes and emails.

Each part of the service had a clear structure for day to day management with service co-ordinators or unit managers leading teams. The management structures were supported by other roles such as senior nurses, clinical nurse specialists and a clinical governance nurse.

Staff told us that the management structures supported their day to day work and personal development. They said they felt very well supported by all of the managers and found them to be open and approachable. Staff told us they were kept up to date with organisational issues and improvements.

There was a comprehensive portfolio of policies and procedures available to all staff. The polices were in appropriate detail for the services provided and they were regularly reviewed and updated to a schedule.

A programme of service audits was set out every year which covered areas such as infection control arrangements, accidents and incidents, medicines arrangements and the effectiveness of clinical supervision. The provider organisation held a regular clinical governance meeting where the outcomes of audits were reviewed. This meant they were able to monitor what improvements were needed and how they were implemented.

The service had a trust quality improvement and research committee which met quarterly to monitor the trust programme of audit and service evaluations. Action plans were reviewed to ensure that they were on schedule and any quality improvement measures identified are implemented into practice within potential re-audit planned to ensured improvements had been sustained.

The audit programme was also monitored through clinical governance committee and patient care committee to further assure any quality improvement measures had been effectively embedded in practice, and meaningful change has positively impacted on care and or service delivery.

Governance arrangements throughout the trust had effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services, these were regularly reviewed and improved accordingly

Managing risks, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had a comprehensive risk management system with a schedule of when risk assessments needed to be repeated and this was adhered to. Summaries of audits were reported in the service's annual report to the trustees.

Fundamental risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities and these were discussed at trustee level.

Senior leaders and managers had a good awareness of risks and performance issues and had identified and carried out action to address this. Accidents and incidents were recorded and reported in a timely manner.

Incidents were dealt with effectively and action was taken to prevent them happening in the future. The registered manager monitored all adverse events and near misses in order to identify any trends.

The trust had a risk management policy and procedure in place and centralised risk registers which included local, corporate and Board Assurance Framework (BAF) risks. Risks were reviewed in 'real time 'at the monthly risk management committee.

Risk relating to specific issues were shared and discussed at the appropriate committees.

The Executive team also reviewed risks in 'real time' monthly or in response to a particular concern, operational managers managed the risk for their respective services. corporate and BAF risk were reviewed at senior forums including trust board.

Risk assurance was provided to the commissioners quarterly through a contract quality schedule and regularly reviewed.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Information systems supported quality patient care and treatment. Information was kept securely and maintained the confidentiality of patients and information was only shared with relevant agencies after patient consent had been obtained

Management records were well organised, and records were detailed and kept up to date.

Care records were easy to follow and kept securely as were personnel records.

There were several computer stations with intranet and internet access available throughout the service and there were sufficient numbers of computers for staff to access information. The computer systems were password protected and staff were aware of how to protect access to computer systems and patient identifiable information.

There were notice boards in various parts of the hospice which had the values and mission and other information to be shared with staff members

All staff received confidentiality training and where information was shared with other organisations there was guidance, for example we saw a policy for the sharing of infection control concerns with other providers.

The registered manager was the Caldicott Guardian for the service. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The hospice engaged well to meet the needs and requirements of their patients and families and

celebrated the good working relationships with the families they cared for. We saw evidence of where patients and families had thanked and praised staff for their care.

The hospice considered feedback from the local community patients as invaluable in informing of the service of what was working well and areas to be enhanced.

The provider had positive relationships with local health and charitable organisations.

The hospice was involved in a large number of community initiatives. The latest one being the Lincolnshire Moonlight Walk, where people taking part help raise funds support for the hospice

The hospice wellbeing team had recently devised a project named 'My story in music'. The project aimed to extend the range of therapies available to patients, care givers and the bereaved by introducing the My story in music programme. The My story in music was part of the Music in care programme, which is an evidenced based programme which links music to life stories, creating positive and meaningful conversations, triggering reconnections to the past and promoting a person's sense of self.

Staff were actively engaged within the organising and their views reflected in the planning and

delivery of services and in shaping the culture. For example, there were staff focus groups that

took place every eight weeks, these were led by the chief executive and attended by staff from all

departments. Agenda items included feedback from the staff survey engagement scores,

feedback on the new appraisal process and suggestions for new income generation streams

The trust undertook an annual staff survey using a nationally recognised staff survey tool. The trust scored 649.5 for the 2018-2109. which meant there was good level of staff engagement. Staff told us they felt engaged within the hospice and that views and feedback were valued and taken seriously. Data showed that 75% of staff took part in the staff survey

Following on from the annual staff survey, the trust had implemented a planned programme of follow up "mini" surveys to focus on specific survey areas and provide ongoing feedback quicker than waiting for the end of the year. A follow up survey was launched in March 2019 asking staff for specific feedback on what St Barnabas were doing well, what could be done differently, what else the leaders could offer to enhance wellbeing and how they could try and ensure a fair deal for staff.

There were a number of sectional questions on the follow up survey under the main question 'If you could change one thing about working for StBarnabas, what would it be?' For example, communication received a 9.9% response from staff, address management skills received a 9.3% response, however, the highest response was for an increase pay which received a 27.8% response. 50% of the workforce responded to the follow up staff survey

There was a monthly newsletter, 'The Barnabas bulletin' which was published within the organisation to provide staff with relevant information.

We reviewed a number of the newsletters and saw such information included articles on new members of staff due to a re-structure, interviews with staff about their job role, award winning teams and recognition of staff awards applying the trusts and values.

The hospice was supporting staff to develop basic sign language skills to support patients and families. The sign language sessions were available to all staff members and volunteers in the trust who wanted to attend.

The hospice played a leading role in promoting end of life care within the local community and had

developed strong links with many community groups.

The hospice was in the process of developing plans for a new model of community services that would link hospice at home services with the day therapy service to strengthen the provision of community care. This would provide a structure for stakeholders to follow and improved continuity of care, support and patient choice

The hospice in 2018 had launched a consistent companion campaign, this is where volunteer's share their time and strengths to encourage and support people in their own homes.

At the time of our inspection, the hospice was working with Lincolnshire learning disabilities team to raise awareness of specific needs of individuals with a learning disability and autism. The hospice nurse consultant was the lead for equality and diversity and facilitated a quarterly forum, which and included representatives from the LGBT community.

The hospice issued a 'Sharing our strengths' annual report magazine to the supporters of the hospice and members of the public. The magazine included subjects such as supporting people in the most difficult times, providing practical support and empowering families and loved ones.

Learning, continuous improvement and innovation

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

There was a positive focus on continuous learning and improvement for all staff and the service tried to learn something from every situation and eventuality. For example, there had been significant improvements made to the hospice, since the small oxygen fire earlier in the year.

Outstanding ☆

Hospice services for adults

As well as Hospice UK, St Barnabas Hospice was a member of the East Midlands Hospice Group, which is a group of several hospices in the region that share good practice and learning. St Barnabas hospice had been involved in the group with the creation of an animation entitled 'The Elephant in the Room' which addressed the very difficult and hard subject of dying. During our inspection we saw the hospice had 'let's talk about the elephant in the room' coasters with information on how to find further information on the animation

The hospice was part of Project ECHO which is a key enabler of the overall Hospice UK five-year strategy to open up hospice care. Using Project ECHO methodology, there is a strong potential for hospice teams to increase their impact by engaging with more communities who often miss out on accessing palliative care input when they need it most.

In 2019 the trust received national accreditation of being a best companies "Ones to Watch" organisation. A Ones to Watch accreditation is a special status awarded to organisations where workplace engagement shows promising signs for the future and where they have demonstrated "good" levels of workplace engagement.

Outstanding practice and areas for improvement

Outstanding practice

When a patient died, the hospice washed and ironed their clothes before returning them to their loved ones.

In conjunction with the local NHS trust, the hospice had devised a short ReSPECT video which supported learning around end of life care plans

The hospice was supporting staff to develop basic sign language skills to support patients and families. The sign language sessions were available to all staff members and volunteers in the trust who wanted to attend.

In February 2019 St Barnabas Hospice was awarded a Sunday Times best companies top 100 not for profit organisation to work for. This was the first time the hospice had entered the competition year and were placed 89th alongside other charitable organisations, including other hospices.

The hospice received national accreditation of being a best companies “Ones to Watch” organisation. A one to watch accreditation is a special status awarded to organisations where workplace engagement shows promising signs for the future and where they have demonstrated “good” levels of workplace engagement.

The hospice had received the following accreditations: Disability confident employer, age positive and mindful employer

The hospice is currently working with the prison service providing support for several inmates with bereavement counselling, with many reporting they now have strategies to help them in the future not only with their bereavement but also around other issues like anger.

At the time of our inspection, the hospice was delivering two projects to reach out to the homeless community and to a local prison offering bereavement care to both communities. The projects include education to support staff to provide palliative care to those who do not normally have access hospice care counselling

Feedback from patients and families was consistently positive both through the comments they made to the inspection team and through the provider’s surveys.

There was a strong culture of caring and compassion throughout the hospice and feedback from patients indicated that the care provided went beyond their expectations.