Severn Hospice Bicton Site

Quality Report

Bicton Heath
Shrewsbury
Shropshire
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Website: www.severnhospice.org.uk

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Severn Hospice Bicton Site is operated by Severn Hospice Limited. The service provides end of life care from 16 inpatient beds.

There were relative's suites, day rooms, kitchen facilities, a sanctuary where anyone including staff could pray, areas to eat and drink, relative's toilets and quiet areas.

The service provides end of life care for adults and a bereavement service for young people. We inspected end of life care including bereavement services for children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the hospice on the 17 May 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

Summary of findings

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 service stayed the same. We rated it as **Good** overall.

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and met the overall target rate.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff understood how to protect patents from abuse and the service worked well with other agencies to do so.
- 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 a wider system and local organisations to plan care.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed priorities and issue the service faced.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.

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

- There were some topics where the hospice fell below the set target for mandatory training.
- There was no requirement for staff to record community acquired pressure areas reported to district nurses on the hospice electronic recording system.
- Risks around sepsis were not fully embedded in the service.
- Not all staff were confident in their knowledge around sepsis.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Deputy Chief Inspector of Hospitals

Nigel Acheson

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	End of life care was the main activity of the hospice. We rated this service as good overall because it was good for safe, effective, caring, responsive and well led.

Summary of findings

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Summary of this inspection

Background to Severn Hospice Bicton Site

Severn Hospice Limited is an independent charity who provides care for people who are living with complex and progressive illness. The hospice cares for patients from across Shropshire and Mid Wales. They have two locations, one in Telford and one in Shrewsbury. The hospice primarily serves the communities of Shropshire, Telford, Wrekin and Mid Wales. It also accepts patient referrals from outside the area.

We last inspected the service in April 2016 and published the report in June 2016. The service was found to be requires improvement in safe and good for effective, caring, responsive and well led. Actions associated with this inspection have now been met.

The hospital has had a registered manager in post since 2011. At the time of the inspection, the manager had become chief executive and the service was going through the process to appoint a new manager who was already in post in the role of director of care.

Our inspection team

The team that inspected the service comprised of an inspection manager, a CQC lead inspector, an assistant inspector and a specialist advisor with expertise in end of life care. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited both wards and attended two home visits. We spoke with 27 staff including trustees, senior managers, matrons, registered nurses, health care assistants, the pharmacist, reception staff, kitchen staff, medical staff, volunteers, the chaplain, social workers and physiotherapists. We spoke with five patients and five relatives/friends. During our inspection, we reviewed eight sets of patient records.

Information about Severn Hospice Bicton Site

The hospice provided the following services:

Hospice at Home:

The service provides care for patients with cancer and non-malignant progressive disease and their carers during the palliative care phase of their illness at home.

Community Outreach:

A service review was undertaken in 2017 and the service now provides clinical support and specialist advice to GP's, district nurses and care homes in identified geographical areas.

The Lymphoedema Service:

This service provides specialist lymphoedema care and advice in line with British Lymphoedema Association guidance and protocols. Treatment through the acute phase of their condition and periods of exacerbation with the goal being supporting self-management

Inpatient Service:

The service provides a 24-hours a day specialist care service which is not disease specific. Care is provided to patients with complex symptoms. The service aims to offer short term care to safeguard bed availability.

Complementary and Creative Therapy:

Summary of this inspection

The service provides a range of therapies offered by professionals

Co-Co:

This service has created over 20 volunteer networks across Shropshire, working with local people and their GPs' surgery to develop a dedicated befriending service.

Bereavement Service:

The bereavement service offers individual support and group meetings. The 'Elephants Never Forget' service helps children and families. The team give practical advice about post death arrangements.

Day Services:

Consultant clinics are held weekly. From July 2017 the hospice has aimed to integrate the national vision of 'Living Well' by improving flexibility and choice. They have created three parts to the service including a coffee morning, and two 8-week programmes. However, day services did not form part of the regulated activities, so we did not inspect this part of the service.

There were two wards at Severn Hospice Bicton site; Breidden and Perry. Each ward was made up of individual en-suite bedrooms.

The hospice is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Personal Care
- Treatment of disease, disorder or injury.

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

Activity

- In the reporting period March 2018 to February 2019 the hospice provided support and advice to approximately 2427 people.

Track record on safety

In the same period the service reported:

- Zero never events
- Zero clinical incidents
- Zero serious injuries
- Zero incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Two incidences of hospital acquired Clostridium difficile (c. diff)
- Three complaints.

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 improved. We rated it as **Good** because:

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and met the overall target rate.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service-controlled infection risk well.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough nursing, medical staff and support staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patient's care and treatment.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported most incidents and near misses.
- The service did not use the safety thermometer, but they used monitoring results well to improve safety.

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

- There were some topics the hospice fell below its target for mandatory training.
- There was no requirement for staff to record community acquired pressure areas reported to district nurses on the hospice electronic recording system.
- Risks around sepsis were not fully embedded in the service.
- Not all staff were confident in their knowledge around sepsis.
- There were some oxygen cylinders on the floor in the treatment room, this meant they were not secure.

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. Managers checked to make sure staff followed guidance.
- 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 gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles.
- All those responsible for delivering care worked together as a team to benefit patients.
- Key services were available seven days a week to support timely patient care.
- Staff supported patients to make informed decisions about their care and treatment.

Are services caring?

Good

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions around their care and treatment.

Are services responsive?

Good

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in a wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences.
- Patients could access the specialist palliative care service when they needed it.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously.

However,

Summary of this inspection

- Staff told us that they would use the translation services of the local hospital if a patient had a translation need. However, not all staff we spoke with were aware of this.

Are services well-led?

Good

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

- Leaders had the integrity, skills and abilities to run the service. They understood and managed priorities and issue the service faced.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders operated effective governance processes, throughout the service and with clear organisations.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats.
- Leaders actively and openly engaged with patients and staff to plan and manage services.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Are hospice services for adults safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and met the overall target rate. However, there were some topics where the hospice fell below the set target.**
- Following the inspection leaders told us there was an overall mandatory training compliance rate of 88% for contracted staff. This met the hospice overall target rate of 85%. The hospice aligned their mandatory training compliance rates with local healthcare providers.
- Leaders also told us that they had 106 bank staff and 38 of these bank staff were not compliant for either some or all sessions. Leaders recognised that most bank staff have other employment and would be completing their mandatory training somewhere else, so they asked for proof of attendance.
- It was recognised by leaders that checks of bank staff training elsewhere was happening but that it was not always recorded. Leaders were working towards the next stage of their electronic system which covered training data collection which they hoped would improve the situation.
- The areas that fell below target as of May 2019 included cardiopulmonary resuscitation (CPR, 84%) information governance (81%), fire awareness (81%), syringe drive updates (76%) and food hygiene (65%). Leaders told us that low compliance rates in syringe driver updates were due to long term sickness, staff retiring or relocating and maternity leave.
- When staff were seen to be falling below target compliance they would be sent an e-mail reminder; compliance reports were sent to line managers. Training compliance was built into staff appraisals and funding of any external courses was not approved unless mandatory training was up to date.
- Staff told us that training courses were readily available and easily bookable. They also said that other courses they identified could be booked with their line managers support.

Safeguarding

- **Staff understood how to protect patents 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.
- Policies and procedures were in place to guide staff on what to do if they had a safeguarding concern. There was a safeguarding vulnerable adult's policy in place. The policy referred to relevant legislation like the Care Act 2014. It contained details on staff responsibilities, details of the local authorities, key principles and types of abuse. It also contained flow charts to support staff. Information was available on how to refer a child protection concern including child protection referral contact numbers.

- Staff knew how to raise a safeguarding concern and systems and processes were in place for the reporting of abuse. The service had its own social work team, one of the social workers was the safeguarding lead.
- Staff felt confident to speak to the social work team or their manager if they had any safeguarding concerns. Staff could give examples of when they had raised safeguarding concerns and were aware of the safeguarding policy.
- Disclosure and Barring service checks were made. Leaders asked to see disclosure and barring certificates and asked staff to sign up to the annual update service. When subscribed to the update service the hospice did an annual check to see if staff were still subscribed and if anything has been added against the certificate. Leaders completed on line checks and kept a record of this.
- As of May 2019, staff met the target rate of 85% in safeguarding children level 1 and 2 and adults safeguarding training, deprivation of liberty safeguards (DoLs), Mental Capacity Act, equality and diversity, moving and handling and infection control. Social workers who supported children with bereavement work were all trained to level 3 in safeguarding children.

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 visibly clean.
- The service provided patients with a clean environment. We visited all areas of the service and found all areas to be visibly clean. An external cleaning team completed cleaning of the service. We saw the cleaner kept a record of cleaning tasks completed included bins emptied, floors, surfaces and rooms. The cleaner kept this record in the cleaning cupboard.
- Staff minimised the risk of infection well. All staff were "arms bare below the elbow", washed their hands and kept long hair tied up.
- Hand hygiene was delivered as part of the mandatory infection control training. The infection prevention and control audit from January 2019 to March 2019 showed that staff hand hygiene compliance had improved since January 2019 when there was an 85% compliance rate. As a result, actions had been taken such as, feeding back results and hand washing posters. Following this staff achieved 100% compliance in hand hygiene rates in March 2019.
- Staff had access to personal protective equipment to prevent the risk of infection. We noted that aprons and gloves were to hand for staff providing patient care and that they wore them. Hand gel was readily available.
- Leaders displayed information on infection prevention control. Information displayed included how infections spread, the importance of using gloves and aprons, alcohol hand gel and hand hygiene for healthcare staff. We saw a poster on display advising staff to keep nails short and to only wear a plain band of jewellery. All these actions helped to prevent infections spreading. Clinical waste bags were available.
- Staff were knowledgeable around infection control. Staff could verbalise the infection control measures they would take when looking after the body of the deceased. This included using personal protective equipment and protective bags.
- Systems were in place to assess compliance with infection control audits. Infection prevention and control was an area included in the monthly audit report dated January 2019. The audit report showed that five clinical areas had been audited.
- Results showed compliance by module out of 100%. Areas the hospice did not score well included domestic rooms (50% non-compliance) and care of deceased patients (40% non-compliance). Areas where the hospice did better were policies and procedures (90% compliance) protective equipment (90% compliance) and kitchen areas (90% compliance).
- Outcomes of the audit were recorded in a monthly audit report completed by the clinical governance lead and included the need for a direct link for infection prevention and control into senior managements structures, the need for an urgent review of stock items and to review the induction package and mandatory training. Actions from the audit included an urgent review of the cleaning

schedule, an urgent review of stock items and a review of the induction package and mandatory training. Infection control updates were a standard agenda item on the hospice meeting agenda. At the time of our inspection an infection control lead had been appointed.

- In comparison the external company completing their own audit did not find any issues. This was escalated and as a result the hospice was in the process of implementing their own cleaning schedule.
- The Health and Social Care Act 2008 Code of Practice: Self-Assessment Tool Infection Prevention and Control was utilised in January 2019 to provide evidence and assurance that the hospice met the standards set by latest research, policies and EU directives and that the service understood the impact on the hospice environment. This was recorded in the monthly audit report.
- The service monitored infections. There had been two instances of Clostridium difficile (C-Diff) in the past 12 months (from March 2018 to February 2019). Leaders told us they were supported by the infection control team at the local community trust and acute trust and it was reported through clinical governance. Patients were also screened for MRSA this was recorded in their notes.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**
- There were sixteen inpatient beds over two wards (eight rooms on each ward); both wards were on the ground floor. All rooms were en-suite and overlooked the hospice gardens.
- Additional beds were available, so relatives could stay overnight with patients. There were also relative's suites, day rooms, kitchen facilities, a sanctuary where anyone including staff could pray, areas to eat and drink, relative's toilets and quiet areas.
- Patients and their families could access the gardens which had a variety of features, plants and shrubbery.
- Specialist equipment such as mattresses and hoists were available for patients who needed them. Staff in the community could order equipment and arrange urgent delivery.
- The service had enough syringe pumps. Syringe pumps were maintained and used in accordance with professional recommendations.
- There were arrangements in place for the testing of electrical equipment. Equipment had been tested for safety and had stickers on with the date they had been serviced.
- Staff followed policy in relation to clinical waste. The waste management policy covered general, confidential and clinical waste and that yellow bins. The policy was in date and had a revision date of October 2019. We observed that clinical waste was put into the correct yellow bags and these were not over full.
- Policies were in place for the prevention and management of needle stick injuries including inoculation incidents and exposure to blood borne viruses. The policy contained details on the disposal of sharps and what to do if there was a spillage. There was also information on sharps containers being disposed of when three quarters full and explaining they must be signed and dated and have details of what to do if there was a spillage.
- Arrangements were in place for the storage of deceased patients. There was a cold room available which could store up to six deceased patients whose bodies were awaiting collection by the undertakers. The room had an external temperature display which would sound an alarm if the temperature fell out of the desired range.

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 assessed patient risk and ensured it was recorded. Comprehensive risk assessments were in place for patients who used the service. Staff completed these electronically.

- Staff inputted data into the electronic system which calculated risk scores, for example, if the patient's risk was high, medium or low. Patients were assessed on admission for bed rails.
- Staff completed documentation to record levels of risk. Documentation included skin repositioning schedule sheets with details such as the date, time and position of the patient. Skin assessment tools included the level of risk, frequency of turns, mattress type and details of the skin inspections needed for each patient. If a patient was found to be at a higher risk the frequency of turns would be increased. The service had tissue viability link nurses who could offer staff support. Special boots were used for patients heels when they were at risk of pressure sores.
- Oral risk assessments and care plans were completed when required. Information was recorded around the patient's lips, airways, saliva, medications and if they were prescribed oxygen. One care plan of oral care included actions such as giving the patient frequent sips of cold water, ice lollies, pineapple chunks and sugar free chewing gum.
- The service used assistive technology to reduce identified risks. Patients who used the service had the option to use a foot bell if they were unable to use the regular call bell system. There were also sensors patients carried in their pockets or in the corner of rooms that would set off an invisible beam. This would let staff know if a patient had got up and was at risk of a fall. Staff told us they had effectively used video monitoring to ensure patient safety (with consent). We observed patients had access to their call bells and staff answered these quickly.
- The hospice had a suicide policy in place. The policy referred to statutory requirements such as the Care Act 2014 and the Mental Capacity Act 2005. The policy contained flow charts on the risk of self-harm and assessment, and suicide risk. Ligature risks were addressed in the hospice safeguarding vulnerable adult's policy.
- Medical staff were available 24 hours a day, seven days a week to provide medical support. The service had their own doctors who reviewed patients' medical conditions at least two times per day. If a medical emergency were to happen staff would contact the emergency services if appropriate.
- Pressure areas were reported to the district nurses who staff felt provided a prompt response, however, there was no requirement for staff to record community acquired pressure areas reported to district nurses on the hospice electronic reporting system. Staff told us they reported all community patients 'skin problems to the district nurses who would then assess and dress wounds, refer to tissue viability and complete the incident reporting.
- Following our inspection leaders told us they had now adopted the same reporting system as their community trusts and were in the process of introducing this to all staff.
- Risks around sepsis were not fully embedded in the service. One staff member we spoke with told us they had a sepsis tool available to use and provided us with a copy of this. However, in the clinical governance meeting minutes dated March 2019 the sepsis screening tool was reviewed, and a decision made that it was not appropriate for use at the hospice. We spoke to leaders about this who told us that this decision was currently being reviewed.
- Not all staff were confident in their knowledge around sepsis. We spoke to nursing staff and nursing assistants about sepsis and found there were some gaps in knowledge. For example, one nurse we spoke with told us that patients needed to have antibiotics within two to four hours when this should take place within one hour.
- There were systems in place for staff who were lone working. We observed staff in the community carried an alarm device and all visits were logged on the computer so staff at the hospice knew where each member of staff was.
- If staff were going straight out on a visit from home, they would phone in to the office to advise where they were. Reminders or alerts were recorded on the front page of patient files, for example, if there were environmental risks such as a dog that caused a risk.

Nurse and Medical staffing

Good

Hospice services for adults

- **The service had enough nursing, medical staff and support staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.** Managers regularly reviewed and adjusted staffing levels and skill mix.
- Teams of nursing, medical staff and allied health professionals provided patients with the care they needed. Each ward had two identified teams supported by a team leader. Teams were made up of nurses, nursing assistants and volunteers, medical staff were also available.
- The service had their own bank of registered nurses and health care assistants, supported through an electronic booking system. Matrons were responsible for co-ordinating daily reviews of staffing.
- The service employed 24 full time nursing/allied health professionals/other qualified staff from March 2018 to February 2019. During the same time, they employed 24 full time health care assistants and 22 other non-qualified staff.
- There were 41 nursing/allied health professionals/ other qualified staff who worked less than 37 hours per week from March 2018 to February 2019. There were also 22 health care assistants and 30 other non-qualified staff.
- Data showed that there were 33 nursing/allied health professionals/other qualified staff on zero hours contact in addition to 17 health care assistants and 12 non-qualified staff.
- From March 2018 to February 2019 the service employed three medical staff that worked 37 hours and over per week.
- During the same period there were six medical staff who worked less than 37 hours per week. There were arrangements in place for 24-hour medical cover.
- The service had introduced a dependency score tool to help ensure staffing levels were safe. Escalation plans were available to be used alongside the tool. Actions of escalation included rescheduling non-urgent meetings, completing incident forms and urgent call outs being passed back to GP or nursing teams.

Records

- **Staff kept detailed records of patient's care and treatment.** Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Staff kept detailed patient records to ensure consistency of care. We reviewed eight patient records and found they contained up to date information, were dated and contained signatures. The service had a mixture of paper and electronic patient records.
- Paper records which contained confidential information were kept in the nurse's office which was kept secure via a key entry pad.
- Staff accessed patient records when they needed to. Information needed to deliver safe care and treatment was available to relevant staff in a timely way this included care plans, risk assessments and case notes.
- Leaders completed a records audit in 2018 to 2019. The audit standards were based on Ambitions for palliative and end of life care: a national framework for local action 2015 to 2020, Care Quality Commission sector specific guidance: Hospices for adults 2018, Hospice UK-Rehabilitative Palliative Care enabling people to live fully until they die in 2015 and Leadership Alliance for the Care of Dying People; one chance to get it right: improving peoples experience of care in the last few days and hours of life.
- Actions from the audit included delivering staff training on care planning and changes to templates, implementing a carers assessment tool and moving towards a total patient pathway with collaborative care plans.
- Staff kept a mortuary register with details such as; how long deceased patients were stored, which ward, if there was any jewellery and the signature of the undertaker.
- Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) documentation was completed appropriately for those patients who needed these orders. We reviewed five DNACPR forms and found that documentation included, if the person had capacity to make decisions, summary of communications with patients and family and signatures of the person making the decision.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The service had pharmacist support for three days a week (22.5 hours), this was funded by the local clinical commissioning group (CCG). There was no pharmacist at the service when we last inspected.
- A pharmacist technician from a local trust visited the service on a weekly basis to check medicines stock.
- The pharmacist had identified areas for improvement and took actions which included; creating policies on cytoxic waste disposal, medicines reconciliation for clerking in patients and their prescribed medications and supporting prescribing across the interface for example GP's.
- The pharmacist was involved in ongoing work such as reviewing current policies and working on a patient safety sheet for self-administration of opioids. Opioids are primarily used for pain relief. The director of care was the controlled drugs officer.
- Policies, procedures and guidelines were in place around medicines. These included guidelines for prescribing anticipatory medicines, medicines policy, covert administrations of medications, medicines brought in by patients and use of medicinal products beyond (off-label) and without (unauthorised) marketing authority.
- Leaders told us 28 qualified staff that worked on the inpatient unit at Bicton all had annual competency tests around medicines. We reviewed some examples of medicine assessments and saw they included dispensing of a controlled drug, undertaking a medicine round and were signed by an assessor.
- Leaders told us that patients maintained responsibility for the administration of all their medicine in day services and community services unless authorisation was written by their GP.
- Measures had been put in place to reduce the risk of medication errors. Red lights were installed outside treatment rooms so staff could let others know they did not want to be disturbed, when dealing with patient medications.
- Staff had access to syringe pumps. There were syringe pumps and subcutaneous access monitoring forms available for staff to complete. The form contained the date and time of the check, and a pump checklist which included rate, volume to be infused and battery life.
- Staff kept detailed records of medications given to patients via a syringe pump. The records had information on the type of medication, amounts, batch numbers and expiry dates.
- Medications were stored securely at the correct temperature. Staff kept a record of fridge temperatures by recording this daily, however we did see two gaps in recording on Breidden ward.
- Rooms where medications were stored had a key coded lock to prevent unauthorised access. The room temperature was monitored and if the room became too hot an automatic cooling system would start.
- The procedure if the medication fridge became faulty was to move all medication to the other fridge immediately and to seek guidance from the steward. The steward would then make arrangements for someone to come out and fix it. The hospice used the terminology steward for a porter.
- Staff kept out of date medications separately whilst awaiting disposal. There was a destruction book in place, matrons had responsibility for this. Staff told us they alerted the matron when had any medications for destruction.
- Staff completed medication administration charts to show patients had received their medicines. We found that prescriptions were signed and dated, allergies were documented, and writing was legible.
- We observed a nurse giving a patient medication. The nurse checked the patients name, address and the photograph on the medication sheet.
- Prescription pads (FP10's) were stored in a locked cupboard in the treatment room. There was a FP10 prescription recording book which two staff needed to complete to sign out a prescription. Staff told us this was used by the doctor only and that they would take this to the doctor.

- There had been some ongoing issues about nurse prescribers in the community accessing a prescription pad. The hospice continued to work with the local CCG around this and this had been escalated to the senior management team.
- Processes were in place for the recording and monitoring of controlled drugs. Staff recorded the controlled drug and recorded the remaining stock balance. We reviewed the stock balances and compared them with the records and found these to be accurate, and medications were in date.
- Oxygen cylinders were secured to the walls in corridors. However, we saw some cylinders were on the floor in the locked treatment room. There was nothing in place to ensure these were secure and did not fall over. The medication policy that contained information on medical gases was not clear on the storage of empty oxygen cylinders.
- We reviewed a medicines optimisation safe and secure handling of medicines audit completed in February 2019. The audit included areas such as how were medicines and medicines related stationary managed, if medicines were appropriately prescribed, administered and supplied in line with relevant legislation, current national guidance or best available evidence, if people received specific advice about their medications in line with current guidance or evidence and how the service made sure that people received their medicines as intended and if it was recorded appropriately.
- The audit asked what the standard was, what was seen today, what to do to close the gap (actions) for example, sourcing a replacement cupboard, this had a named person responsible for the action with a target date for completion. Areas for improvement included there were ampoules of water for injection and sodium chloride stored on the work surface, a cupboard was cramped with baskets stacked on top of each other and a small number of anticipatory drugs did not have a frequency of dose, but the dose and route were explicit.
- The service had completed an audit of prescribing and administration of as needed (PRN) medicines in March 2019. It had recently been highlighted that some areas of medicines management needed to improve. One of the areas identified for improvement was the prescribing of as needed (PRN) medicines on the patient's administration prescription sheet.
- As a result, an audit of as needed (PRN) prescribing was carried out by the pharmacist across all sites. Areas where prescribing met legal requirements were doctors' signature, route of administration, dose and date of prescribing. However, the legal requirements were not met for PRN prescribing with regards to directions for use, for example, when required for pain, directions for maximum dose to be given in 24 hours or frequency of dose.
- Actions included to discuss the audit results at the next doctors meeting and supporting information identified. We spoke with the hospice pharmacist who had created information sheets on frequency of doses of PRN medications, due to dose frequency not always being completed. The pharmacist was also attending MDT meetings and writing new policies
- We reviewed a copy of the medicine's management, medical gases and controlled drugs action plan dated April 2019. The action plan included a section on the management of controlled drugs and was evaluated in May 2019. The action plan showed an overall compliance rate of 100% and included a goal of having clear instructions on when and how often to use a drug and maximum daily amount and frequency of doses. The action plan which included actions around the management of controlled drugs was completed. During the inspection we reviewed three medication charts and found all were completed appropriately.
- A general medicine audit dated April 2019 audited areas such as standard operating policies, storage and destruction of medications, patients own medications and purchasing and supply of stock medicines. The audit identified areas for improvement, for example, it identified that there was no guidance on what to do if fridge temperatures were out of range and that stock levels were not recorded on order sheets.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported most incidents and near misses.** Managers investigated

incidents and shared lessons learned with the whole team and wider service. When things went wrong staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patients' safety alerts were implemented and monitored.

- From March 2018 to February 2019 there were no serious incidents or never events reported at the hospice. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There was an incident reporting procedure in place which contained staff roles and responsibilities and a risk analysis matrix including duty of candour. The policy was in date and next for review in 2021.
- Nursing staff understood duty of candour and the need to be open and honest and to offer an apology. There was a duty of candour and openness policy in place that outlined the duty of candour requirements, contained a definition of harm, the principles of being open and an algorithm of the process. There had not been any recent incidents that met the threshold for duty of candour.
- We reviewed a root cause analysis on a grade three pressure sore that was completed for an incident dated February 2019.The report included an outcome and learning; a continence assessment was not carried out and information was not given to carers. A recommendation was made that staff seek advice from tissue viability at the earliest opportunity.
- We reviewed the minutes from senior nurse meetings and found that incidents and root cause analysis feedback were discussed. For example, in the minutes dated September 2018, it was noted there was increased incidences of controlled drugs errors and it was recorded how the red lights on treatment room doors to stop people just walking in were working.
- The pharmacist told us of an incident when a junior doctor at the hospice identified that a patient had been supplied with the wrong does of medication in the community. As a result, this was shared and discussed with the community pharmacist.
- The process for national safety alerts was that they were disseminated through the senior management team to action.

Safety Thermometer (or equivalent)

- **The service did not use the safety thermometer, but they used monitoring results well to improve safety.**
- The hospice kept a record on clinical governance monthly statistics. We reviewed the data from April 2019 and found that there had been four pressure ulcers on Breidden ward all of which had developed out of service. On Perry ward, there had been seven pressure ulcers. Again, all of which had developed out of service.
- Falls statistics were also provided. Monthly statistics from April 2019 showed that there had been one fall on Perry ward and none on Breidden ward.

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

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**
- End of life care plan documentation was available. The hospice provided us with a copy of their Severn-Hospice end of life plan for caring for adult patients in the last few hours and days of life.
- The service completed "National Institute for Health and Care Excellence" templates to demonstrate the needs of people were being met, for example, patients living with dementia.
- The plan included a flow chart on diagnosing dying and using the end of life plan to support patients in the last hours or days of life, which included a multidisciplinary team assessment to ask was the

person be in the last hours or days of life, discussion with the patient, relative or an independent mental capacity advocate (IMCA) if needed. Data received showed 128 end of life care plans had been completed and implemented within the last six months.

- The end of life plan contained relevant information. The plan included space for details on patient and carer understanding and concerns, an initial assessment, hydration and nutrition, anticipatory prescribing, (anticipatory medicines are a small supply of medications for people to keep at home just in case they are needed) current issues and details for a repeat assessment.
- Patients had electronic personalised care plans in place, these were up to date and reflected any complex needs.
- Leaders incorporated ambitions for palliative care into learning and improving. Leaders at the hospice provided us with a presentation on their living well programme. The presentation included the six ambitions for palliative care 2015, such as each person is seen as an individual, maximising comfort and wellbeing and all staff prepared to care.
- The hospice had identified a series of living well ambitions. These included patient's goals for living placed at the heart of holistic support, there was a strong collaboration between patients, relatives, careers and the multidisciplinary team, enabling and empowering individuals to achieve their goals.
- The hospice had an audit schedule to measure and drive improvements to the service, which included areas such as medicines management, medical gases and controlled drugs. The hospice used hospice UK tools for measuring quality. Additional audits also took place, such as advanced care planning in motor neurone disease and notes audits.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.** The service made adjustments for patients' religious cultural and other needs.
- Patients had a choice of meals and access to plenty of drinks and snacks. Patients were also able to request alternative meals. Volunteers refreshed water jugs and sat with patients to provide encouragement with their nutritional needs.
- We spoke to a volunteer who told us they were informed of any patient dietary needs such as, if a patient was diabetic or needed a gluten free diet.
- One patient told us "They are very accommodating with foods, and the variety is amazing no problem to have what I like".
- Staff did all they could to support patients' choice. We heard of an example when a patient had wanted a drink of beer and the hospice did not have any so staff went out and brought them one. Another patient with a poor appetite wanted a toffee yogurt so staff went to the shops for one.
- The hospice provided food for relatives and visitors. Families and visitors were able to have food and drinks from the kitchen and leave a donation. There were kitchen areas throughout the hospice where relatives could make drinks and store food.
- Patients' dietary needs were taken into account. Kitchen staff had a white board where they could record patients' dietary needs for example, if they were diabetic or on a soft diet.
- We saw patients' nutritional needs were assessed and risks calculated using the malnutrition universal screening tool (MUST). The service did not have their own dietitians but told us they would contact the local hospital for advice or to make a referral.
- We noted that there was a sign in the dining areas to speak to staff about ingredients if a patient had a food allergy.

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 and gave additional pain relief to ease pain.
- Nursing staff told us they asked patients to score their pain level from zero out of 10 with 10 being the highest. They told us that if a patient could not

communicate they did not have a specific tool but would look for visual signs of pain. Medical staff told us they used the Abbey Pain Scale and DisDat tool to assess pain and distress levels.

- Medical leaders told us that they did not use the Core standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015 but they followed West Midlands guidelines, Palliative Care Formulary 6 and NICE guidance for palliative care symptom control.
- Staff managed patients pain well. Patients told us their management of pain was very good, and staff were very understanding of their pain management. The hospice had heat packs patients could use to help them with pain. Staff were responsive to patients' pain relief.
- Staff monitored and recorded patients' pain. We saw that care plans referenced patient pain levels. For example, we saw one patient had declined pain relief, and on another day had not reported any pain.
- We went on a home visit with staff to see a patient who was receiving support from the outreach service. The patient needed advice on symptom control for pain and breathlessness. As a result of the visit the nurse gained consent to arrange a prescription and planned to speak to the patient's GP.
- We saw staff teaching presentation slides around pain assessment and how this may alter pain management. The presentation had a definition of pain, key points for assessment, what to ask, types of pain and information on different types of pain relief.
- End of life medications were prescribed and administered in line with good practice and guidance. Anticipatory medications were prescribed; the hospice had a supply of syringe pumps and used them. Anticipatory medicines are a small supply of medicines to keep at home just in case needed.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment.** They used the findings to make improvements and achieved good outcomes for patients.
- There was a clear approach to monitoring, auditing and benchmarking the quality of the services and the outcomes for people receiving care and treatment.
- The hospice used patient feedback tools to measure patient outcomes. Feedback involved rating and commenting on the care and support by the nursing and medical teams, physiotherapists, occupational therapists, the social work and chaplaincy team.
- Quality and outcome information showed that the needs of people were being met at the hospice. Leaders completed "National Institute for Health and Care Excellence" (NICE) quality standard service improvement templates. The templates had details of how the current service compared with selected statements and what was the source of evidence to support this. For example, it was felt by leaders that the service achieved the standard that people with dementia received care from staff appropriately trained in dementia care. The evidence was dementia link nurses supported colleagues in each team and there was a strong connection with local NHS dementia leads and dementia rooms were available.
- The hospice leaders assessed 'End of life care for adults (NICE) 2011, (updated March 2017) guidance and how it compared with selected statements. The hospice assessed itself as having achieved selected statements one to nine through the end of life services and pathways such as hospice at home, inpatients, the outreach service and the day service.
- Another quality standard template measured by the hospice was quality standards around diabetes in adults where the hospice was found to be meeting the NICE set standards. Diabetes in adults 2011, (updated 2016). Quality statement 6: Referral for urgent diabetic foot problems (QS6). For example, adults with type two diabetes were offered a structured education programme at diagnosis and adults at moderate or high risk of developing a diabetic foot problem were referred to the foot protection service.
- Leaders told us how the hospice was at the forefront for researching adult palliative care for those with neuromuscular disease. A model tested by the hospice had been presented at international meetings and was being used to define NICE guidelines.

- The hospice was part of a registrar led group which sought to conduct research across hospices in the West Midlands, the hospice medical director was lead for the group. A registrar is a junior doctor who has completed their foundation training but is still in a speciality area of medicine.
- The hospital benchmarked itself against other hospices. Areas benchmarked included number of deaths, discharges, occupied beds, and patients who developed different grades of pressure ulcers.
- One staff member was due to attend the 16th World Congress of the European Association of palliative care in Berlin, to present a paper on cannabis use in rural palliative care caseload.

Competent staff

- **The service made sure staff were competent for their roles**. Managers appraised staff work performance and held supervision meetings with them to provide support and development.
- Staff received regular appraisals. Data showed that 100% of medical staff and 99% of nursing staff, allied health professionals (AHP) or other qualified staff had received an appraisal in the last twelve months. In addition, 98% of healthcare assistants and 90% of non-clinical staff had received an appraisal.
- There were arrangements in place for supporting and managing staff to deliver effective care and treatment. There was a structured induction programme in place that staff and volunteers completed when they started to work at the hospice.
- We reviewed one volunteer induction checklist and one staff induction. Checklists were signed off and included a site tour, demonstrations such as call bells, emergency bells, answering the telephone and discussion on communication, confidentiality and signing in and out.
- There were processes in place for the induction of new staff. The staff induction included the organisational structure, confidentiality, communication and code of conduct. It also contained a competency sheet which was signed off, such as demonstrating an understanding of the importance of care after death and having an understanding, recognition and knowing the importance of monitoring pressure damage areas. The induction period lasted two weeks.
- Staff could attend a variety of courses to support their learning needs. Courses included mental health, first aid awareness, communication skills, end of life care, a dementia conference and spiritual and religious care.
- The hospice was introducing the nurse associate course for health care assistants in partnership with a local university.

Multidisciplinary working

- **All those responsible for delivering care worked together as a team to benefit patients.** They supported each other to provide good care and communicated effectively with other agencies.
- There was a multidisciplinary team in place and they worked well together. The multidisciplinary team included doctors, nurses, occupational therapists, physiotherapists, volunteers, a pharmacist, cleaners, kitchen staff, health care assistants, volunteers and social workers. The team worked together to assess, plan and deliver care and treatment.
- The pharmacist shared an office with the hospice motor neurone disease specialist. This meant that they were able to spend time discussing this specialism.
- The bereavement team referred to and received referrals from children's mental health services.
- Multidisciplinary outcome discussions were recorded in patient notes which included areas such as social, physical, reason for admission, spiritual and emotional. Complimentary therapy sheets were also completed, such as when a patient had a hand massage.

Health promotion

- Some staff were being trained to be mental health first aiders. There were posters on display throughout the service that displayed this information. A mental health first aider was the first point of contact to offer

support and signpost individuals with mental health concerns to appropriate help. The aim of the role was to help detect mental ill health earlier and to promote and support recovery.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- The hospice was open 24 hours a day, seven days a week. There was open visiting for family and friends. There was also an outreach team and a hospice at home service.
- There was a triage nurse based in the office from Monday to Friday 9am to 5pm. Over the weekend's; advice was given by ward staff, the consultant on call, the local hospital and local out of hours doctors.
- The physiotherapists at the hospice worked from 8.30am to 4pm Monday to Friday.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment.** They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.
- Staff understood mental capacity assessments and best interest decisions but told us it was usually the doctors who completed them.
- Consent statements were in place for patients in areas such as confidentiality, property disclosure, consent to use own medicines and consent to medical photography. We went on an outreach home visit and observed consent being taken to arrange a prescription.
- Staff had displayed information on a board about deprivation of liberty safeguards. There was information on what the words meant, details of the assessment, what would happen which was patient focussed and what to do if there was a disagreement over the decision.

Are hospice services for adults caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Patients and their family members and friends gave positive feedback. They told us they felt safe and happy and the care was marvellous and excellent. One relative we spoke with told us they felt comfortable knowing their family member was getting the care they needed and was being looked after.
- One patient's friend told us the hospice at home team had been fantastic, they couldn't do what they did without them and they looked after them well.
- One volunteer told us they felt staff did a brilliant job and if they ever needed care they would be happy for staff to look after them or their family member.
- Staff interacted well with patients. They treated patients respectfully and gave patients the time they needed whilst supporting their needs. We observed creative therapy staff supporting a patient to make a keyring and being given enough time to do this.
- Thank you, cards were on display, at the hospice. Comments from thank-you cards showed that patients and carers felt they had been treated with compassion. One comment thanked the staff for the dignity and respect shown in a patient's last few days of life.
- Staff were kind and considerate whilst sharing sensitive information with families with respect and compassion. Staff checked on families who had received bad news and they were given some time alone.
- Staff always respected patient confidentiality. For example, staff closed curtains when carrying out any care and support. Doctors and other staff closed bedroom doors when speaking with patients. We observed staff knocking on doors before entering bedrooms.

Good

Hospice services for adults

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.** They understood patients' personal, cultural and religious needs.
- Staff worked closely with social workers who provided a bereavement service. With consent staff made referrals for ongoing support.
- Staff had a good understanding of patients cultural, religious and social needs. Staff documented these when the patient arrived at the service. We spoke with the hospice chaplain who told us they supported all patients and patients were given the opportunity to have a wooden cross to keep with them until the time of passing. Patients were also given the opportunity to have a wooden heart if they did not have a religion.
- Staff understood the impact a person's care, treatment or condition had on them and on those close to them both emotionally and socially. We observed a family who were upset being supported by staff. Staff spoke with patients and their families in a sensitive way; patients were offered the support of a psychologist if needed.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions around their care and treatment.**
- Staff communicated appropriately with patients and their families; they communicated with kindness, respect and in a friendly manner.
- When appropriate patients and family members told us, families were involved in patient care planning and decisions around care. Patients felt their views were listened to in relation to the care they received. Leaders told us that they used the this is me document to look at what was important to each individual, what they were finding difficult and what would make them feel better; however, we did not see the document in the sample of notes we reviewed.
- Staff asked patients and their families about their preferred place of passing when they were admitted to the service. If the patients preferred place was at home, they would ensure the right services were in place to support this.
- There were no restrictions on visiting hours. This supported people to keep in touch with friends and family when they were in the hospice.

Are hospice services for adults responsive to people's needs? (for example, to feedback?)

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in a wider system and local organisations to plan care.**
- The facilities and premises were appropriate for the services delivered. Facilities were available for families to stay.
- Leaders took steps to identify any gaps in the service and acted to try to address the gaps. For example, we reviewed the minutes of the senior nurse meeting held in September 2018 and saw there was reference to identified gaps in service such as support groups and a list of adjustments the hospice could make with proposals.
- Staff told us they would use the translation services of the local hospital if a patient had a translation need. However, not all staff we spoke with were aware of this.
- Leaders told us that they were networking with various other agencies such as Age UK, Macmillan, Red Cross and the fire service which they connected to through their coffee mornings or pop ups around the country. The organisation had secured funding for an extension

within their Living well initiative. The service aim was to open doors wider to the local population. Leaders told us the new building would be a community 'hub' of information and activity and include a public cafe.

- The Co-Co service had created over 20 volunteer networks across Shropshire, working with local people and their GPs' surgery to develop a dedicated befriending service.
- Leaders also told us the team had delivered a two-day palliative care course to trained community nurses. As part of this they had asked local nursing homes how they could support them with training in order to adapt the course to meet their needs.

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 co-ordinated care with other services and providers.
- The hospice outreach team worked with patients mainly in the last twelve weeks of life. The team was made up of senior nursing staff. If a patient became unwell at home, nursing staff could do clinical observations and take bloods when in the past staff would have needed to refer the patient to the district nursing team.
- There was a hospice at home team with a night service. This was mostly for patients in their last six weeks of life to support people with personal care and support. The service was mainly staffed by nursing assistants but there were nursing staff who supported with areas such as uncontrolled symptoms.
- The service took the hospice out into the community though their day services pop up coffee mornings.
- There was a day hospice room that had many activities for patients such as jigsaws, magazines and other crafts. The hospice also allowed visits from pets.
- Staff gave us an example of a patient who wanted to die in the hospice but wanted to go home to visit. The hospice made arrangements such as, ensuring there was the right equipment to enable it to happen.
- Staff demonstrated a person-centred approach to care planning and delivery of care. For example, care plans could be chosen depending on the patients' needs. Records in the care plan were free text meaning staff could record as little or as much as needed. We saw individual care plans on moving and handling, elimination, bowel function, pain, anxiety and fear. Care plans were detailed and regularly reviewed.
- We saw a room designed for patients' living with dementia. The room had more space, door handles that lifted instead of pushing down and an alarm on the patio door leading to the garden.
- When a patient died staff completed a bereavement talk with family when they discussed about any next steps and gave families and friends of the deceased a bereavement pack. The bereavement pack included various leaflets to guide people through what they needed to do next.
- There were rooms available where people could go if they needed some time alone.
- Staff could make a referral for psychologist input, the psychologist worked 1.5 days a week and was employed by the local trust.
- The hospice had a team of creative therapists who spent time with patients doing arts and crafts and making items such as brooches. One patient showed us a lavender bag which they had made.
- Complimentary therapists worked alongside the hospice staff. The aim of the therapy was to help patients relax, reduce stress, improve sleep patterns, improve physical symptoms and alleviate anxiety and depression.
- There was a lymphoedema clinic to support patients to control the symptoms of lymphoedema. Lymphoedema is a long-term condition that causes swelling in the body's tissues. Staff at the clinic could advise patients about treatments that could control symptoms. We did not observe a lymphedema clinic as there was not one taking place on the day of the inspection.
- Those experiencing a bereavement were given the opportunity to have bereavement support from the hospice social work team or a volunteer. Services

included individual or group sessions, a parent's group and a group for people who had suffered the loss of a partner and had dependent aged children. There were also childrens' therapeutic days.

- Those who had experienced a bereavement were able to come back for support in the future. Letters were sent to relatives following a loved one passing, if consented this included a bereavement service for children; there was no time limit for accessing this service.
- There was a sanctuary in the hospice where people of any religion could go to pray or to have some quiet time. In the sanctuary people could light a candle. There was a book where people could write thoughts and messages.
- The chaplain at the hospice saw anyone regardless of their beliefs and completed communions and blessings. People of different faiths could access their own faith leader. People were given the opportunity to have a small wooden heart if they did not have a faith.
- There were pictorial communication tools available for staff to communicate with patients if they were unable to use verbal communication. These included pictures of drinks, people, food types and body parts.
- Staff working in the community told us they were allocated patients daily, but timings were flexible to allow extra time when needed.
- Information was displayed on a notice board at the hospice on needs of Buddhist patients. This had been put in place due to a Buddhist patient who needed care and support.
- There were large gardens with benches where patients and their family could sit outside and enjoy the grounds.

Access and flow

- **Patients could access the specialist palliative care service when they needed it.** Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- There was an inpatient referral admission process in place. This included the referral criteria, reason for referral, the referral process, admission process and urgent admission.
- The referral criteria was patients who had an incurable, life limiting advanced and progressive disease where the focus of care has changed from curative to palliative living. Patients living within the catchment area could be referred to hospice inpatient care. Under certain circumstances referrals from outside the area would also be considered.
- Reasons for referral to the hospice included the control of pain or other symptoms, care in the last few days of life, psychological or spiritual support, rapid deterioration in condition and when a short-term admission would ensure longer term support of the patient at home.
- Inpatient units generally admitted patients between the hours of 9am and 4pm, however urgent admissions could be arranged for the same day or out of hours if appropriate and depended on bed availability. The process was that requests for urgent admission must be discussed with a senior hospice doctor, who was available 24 hours for urgent advice.
- At the time of inspection there was no patients on the hospice waiting list. Leaders told us of situations when a bed was not available, patients would be supported through the hospice outreach and hospice at home service. The hospice reported their waiting times were low at zero to two days.
- The average length of stay was 10 to12 days with around 30% of patients being discharged home with hospice community services.
- There were discharge processes in place which involved processes such as liaising with community staff, ensuring equipment was in place and home visits by occupational therapists.
- There was a triage nurse based in the office Monday to Friday 9am to 5pm. This meant families could have a faster response; this was a new development. Leaders told us in the past patients had needed to leave messages which could lead to a delay.
- The hospice held daily bed meetings when they discussed potential discharges. On a Friday a second meeting was held in the afternoon. We attended a meeting on the day of the inspection and noted discharges were discussed.

Learning from complaints and concerns

Good

Hospice services for adults

- **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 the staff.
- There was "your feedback" forms readily available for patients or their families to complete. Comment boxes and cards asked for a rating. Areas for feedback included food, hygiene and environment.
- One staff member we spoke with could give an example of how practice had changed as a result of a complaint. The issue was in relation to the patient's clothing going missing. As a result, staff now completed an inventory of what the patient brought in.
- We reviewed two complaints and found an apology had been given for both and concerns were addressed. One complaint was not within timescales, however holding letters to let patients/families know there was a delay had been sent.

Are hospice services for adults well-led?

Good

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

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- There was an established leadership team in place. The day to day management of the hospice was undertaken by the senior management team which included a chief executive officer, a director of care, a director of income generation, a medical director and a director of finance and information. The senior management team was accountable to the board of trustees which included a chairman and vice chairmen.
- We spoke with two hospice trustees who told us they were kept well informed of what was happening within the hospice and they attended regular meetings. The trustees at the hospice were unpaid volunteers from a variety of backgrounds.
- Staff told us they found managers approachable, who listened to them, they received feedback, were informed of any changes and leaders were on the wards most days.
- Staff were passionate about their job, they told us, at team meetings everyone was able to input and "the nursing team were brilliant". They also told us the chief executive's door was always open.
- The service had appointed a clinical governance lead to focus on driving; clinical audit, developing mechanisms for reporting and the engagement and education of clinical teams.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action.**
- The hospice had a clear mission and vision, however not all staff could articulate this. The mission was to provide the best care and a better life for people living with an incurable illness and for those important to them. The vision of the hospice was a world where people are cared for at the end of their life as well as they were at the beginning.
- There was a service strategy 2018 to 2022 in place. The strategy referred to nationally published documents including; the strategy for end of life care, Department of Health 2008, the care of the dying in the last days of life "The National Institute for Heath and Care Excellence" (NICE) 2015, more care less pathway (DOH) 2013, one chance to get it right, leadership alliance for the care of dying people (2014) and ambitions for palliative and end of life care, a national framework for action (2015).
- The strategy had six objectives which they had aligned to Care Quality Commission (CQC) domains. These included to improve access, establish living well as the future concept, culture for hospice care, establish Severn Hospice at home as an integrated and financially sustainable model of homecare, establish partnerships that maximise influence, to be the local

lead for palliative and end of life education and to connect compassionate communities as a voluntary aim with clinical services. There was also an action plan in place to achieve each objective.

- Leaders told us that the strategy was reported through the committees, had annual reviews through the board and regular updates were given to the clinical governance committee.
- We observed a sign at the hospice displaying the hospice mission and vision and team philosophy.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.**
- Staff told us they were happy in their jobs and it was "not a job it was a privilege".
- Staff working in the community told us they felt they got "massive support" by those in senior positions. They also told us they could discuss any concerns immediately and had face to face handovers daily.

Governance

- **Leaders operated effective governance processes, throughout the service and with clear organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from performance of the service**.
- Regular clinical governance meetings took place. We reviewed the meeting minutes from March 2019 and saw there was a list of attendees but not their profession. Clinical audits were presented at the meeting, incidents were discussed including a summary and actions. Other topics of discussion included complaints, policies for approval, and IT equipment. The hospice had appointed a part time clinical governance lead.
- We reviewed the minutes of the senior nurse meeting held in September 2018 and saw there was information on key documents including the six ambitions for palliative and end of life care, and the hospice living well ambitions. There was also reference to identification of gaps in the service such as support groups and a list of adjustments the hospice could make and proposals. Other areas discussed included bed meetings, audit results and pharmacy.
- The board had established various committees, sub committees and an advisory committee. Committees included finance, clinical governance, corporate governance and human resources, fundraising, retail, nominations, communications and marketing and a property and estates strategy group (advisory committee). The scheme for the corporate governance clearly set out the committee members, frequency of meetings and who needed to attend.
- The hospice had a strategic approach to monitoring outcomes, including future development to improve outcome monitoring. There was a quality account document in place 2019 to 2020. The document contained details on achieved reviews of last year's quality performance including of development of hospice at home, review and restructure of traditional community specialist nurse service, medicines management and improvement of facilities. It also set out the priorities for achievement in 2019 to 2020 in areas of patient and relative experience, clinical effectiveness and patient safety.
- The hospice leaders mapped aspects of their work to each of the CQC domains using the key lines of enquiry. The purpose of this was to reinforce to staff everything they do and how it aligned to the Health and Social Care Act 2008.
- The hospice completed a comprehensive service report which included data on numbers of referrals, deaths, discharges, bed occupancy, patient's primary diagnosis, patient's geographical area and source of referral. This meant that the hospice were able to find information on the above quickly if needed.
- The board met five times per year. We reviewed the board meeting minutes from March 2019 and May 2019 and found they contained information such as; what was on the risk register and the position of the clinical commissioning groups. Reports shared at board included the chief executive report and a report from the director of income generation and director of care.

- Each committee had clearly defined roles and responsibilities which had been set out in a specific document. For example, the role of the clinical governance committee included assuring policies and processes were in place to deliver the highest standards of care and compliance with legal and regulatory frameworks.
- The service recognised it had work to do on keeping all staff data in one place so that they could accurately record staff information such as staff training. Leaders told us to resolve this the organisation had invested in a new electronic programme.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision making to help avoid financial pressures compromising the quality of care.**
- The hospice had a risk management policy in place. The aim of the policy was to create robust structure, systems and processes that minimised or eliminated as far as was reasonably practicable risks to patients, staff and the hospice, by promoting consistency in practice in clinical areas; the policy was in date and version controlled. Responsibility for risk management lay with the board of trustees.
- We reviewed the minutes of the corporate governance and human resources committee meeting dated January 2019 and we noted there was a discussion around the risk register. Other topics included a report from human resources and a voluntary services update.
- There was a systematic programme of audit to monitor quality, operational and financial processes and systems to identify where action should be taken, this was reflected in the audits completed, the knowledge of leaders and at board level.
- Risk assessments were completed and recorded on risk assessment forms. For example, we saw staff completed risk assessments for various reasons including outside drains, corridors and the flower room. Risk assessment forms were signed off by the health and safety committee, the forms contained the date this happened.
- The hospice had external companies to visit and complete risk assessments. For example, a legionella risk assessment was completed in April 2019 and a fire risk assessment review was also completed by an external company in 2017. This followed up on the previous fire assessment completed in 2010.
- The corporate governance committee was responsible for reviewing all risks and changes reflected in new versions of the risk register. The process for closing risks was that the proposal to close were taken to the hospice board for approval. We reviewed the risk register and found there was a risk scoring matrix.
- The Severn Hospice risk register 2019 had 11 risks and covered both sites. Each risk had a control procedure, likelihood, planned action, lead and a review date. Risks included; limited space to accommodate the range of day services to support development of community services in line with strategic objectives, financial risk and inability to recruit into key posts.
- The hospice had a pandemic contingency plan in place. The plan contained details on objectives, priorities, impact on staff, phases, assuring the supply chain and storing large numbers of bodies.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats**
- There were blue bins available for any confidential waste which were collected by an external company.
- The service regularly completed notifications to the Care Quality Commission when a patient had died or had a serious injury.
- Staff kept patient records securely. Electronic patient records were kept securely on computers which were password protected. Leaders told us temporary staff were given temporary access to the any electronic systems. Records contained details of peoples' emotional, social and spiritual needs alongside their physical health.

- There was a confidentiality and data protection policy in place with a review date of April 2022. The policy contained relevant information such as access and disclosure of personal information, information sharing, reporting breaches of and risks to confidentiality.

Engagement

- **Leaders and staff actively and openly engaged with patients and staff, to plan and manage services.**
- The hospice staff used patient feedback tools to measure patient outcomes.
- Leaders told us that the hospice led a multi-organisational Shropshire End of Life Group which determined the joint local strategy.
- There was regular communication with staff via 'keep you in the loop letters. We reviewed information from November 2018, May 2019 and February 2019 and saw they contained updates in areas such as the dependency score, amount of patient falls, pressure sores and long service awards for staff. There was a staff support board with information on what was wellbeing for staff, minutes from the health and safety committee meetings and information of staff forum messages.
- The hospice held various staff awards to recognise staff contribution, which included long service awards staff members. The hospice sought out staff opinion through the use of a staff survey.
- The hospice had a handbook for staff. The handbook contained useful information for staff including income generation, dress code, appraisals, the care directorate and information about the wards.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
- The medical director undertook the lead for education and in 2017 was awarded the Honorary Professor for Palliative Care by a local university. The role involved taking responsibility for the development and delivery of a programme of education aimed at district nurses, GP's, hospital doctors and other health professionals as well as the hospice's own staff.
- During a visit with hospice at home carers, staff told us they had completed a verification of death course. They felt this was very positive and it added to the quality, continuity and care of patients and family.
- The hospice provided training education to external groups to deliver palliative care such as verification of death, food hygiene, and spiritual and religious care. The prospectus was available on the hospice website.
- There were cards at reception which family could leave to let the patient know they had visited.
- The work of the hospice audits had been translated into poster presentations and accepted at national conferences. The hospice also had papers published in various journals.
- An extra mile award was awarded to the hospice "Special Achievement" in a local advertiser Business and Community Award.
- Two ward sisters, two outreach nurse and one registered nurse completed degrees in palliative care. One health care assistant completed a nurse practitioners' degree. One ward sister had completed a level 5 City and Guilds course in leadership and management.
- The Breidden was awarded Special Achievement by a local Advertiser Business and community award. The organisation was awarded Queens Award for voluntary services.
- Leaders told us how the hospice was at the forefront for researching adult palliative care for those with neuromuscular disease.

Outstanding practice and areas for improvement

Outstanding practice

- In relation to neuromuscular disease, a model tested by the hospice had been presented at international meetings and was being used to define NICE guidelines.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure there are clear agreed processes and protocols around sepsis and that all staff are aware of these.
- The provider should ensure there are accurate, workable systems in place to record staff training and that all mandatory training is completed by all staff.
- The provider should ensure oxygen cylinders are stored in accordance with hospice policy and that the policy is clear on the storage of used oxygen cylinders and collection.
- The provider should ensure all relevant staff know how to access translation services if an interpreter is required.
- The provider should consider recording referrals made to district nurses around community acquired pressure damage on their electronic reporting system.