

Rowcroft House Foundation Limited

# Rowcroft Hospice

## Inspection report

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

### Ratings

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

# Summary of findings

## Overall summary

Our rating of this service went down. We rated it as good because:

- 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 effective care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. They monitored patient's outcomes, evaluating the effectiveness of interventions to ensure patients achieved their goals. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Leaders were active in the local community and health economy, representing the hospice and influencing improvements to meet the needs of local people. The service planned care to meet people's needs, took account of patients' individual requirements, and made it easy for people to give feedback. Staff responded promptly in changing the way services were delivered during the pandemic to better meet the needs of patients. People could access the service when they needed it.
- Leaders had a shared purpose to provide outstanding care. They ran services well using reliable information systems and supported staff to enhance their skills and improve the care they delivered. Leaders developed systems which supported innovation, they were focused on improving care across the local health economy. Services were developed to meet the needs of patients. 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.

However:

- Not all staff eligible to complete safeguarding level three training had done so.

We rated this service as good because it was safe, effective, caring and responsive, with good leadership.

# Summary of findings

## Our judgements about each of the main services

### Service

**Hospice services for adults**

### Rating

Good



### Summary of each main service

Our rating of this service went down. We rated it as good because:  
See overall summary for more information

# Summary of findings

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# Summary of this inspection

## Background to Rowcroft Hospice

Rowcroft Hospice is operated by Rowcroft House Foundation Limited. It offers community and inpatient hospice care for people affected by life-limiting illness and serves the communities of Torquay and South Devon.

The Rowcroft inpatient unit is a 12-bed facility which provides respite care, symptom control and care for patients at the end of life. The hospice delivers end of life care in patients' homes and this service works closely with the hospice inpatient unit to support the care needs of patients. There is a team of clinical specialist nurses, healthcare assistants, therapy services, and bereavement services. There is a team of consultants and specialty doctors who support the inpatient unit and home visiting services. Hospice staff work closely with clinical nurse specialists and medical staff at the local acute trust. This close working relationships enables collaborative working across the acute and community services, providing a more seamless service to patients and their families. The clinical nurse specialist team also provides specialist end of life care to local nursing and care homes. The Rowcroft educational team ran events and courses for health and social care professionals to enhance their palliative care knowledge and skills.

The service is registered with the CQC to provide:

- Personal care
- Treatment of disease, disorder and injury

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach. We previously inspected Rowcroft Hospice in 2016 using our adult social care framework. This was the first inspection of the hospice using our healthcare framework.

## How we carried out this inspection

We visited the inpatient unit, the hospice at home and clinical nurse specialist teams. We held interviews with service leads and executives. We spoke with 17 staff including nurses, health care assistants, doctors, consultants, reception and non-clinical staff. We also spoke with three patients or their relatives who had experienced support from hospice staff. We observed care and treatment provided in patients' homes and in the inpatient unit, reviewed data about the service and reviewed four patient care records.

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

## Outstanding practice

We found the following outstanding practice:

- We saw that senior leaders engaged with the wider health economy and were engaged with appropriate networks aligned to their service and its future vision and strategy. We saw that the hospice strategy aligned to local plans in the wider health and social care economy. Senior leaders actively influenced service and care improvements locally. There was a culture of innovation and improvement within the service.
- The hospice took a lead role in developing training initiatives for other providers, often leading to innovations in end of life care across the local health economy. This included a traineeship programme for acute and mental health

# Summary of this inspection

practitioners. A 2019/20 bespoke training package for domiciliary care workers was also developed. The aim was to increase the confidence and competence of care workers in the community providing end of life care in order to reduce inappropriate admissions to hospital. Project evaluation showed increased confidence of domiciliary care workers in supporting patients at the end of life in their homes.

## Areas for improvement

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

### **Action the service SHOULD take to improve:**

- The service should continue to take action to improve mandatory training compliance, particularly in relation to level three safeguarding training and face to face modules.






# Our findings

## Overview of ratings

Our ratings for this location are:

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

# 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 stayed the same. We rated it as good.

### Mandatory training

#### The service provided mandatory training in key skills to all staff.

Mandatory training was comprehensive and met the needs of patients and staff. A training needs analysis had been carried out in 2019. Training needs were identified for different teams and specific roles. This included staff and volunteers, for example, in relation to moving and handling training. Other mandatory training included modules in infection prevention and control, chaperoning, health and safety and basic life support. All staff received end of life care training. Additional competency training modules including for syringe drivers (a battery operated pump that delivers continuous infusion of medicines) and wound care were completed. Staff told us they were given time to complete these modules within their working hours.

Managers monitored mandatory training and alerted staff when they needed to update their training. New staff were provided with a programme of orientation and basic skills needed to fulfil their roles. Completion was overseen by their line manager.

Staff received mandatory training and mostly kept up to date with it. Staff training compliance was reported to the executive team and to commissioners of the service. Compliance levels in each staff group were rated as red, amber or green to demonstrate where training had not been attended. As of September 2021, compliance for staff on the inpatient unit was 85%, for community services 82% and for the hospice at home team 94.5%. The executive team informed us that rates of training compliance had been affected during the COVID-19 pandemic and efforts had been made to improve. For example, compliance rates for the inpatient unit had increased by 13% and for the hospice at home team by 11% since March 2021. The hospice training target was 90%.

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

### Safeguarding



# Hospice services for adults

**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. However, safeguarding training compliance was below target.**

Staff received training specific for their role on how to recognise and report abuse. The hospice had aligned their safeguarding training requirements with the local NHS Trust and national guidance. This included level three adult safeguarding for senior clinical staff and level two adult and child safeguarding training for registered nurses, with all nursing staff working towards level three training. The hospice safeguarding lead was trained to level five. Level two adult safeguarding training compliance was at 82% and level two child safeguarding compliance was at 76%. Safeguarding training compliance rates for level three adult safeguarding were low at 40%. However, managers told us this was because there had been difficulties accessing the required face to face training, due to the pandemic, since the requirement for level three training had been implemented. Training compliance was regularly discussed at meetings and managers had scheduled staff in for the required training and supported them to attend.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was clear guidance within the safeguarding policies about how to escalate concerns. A “Report” form was included in the policy and contained external contacts for escalating concerns. Staff reported that they understood the requirements and knew who to raise concerns with. Safeguarding alerts were reported on the patient safety and experience dashboard and were reviewed by the quality improvement group monthly. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

## 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.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The service generally performed well for cleanliness. We viewed monthly infection control audit data and saw that the inpatient unit scored between 89% and 97% for infection control compliance in 2021 to date. This included an assessment of hand hygiene performance which was 100% in September 2021, as well as the cleanliness of both patient and non-patient areas within the clinical unit.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. “I am clean” stickers were in use to provide assurance that equipment had been cleaned after use.

Staff followed infection control principles including the use of personal protective equipment (PPE).

On the inpatient unit, staff ensured they were bare below the elbow, followed hand hygiene protocols and changed PPE between patient contact.

For every community visit, staff changed all PPE before entering the patient’s home and removed it once outside and disposed of it in sealed plastic bags.

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Areas of the inpatient unit had been repurposed to reduce risks of COVID-19 transmission. This included single isolation rooms and a dedicated area for COVID-19 positive patients to enable isolation in the event of an outbreak. Shared inpatient bays had enough space between beds for social distancing and patients and staff were regularly tested for COVID-19. There was dedicated space to allow staff and visitors to the unit to be tested for COVID-19 and maintain two metre social distancing from others.

The service used infection control measures to prevent the spread of infection before and after the patient died. There were suitable arrangements with funeral directors for the transfer of the deceased.

## Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We observed staff responding promptly to patient's needs.

The design of the environment followed national guidance. All clinical areas had floor coverings which were easy to clean. Safety checks and maintenance plans were adhered to. There were risk assessments for fire safety, water safety and building and grounds maintenance. Action taken to minimise risks was timely and there was a regular schedule of assessment and works by external contractors.

A Patient Led Assessment of the Care Environment (PLACE) audit was carried out in June 2021. The audit looked at the suitability of the environment, including in relation to privacy and dignity. Results of the audit were positive in this regard.

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

Clinical equipment, including beds, hoists and assisted baths were regularly maintained. Calibration of medical devices was carried out annually. Equipment that was faulty was repaired or replaced. For example, the hospice had recently replaced syringe driver pumps on the inpatient unit. Staff carried out daily safety checks of emergency equipment. Equipment used for emergency situations was appropriate and accessible for staff when needed. We saw this was logged as checked daily and single use equipment was within 'use by' dates.

The service had suitable facilities to meet the needs of patients' families. Rooms were spacious and equipped with bathroom facilities. There were suitable facilities for patients requiring assistance with hygiene needs, including disability access bathrooms and assisted baths. Chairs were fully adjustable and could be used by relatives/carers if they were staying for longer periods of time. Patients and their families were able to easily access outside space if they wished.

Staff disposed of clinical waste safely. Staff segregated clinical waste and stored it securely within designated storage areas. Sharps waste was stored in line with requirements using colour coded pharmaceutical waste bins that were appropriately labelled.

## Assessing and responding to patient risk

# Hospice services for adults

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately in line with patient's wishes. Where appropriate the National Early Warning Score (NEWS2) system was used as an indicator for action based on patients' vital signs such as blood pressure, respiration and heart rate. NEWS2 is nationally recognised tools to identify and escalate deteriorating patients. There was a sepsis in palliative care protocol that was based on the local NHS trust sepsis screening protocol and included neutropenic sepsis. Staff had received training in the recognition of sepsis and there were clear guidelines for staff to follow, including a nationally recognised sepsis toolkit. Patients had a treatment escalation plan detailing the level of treatment deemed appropriate and in line with their wishes. This included clear instructions where it was no longer appropriate or wished for a patient to be admitted to hospital should their condition deteriorate.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed four patient records and saw that risk assessments were routinely completed on admission and regularly reviewed. This included the assessment of the risk of pressure sores, falls, the use of bed rails, malnutrition and dehydration and moving and handling.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients including if they were thought to be at risk of self-harm or suicide. The service had access to a clinical psychologist through the local NHS trust, who provided support for hospice patients and their families. Staff could also access the local mental health trust for further support.

Shift changes and handovers included all necessary key information to keep patients safe. This gave key information including treatment escalation plans, do not attempt cardiopulmonary resuscitation (DNACPR) decisions and patient's care wishes. A handover form was created at each shift change and staff had enough time and opportunity to discuss changes in patients' conditions and other care information.

## **Nurse 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, and gave bank, agency and locum staff a full induction.**

Managers calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. We reviewed rotas and saw that planned staffing was six staff for an early shift, five for a late and four for a night shift. There was a minimum of two registered nurses on a shift, with a third working the morning shift.

Planned versus actual staffing was monitored using a patient care dashboard. We reviewed the dashboard for the most recent six months and saw that actual staffing ranged from between 93% and 109% of the planned numbers. Managers told us that additional staff above the planned establishment were sometimes required where patient dependency increased.

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Managers monitored rates of sickness, staff turnover and vacancies, including reasons for any increases. The COVID-19 pandemic had presented challenges for staffing the service. For example, we saw that the clinical sickness rate was 8% for the current year, compared with 3.9% for the previous year. Managers and staff told us this was due to staff self-isolating as well as an increase in sickness. Managers were aware of the challenges faced by clinical staff that impacted on sickness and they put in place flexible working and support to maintain morale as much as possible.

Managers had reviewed and reduced the number of inpatients accepted in the unit at any one time in response to staff shortages. At the time of the inspection they had a maximum number of 12 beds operating on the inpatient unit, as opposed to the 13 they were registered to provide. This ensured safe staffing numbers followed national guidance. The service had kept commissioners and stakeholders informed of staffing issues and action taken to address them.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

The hospice used a regular team of bank staff on the inpatient unit and this activity was monitored alongside other staffing within the dashboard.

The managers could adjust staffing levels daily according to the needs of patients. The dependency tool operated alongside the use of professional judgement to adjust staffing levels based on patient need. This included adjustments following increased dependency, for example, where a patient was identified as requiring one to one care or increased monitoring. As part of their 2018 superfluid strategy, the service had a team of 'superfluid' nursing staff who worked across both inpatient and community services. As a result, they were able to be moved to support aspects of the service where there was the greatest need.

The service had a reducing vacancy rate for clinical staff with four whole time equivalent vacancies in the most recent quarter of the year compared with five for the previous quarter.

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**

The service had enough medical staff to keep patients safe. There were 1.6 whole time equivalent consultants in specialist palliative care employed by the hospice. In addition, there was one whole time equivalent speciality doctor post, shared by two post holders, who worked the additional portion of their whole-time equivalent post at the local NHS trust. The service supported trainee doctors and medical students.

The service always had a consultant on call during evenings and weekends. This included rotation with other specialist palliative care consultants in the locality.

## Records

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

Patient notes were comprehensive, and all staff could access them easily. Patient records were in both electronic and paper format. Staff had access to electronic devices to access records although care plans were printed and stored in

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paper form to ensure they were readily available to relevant staff. Managers told us that they had introduced the electronic patient record system immediately prior to the pandemic and this had resulted in a slower than anticipated roll out of a completely electronic system. There were plans in place to comprehensively address this and they had identified the risks associated with having patient records in two formats. Action to mitigate the risks included having duplicate paper copies of care plans and risk assessments so that these were accessible to all staff.

Patient notes in the community and the inpatient unit were comprehensive and all staff could access them easily. Records we reviewed had individual assessment and care plan documents which were personalised and included patient wishes and consent to share information. When patients transferred to a new team, there were no delays in staff accessing their records.

Hospice at home and community staff recorded updates on the electronic patient record system when they got back to the hospice. Paper records kept in patient's homes were used by district nurses and hospice Clinical Nurse Specialists (CNS) recorded information in them that needed to be shared.

An audit of record compliance was carried out in January 2021. This identified some gaps in recording of information such as ethnicity and diversity questions. As a result, a new page was created on the system as a prompt for staff to complete. A re-audit was planned for January 2022.

## Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We looked at two treatment charts and three patient records on the inpatient unit. Allergies were recorded. Administration of medicines were accurately recorded, and explanations were given if medicines were not given for any reason. Staff made sure patients received their medicines, especially those that were time specific. The service had a service level agreement with a local community pharmacy service to provide clinical pharmacy and medicine supply service. Staff told us they were able to obtain medicines promptly. The pharmacist visited the inpatient unit twice a week and attended the multidisciplinary meeting to discuss patient care.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff stored, handled and recorded controlled drugs in line with requirements. The inpatient unit had locked cupboards on walls within treatment and patient rooms. We saw checks on temperatures were completed and logged by staff daily, and stocks of medicines were checked by registered nurses.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service completed medicines audits which included checks on staff compliance with policies, medicine errors and the administration and recording of controlled drugs. Incidents involving medicines were investigated and actions to improve practice were monitored to prevent a recurrence of the incident. We viewed a record of a medicines safety huddle where incidents in recording controlled drug administration was discussed with a range of staff. Action included reminding staff of their responsibilities, increasing the frequency of audits and additional training, supervision and assessment of competency as required.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We observed nursing staff on a home visit and on the inpatient unit assessing patients to ensure medicines prescribed via syringe drivers were effective in reducing their pain and discomfort. This included discussing needs and options with

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patients and their carers. Staff were in the process of undertaking a scoping exercise to explore a potential project to support carers in the community to administer subcutaneous medicines (injections of medicines just beneath the skin). The scoping involved identifying carers who were willing to participate in a pilot to receive training to administer medicines.

Staff followed current national practice to check patients had the correct medicines. We saw staff checking the right medicine was provided to the right patient, at the right time, in the right way and in the right format by checking prescriptions and patient identity.

## Incidents

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

Staff knew what incidents to report and how to report them. Incidents were recorded on the electronic record system and reviewed operationally by senior staff on a weekly basis. Staff felt confident about reporting incidents and we saw there was a good reporting culture. Incidents recorded included medicines, falls, pressure ulcers, accidents and staffing issues. Serious incidents were reported externally in line with national guidance, for example, pressure ulcers of grade three or above.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. This included an apology at the time of the incident and an explanation of investigation findings and actions to minimise the reoccurrence.

Staff received feedback from investigation of incidents, both internal and external to the service. Data on incident reporting was collated, reviewed and shared routinely at a range of internal meetings. Rowcroft Hospice was a part of a network of hospice providers across the region who met regularly, sharing learning and good practice. Trends were identified and experiences shared to improve quality and safety across the region.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. This included addressing staff competencies when an incident regarding staffing was raised. Actions were implemented to ensure training and competency assessments were completed in a timely way, thus ensuring there were enough staff to administer blood transfusions and intravenous medication.

## Safety thermometer

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**

The service continually monitored safety performance. The incidence of pressure ulcers, medication errors, falls and other incidents was routinely recorded. A quarterly quality report was reviewed by the clinical sub-committee, learning cascaded to teams and information shared with the board of trustees. Benchmarking data was submitted to Hospice UK. This showed a higher than average number of low harm falls and hospice acquired pressure ulcers. We saw that the hospice reviewed and acted on trends and increased incidents. For example, through deep dive investigations of both

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pressure ulcers and falls. Investigations showed that the increased trend was aligned to an increase in patients with more complex needs. An investigation of a pressure ulcer serious incident by the clinical commissioning group (CCG) concluded that the incident was unavoidable due to the poor health of the patient. As a result, the incident was declassified from a serious incident.

Inpatient safety and experience reports were shared with staff, patients and visitors on a monthly basis.

## Are Hospice services for adults effective?

Good 

Our rating of effective went down. We rated it as good.

### Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Organisational and care policies took account of relevant national guidance, for example NICE Quality Standard 13 End of life care for adults and NICE guidance 31 Care of Dying Adults in the Last Days of Life. Patients had personalised care plans and assessments took account of people's emotional, spiritual and social needs. Care in the last days and hours of life delivered the Five Priorities for Care of the Dying Person.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had received training in the Mental Health Act and understood the principles of caring for patients who were subject to it. This included ensuring that patients had access to relevant advocates to support their rights and wishes.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff recognised these aspects of care as equal to those relating to physical needs.

### Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Staff regularly checked if patients were eating and drinking enough to maximise their comfort and health outcomes.

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We saw nurses talk to patients about nutrition and hydration, the use of nutritional supplements and finding out foods that patients could tolerate and would prefer. Hospice catering staff met with patients to discuss preferences and created individualised meals to promote nutrition, comfort and preferences. Staff told us that catering staff went out of their way to ensure patients had the food they wanted. Staff told us that the meals consistently received a five star rated feedback from patients and families.

Staff fully and accurately completed patients' fluid and nutrition charts where needed and encouraged intake in line with patient wishes. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

When patients were no longer able to eat or drink, or when intake was minimal due to overall deterioration in their health, staff prioritised the delivery of oral care in line with evidence-based practice. The focus of this was to promote comfort. Information about mouth care was available to patients and their relatives and staff supported relatives who wished to be involved in this aspect of their loved one's care.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients had access to pain relief when they needed it. Anticipatory medicines were prescribed for patients on the inpatient unit and 'just in case' medicines in the community for symptom control. These were medicines prescribed to be administered as needed and not as a regular prescription. For example, medicine for nausea, agitation, breathlessness and pain relief. We found 'just in case' medicines were prescribed and given as needed.

Patients were admitted to the inpatient unit to assess and manage their symptoms so that they could be effectively controlled. Assessment of needs included patient wishes to ensure that priorities for symptom management were in line with this. Complementary therapies were used alongside pharmacological interventions for pain relief.

Patients received pain relief soon after requesting it. We observed staff responding promptly when patients were in pain and there were ongoing assessment processes in place to establish the effectiveness of medicines given.

Staff prescribed, administered and recorded pain relief accurately. Medicine and pain assessment charts were completed as soon as pain relief was administered. The effectiveness of pain relief was routinely evaluated.

## Patient outcomes

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

The service participated in relevant national clinical audits. They participated in the hospice UK benchmarking activity which showed the hospice performed largely in line with other similar services over time. Benchmarking data was focused on patient safety and risks in relation to falls, pressure ulcers and medicines incidents. Where benchmarking showed an increased level of risk, for example, in falls or pressure ulcers, the hospice took action to improve. This was using deep dives and changes to work practices as necessary.



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Service leads monitored patient outcomes. They had used the Outcome Assessment and Complexity Collaborative measure as part of a pilot on the inpatient unit in 2019. Results showed improvement in patient outcomes during admission. For example, in relation to pain, nausea and vomiting and worry about friends and family. Managers told us they had not formally adopted the measure at the time of inspection due to the implementation of the electronic patient record system. However, there were plans to use the learning from the pilot to develop a comprehensive approach to recording patient outcomes.

A 'breathe easy' project had been run by the hospice from September 2019. This had paused during the pandemic and the project redesigned to be delivered virtually in 2020. The programme supported 21 patients with non-malignant respiratory conditions and their carers across five, four-week self-management programmes. The service involved physiotherapy, occupational and complementary therapy interventions as well as nurse led advance care planning and carer strategies. They used recognised measures to evaluate the success of the service on patient outcomes. This included the Hospital Anxiety and Depression (HAD) scale which showed a reduction in anxiety for all patients following the courses. A chronic obstructive pulmonary disease self-assessment test (CAT) showed that 60% of patients reported improved or stable symptoms. A breathlessness scale showed that 100% of patients reported improved or stable breathlessness levels.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a plan of annual audits which were reported to the executive team and commissioners. Improvement actions were identified following these audits and demonstrated how staff compliance with practice had improved. For example, there had been a 30% reduction in medication errors between March and June 2021, following additional investigation, support and training as a result in an identified upward trend in errors occurring.

Managers shared and made sure staff understood information from the audits. We saw information was presented to staff in formats which clearly showed audit results and where improvements were needed. Regular audits included consent, duty of candour, records and care plans, discharge letters, waiting times and admission delays.

## Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Senior staff had completed specialist modules in palliative and end of life care. Some nursing staff had completed advanced nurse practitioner training.

Managers gave all new staff a full induction tailored to their role before they started work. Training and competency assessments were carried out. For example, in relation to the administration of intravenous medicines and syringe drivers. New staff had regular probationary reviews and worked shadow shifts until confident. Probation plans included achievable goals with support provided based on individual needs.

As well as mandatory training, new clinical staff completed essential skills training which included enhanced communication skills and other training specific to their roles.

Managers supported staff to develop through yearly, constructive appraisals of their work. The hospice's approach consisted of an annual meeting, with six monthly review, quarterly check in and regular one to one meetings, focusing on continuous feedback to improve performance. Overall, 72% of staff had received a formal appraisal in the last year.

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This had been impacted by the pandemic and we saw that several appraisals had been postponed. However, the hospice had a plan to address this and improve completion levels in the coming months. It was recognised that staff needed additional support during the pandemic so one to one and group support sessions were set up. This included wellbeing briefings during the height of the pandemic. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Externally facilitated group and one to one clinical supervision was available and staff were encouraged to attend. In addition, huddles took place on a regular basis so that staff were involved in reflective learning sessions when things went wrong or had been difficult. The hospice had adopted a restorative practice model to improve learning and relationships. Managers had been trained as restorative practice facilitators with an aim of ensuring everyone had a voice, encouraged responsibility and accountability, created a non-blaming environment and dealt with the problem rather than the person. Staff told us they felt supported in their roles and that they had access to clinical supervision when they needed it.

The clinical educators supported the learning and development needs of staff. There was a clear, structured training programme that was accessible to staff internally and externally. Managers made sure staff received any specialist training for their role. Subjects included the fundamentals of care, recognising dying, palliative care emergencies, symptom management and the use of syringe drivers. It was evident that when providing new services, that learning, and development needs were considered. For example, a 2018 project to improve the palliative care of patients with heart failure included a training needs analysis and provision of specialist training for staff involved in the project.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This included attendance at specialist conferences as well as external training courses.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were trained to fulfil their role and had regular supportive meetings with managers to identify training and support needs.

## Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff attended external multidisciplinary meetings to ensure palliative care input for patients in the community or other inpatient settings. This included CNS attendance at a local heart failure multi-disciplinary team (MDT). The medical director chaired a regular local motor neurone disease MDT. Staff told us that some GP practices held Gold Standard Framework meetings where MDT staff met regularly to review the care of patients at the end of life. The focus of these meetings was to provide collaborative care in the community and reduce unnecessary hospital admissions. Some of these meetings had been online during the pandemic. Other meetings had been stopped because of the pandemic. However, a number of previously cancelled meetings were starting up again and CNS were consistently in attendance to provide specialist input.

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There was a weekly multidisciplinary meeting held on the inpatient unit with input from medical staff, nurses and allied healthcare professionals such as a physiotherapist and occupational therapist.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. There were internal psychological and support services available for patients who required additional specialist support.

## Seven-day services

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

Consultants led daily ward rounds, including at weekends. Patients were reviewed by consultants as required. Out of hours on call arrangements were in place so that staff could access support as needed. Hospice at home services were available 24 hours, seven days a week.

Specialist nursing and medical support was available seven days a week and patients were reviewed daily. Specialist consultants were always available for advice. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

## Health promotion

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

The service had relevant information for patients to use and make choices. Staff openly discussed options with patients and their families. Honest information was given to enable patients to balance risks with personal choice and quality of life considerations. Emphasis was given to how patients wanted to live their lives and methods of meeting those choices. Patients and their families were supported by teams across the service to 'make every day the best it can be' in line with the hospice's vision.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Informed consent was obtained for invasive procedures such as blood transfusions which required written consent. Written consent for sharing information was also sought. Consent was audited annually. Results showed that 94% of patient records had evidence of consent for sharing information internally. Consent to external sharing of information, for example, with GPs or other professionals, was at 99%.

Do not attempt cardiopulmonary decisions (DNACPR) were made appropriately and in line with national guidance. There was evidence of discussion with patients and those close to them.

Staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood the relevant consent and decision-making requirements of legislation and

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guidance, including the Mental Health Act, MCA and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff described situations where mental capacity assessments and best interest decisions had been made. They were aware of how to access independent mental capacity advocates as a legal safeguard for patients who lacked the capacity to make specific decisions.

Managers monitored the use of DoLS and made sure staff knew how to complete them. Managers monitored how well the service followed the MCA and made changes to practice when necessary. They audited DoLS to ensure that approved documentation and processes were followed.

## Are Hospice services for adults caring?

Good 

Our rating of caring went down. We rated it as good.

### Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way, giving them the time to interact. They introduced themselves and explained the focus of their visit / care. Hospice at home and community staff communicated openly with the patient and family when visiting them at home. They allowed time for questions and showed empathy in their interactions.

Patients said staff treated them well and with kindness. We were given examples of when staff had gone out of their way to support people. This included arranging a 'lockdown' wedding for a patient who wished to marry their partner at the hospice.

Staff followed policy to keep patient care and treatment confidential. They were discreet in their interactions and took time to ensure privacy and dignity. This included ensuring patients in shared bays had enough space and privacy away from others, using privacy curtains and taking action to ensure discussions were not overheard.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. They recognised the totality of patient's care needs, assessing them holistically to ensure that emotional and social aspects of their care were considered. They took action to ensure patients stayed connected with their loved ones, even when communication was difficult. During the pandemic all patients continued to have nominated visitors, with risks appropriately assessed and minimised. Staff supported them to stay connected using electronic devices for phone and video calls.

### Emotional support

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

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Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff sitting with patients and family members, giving them time to talk. Staff were kind and caring and recognised the emotional needs of patients. They responded promptly to both verbal and non-verbal cues about people's emotional needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us they were able to find space within the hospice for private conversations, especially for those patients who were cared for in shared bays.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Clinical staff had attended advanced communication training and understood the importance of clear, honest and compassionate communication for patients at the end of life.

The hospice set up and delivered an emotional wellbeing helpline at the start of the pandemic. The helpline provided supportive listening to people adversely affected by the pandemic. They provided support for bereavement and for those dealing with the impact of increased social isolation and its effect on their mental health.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The multidisciplinary team consisted of social work and bereavement staff. They worked collaboratively with clinical staff to support the emotional as well as social and physical needs of patients. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. As part of their inclusion workstream, the hospice explored ways to improve understanding of different cultural, social and religious care needs. Work included reaching out to different cultural groups to better understand the cultural needs of people at the end of life.

The hospice partnered with local businesses to provide 'special moments' to patients. Examples included providing a cream tea for a patient and their friends, another patient had a performance at the hospice from a classical singing star.

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

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

Staff made sure patients and those close to them understood their care and treatment. Patients were assessed daily on the inpatient unit and medical staff gave them time to discuss their treatment. Nurses and members of the multidisciplinary team gave information about care interventions, ensuring patients understood and were involved in all care decisions.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Communication needs were routinely assessed on entry to the service and were reviewed as needed. Communication assessments included the identification of aids such as written materials in braille or large font, interpreters, use of British sign language and the need for pendant call alarms to ensure access to staff when they needed it. The hospice had an inclusion workstream and an inclusion lead. We saw that the group had explored communication issues experienced by deaf people on the inpatient unit and the community. Key actions included

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hearing awareness training for staff and accessing interpreters. A hearing loop was available on the inpatient unit. Following a complaint from a relative, the hospice recognised that when English was not the first language, interpreters were not always considered. As a result, they raised awareness among the staff team of translation services available and when to use them. Staff we spoke with understood how to access interpreters.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The hospice participated in the annual national 'Famcare' bereavement survey where those close to patients that had died in the care of hospice staff provided feedback. We reviewed the last two years' survey reports and saw that feedback was consistently positive. There were no negative responses and most survey participants said they were extremely satisfied with the care delivered. This included areas such as emotional support for patients and their families, attention to symptoms and their management, dignity and comfort, and inclusion in decision making and delivery of care.

Staff supported patients to make advance decisions about their care. Staff were trained in supporting patients with advance decisions. We saw evidence of advance care planning in patient records, including in the community. There was evidence of involvement of the patient and their family. Treatment escalation plans were recorded and centred around patient wishes, for example, identifying ceilings of treatment such as not wishing to be admitted to hospital. The hospice had worked collaboratively on an advance care planning brief intervention pilot, where staff were trained in brief, evidence based structured conversations. Additional training was being provided for staff internally and externally in order to use the results from the pilot to improve practice.

Patients and their families gave positive feedback about the service. One relative told us that 'the care is amazing – they look after us all', a patient told us they felt 'safe and cared for'. The hospice participated in 'I want great care', an independent feedback mechanism for both patients and relatives to complete. Feedback was mostly positive, for example, reporting that staff were caring, quick to respond, supportive and respectful. One relative stated that they 'could not have hoped for any better.' Survey results showed that both the inpatient unit and community services performed well in relation to dignity and respect, involvement in care and the caring approach of staff. Inpatient and community results ranged between 4.8 and 4.95 out of five in these areas. Complimentary therapy services scored five.

## Are Hospice services for adults responsive?

Good 

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

## Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The community and the inpatient unit services offered a flexible and responsive service to meet the needs of the patients who used the service. Managers told us there were variances in demand for services for both community and the inpatient service, influenced partly by the COVID-19 pandemic. For example, inpatient activity was below target as a result of the pandemic with an

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increase in patients wishing to be cared for in their own homes. As a result, activity within the community and hospice at home services had increased. We viewed occupancy and referral data and saw that at the end of March 2021, the inpatient unit occupancy was 86% of the target, whereas referrals to the community service was 77% above target and referrals to the hospice at home service was 36% above target.

The leadership team recognised ongoing increases in the proportion of patients wishing to be cared for at home as well as a projected increase in older and more frail people in the community. The expansion of the hospice at home and community teams had been incorporated into the 2018-2023 organisational strategy. Action taken during the pandemic included working collaboratively with NHS partners to share skills to increase hospice at home provision. This involved a hospice healthcare assistant moving to work in the accident and emergency department in exchange for a hospital registered nurse working with the hospice at home team.

The senior leadership team worked collaboratively with partner organisations to explore service development to meet the changing needs of the local community. The director of patient services was the operational lead for the regional end of life steering group, working strategically with the Devon Sustainability and Transformation Partnership. Work included leading a survey of advance care planning across Devon looking at quality improvements to ensure choice and continuity. Practice was shared across the region at forums such as the South West hospices' director of care meetings. These meetings included discussions around audit and research collaborations and action learning to share practice.

Senior hospice staff had worked collaboratively to meet the needs of the local community during the COVID-19 pandemic. For example, working on a COVID-19 end of life care project plan which looked at addressing the delivery of care through the local Nightingale Hospital and in the community. This included actions such as working with the clinical commissioning group to develop policies, training and advice on medicines used for symptom control.

The service had systems to help care for patients in need of additional support or specialist intervention. A key aspect to Rowcroft's strategy was the expansion of non-cancer services to meet the end of life care needs of patients with other life limiting conditions. They recognised locally across Devon that emergency admissions for respiratory and cardiac conditions had the highest demand in the last two years. Subsequently, benefits of end of life care non-acute interventions had been identified. As a result, the hospice had undertaken projects in both heart failure and other respiratory illnesses.

A 'breathe easy' project had been run by the hospice from September 2019. This had paused during the early part of the pandemic and the project redesigned to be delivered virtually in 2020. The programme supported 21 patients with non-malignant respiratory conditions, and their carers across five four-week self-management programmes. The service involved physiotherapy, occupational and complementary therapy interventions as well as nurse led advance care planning and carer strategies. They used recognised measures to evaluate the success of the service on patient outcomes. This included the Hospital Anxiety and Depression (HAD) scale which showed a reduction in anxiety for all patients following the courses. A chronic obstructive pulmonary disease self-assessment test (CAT) showed that 60% of patients reported improved or stable symptoms. A breathlessness scale showed that 100% of patients reported improved or stable breathlessness levels.

Between 2017 and 2019 the hospice had initiated a heart failure project, establishing a steering group and dedicated multidisciplinary meeting involving both heart failure and palliative care specialist staff. This involved developing processes to train and support patients with heart failure and specialist heart failure staff to improve end of life care, advance care planning and access to end of life care specialist input. The heart failure multidisciplinary meeting was embedded in practice at the time of the inspection. Rowcroft hosted a motor neurone disease (MND) special interest

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group meeting quarterly, in partnership with the Motor Neurone Disease Association. Caring for patients with MND was also part of the annual hospice training programme. The service had engaged actively with different faith groups in the local community and had a plan to develop this further to look at how to reach the range of faiths within the community.

Facilities and premises were appropriate for the services being delivered. The hospice was designed to meet the needs of families and friends of patients. Relatives were able to stay by the patient's bedside if needed. There were separate facilities for families to stay overnight, however, this space had been decommissioned during the pandemic to provide more flexible space in case of a COVID-19 outbreak. All patient rooms had access to external space such as a patio which led to the garden, which had won awards and provided a tranquil environment for patients and their families. Patients were able to be wheeled outside in their beds if bed bound.

The service had systems to help care for patients and their relatives who needed additional support or specialist intervention. The hospice offered psychological and emotional support for families and mental health services were available for specialist support for patients. Relatives told us how they had received timely support from the hospice bereavement service following the death of their loved one.

Staff knew about and understood the standards for mixed sex accommodation. Staff worked hard to ensure that single sex accommodation requirements were met. The inpatient service operated using two bays and three single rooms. At the time of the inspection we saw that one bay accommodated six patients and the other accommodated four patients and that these provided single sex occupancy. Service leads recognised the challenge of caring for patients in shared rooms and had developed a proposal to refurbish the unit and increase their single room capacity. Plans were for 10 single rooms and two double rooms. Staff had been involved in workshops to review proposals and there was an aim to complete the refurbishment by 2023/24. Staff told us that mixed sex accommodation was avoided but this led to difficulties admitting patients at times, for example if the only available bed was in a male bay and a referral was for a female. They kept one single room empty to manage the logistics of admissions to minimise risks of breaches.

Accessible bathrooms were available on the inpatient unit. Patients were supported to access these. Individual rooms had en-suite facilities and there were shared bathrooms in each of the two shared rooms.

## Meeting people's individual needs

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

Staff kept detailed records of patient preferences including advance care plans and treatment escalation plans, which documented how they wanted to be treated at the end of their life. We saw evidence of individualised care plans on the inpatient unit and in the community. Staff responded promptly to patient's preferred place of care when nearing the end of their life. They made every effort to fulfil patient's wishes wherever they could. The hospice teams worked together to improve patients' quality of life. This included therapists supporting patients to improve their mobility or the use of complementary therapies to support the management of symptoms.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had received equality and diversity training and there were projects in progress looking at service accessibility for patients with additional needs. This included a specific project looking at care and support for people with learning disabilities, with the involvement of a relative of a patient who had been cared for by



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the hospice at home team. Where possible patients with a learning disability were referred to the hospice at home team in the last few months of life rather than the last two weeks, which was the general hospice standard for accepting patients to the service. This was to support them to understand the process of end of life care in their own home. Staff had received dementia awareness training, and there was a hospice dementia lead working within the community team. The environment was dementia friendly, with signage and facilities colour contrasted to make them easy to read for patients with dementia. The hospice had been assessed by the local dementia leadership group in 2017 and received positive feedback. There were dementia champions among the staff group and dementia friend training was available through the hospice to the local community.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was an accessible information standard assessment on the electronic patient record and staff assessed patient's information and communication needs. Staff provided information in larger font and could access information in braille. They had access to translation services and had identified the need to proactively offer translation services to patients and relatives following a complaint. In this instance, managers recognised that communication had been impacted by a lack of understanding due to a language barrier. Learning from this included action to make sure that staff, and patients, loved ones and carers could get help from interpreters or signers when needed. This had been discussed with staff who were encouraged to consider where an interpreter may be of benefit, particularly when breaking bad news or updating people on changes to treatment.

Staff had access to communication aids to help patients become partners in their care and treatment. There was a hearing loop available on the inpatient unit and within the outpatient service. Staff had received training in communicating with patients with hearing loss.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Catering staff met with patients daily to identify their food and drink preferences and adapted menus to meet their needs. Managers had engaged with local cultural community groups to better understand how staff could meet different needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff provided care after death, which included honouring spiritual and cultural wishes of the deceased person and their family and carers. Patients were asked if they had any spiritual or religious needs and we saw this documented in the electronic patient record system. A spiritual care task force worked to provide inclusive spiritual care for patients and their families. This incorporated the development of The Sanctuary, a spiritual space for multiple faiths or none. A spiritual specialist had worked with staff to develop competencies in spiritual care and a training programme for all staff.

Patients were encouraged and supported to maintain relationships with people that mattered to them. During the COVID-19 pandemic this included the identification of nominated visitors for each patient, expanded to include additional visitors during the last days or hours of life. Electronic devices were available to support connecting patients with people close to them. Regular music therapy was provided to support patients to express their feelings about dying / grief.

## Access and flow

**People could access the service when they needed it and received the right care promptly and within national guidelines.**

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Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The hospice aimed to admit patients referred urgently within 24 hours and those through less urgent referral within five days. Data for 2020 showed that 64% of patients were admitted within 24 hours when referred urgently, this was a slight reduction (6%) on the previous year. Data showed that 68% of Non-urgent referrals were admitted within five days, this was an increase of 4% on the previous year. Managers monitored referrals and followed up those patients not admitted within the agreed timeframe. Data showed that patients were not admitted for a variety of reasons such as inappropriate referral, too unwell to transfer, admitted elsewhere or symptoms resolved.

Managers and staff worked to make sure patients did not stay longer than they needed to. They monitored the average length of stay in the inpatient unit and had a target of 10 days. Data for 2020 showed the average length of stay was 17 bed days. Staff told us there had been an increase in patient complexity on the unit and that this had impacted on the length of stay. The average length of stay during the first quarter of 2021/22 was 13.5 days. There had been no bed days lost to delayed discharge.

The service monitored the preferred place of care and death of individual patients. July 2021 data showed that 97% of patients wishing to be cared for at home achieved this. Staff working in the hospice at home team told us they could generally set up care for patients rapidly discharged from hospital within 24 hours. They surveyed friends, family and carers on a quarterly basis, and this included asking about access to the service. Staff identified an increase in patients being referred later in their illness to the hospice at home service, for example, in the last days or hours of life. This was reflected in some of the survey responses in June 2021 where families wished their loved one had been referred sooner and had been previously unaware of the services. As a result, staff identified an action to increase awareness of the service by providing literature to acute and community colleagues to share with patients in their care.

Managers and staff worked to make sure that they started discharge planning as early as possible. They identified patient's preferred place of care at the time of admissions or entry to the service. Staff worked with patients to identify individual goals which included plans to support discharge home where this was a priority. The focus of the service was to provide support for patients to live well when nearing the end of life and staff recognised the importance of patients being at home when this was their choice.

## Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. They encouraged patients and their families to provide feedback and recorded complaints irrespective of whether they were made formally or not.

Managers investigated complaints and identified themes. Between April and September 2021 there had been one formal complaint. In addition, we saw that informal complaints were recorded and acted on. The person making the complaint was asked about the outcome they were hoping for. We viewed records of complaints and saw that these were taken seriously by staff and included a full investigation.

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Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients and relatives who complained or shared concerns were kept informed at every stage of the complaint process, including investigation and action to address their concerns.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, a relative who had concerns about the care received wanted staff to learn from their experience and agreed to be filmed talking about their experience so that this could be used for staff learning.

## Are Hospice services for adults well-led?

Good 

Our rating of well-led went down. We rated it as good.

### Leadership

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

Rowcroft's leadership structure consisted of trustees, executive, departmental and service leads. There was compassionate, inclusive and effective leadership at all levels. Trustees were selected for their skills and expertise and included those with clinical backgrounds. Leaders had the required level of capacity and capability to lead the service and trustees received relevant training for their roles. Trustees met every quarter and individual trustees chaired various sub-committees with attendance from senior leaders. Sub-committees included clinical, non-clinical, finance and investment, strategy and remuneration.

Leaders recognised the challenges and priorities faced by the hospice. They engaged with staff and external stakeholders to address issues effectively. They ensured the experience of patients and their families were central to decisions made. Staff told us that leaders were visible and approachable. Communication from board to staff was effective and staff told us they had a voice and felt listened to by leaders.

Trustees maintained oversight of operational and sustainability issues through attendance at sub-committees. Quality and safety of care were clearly prioritised at all levels of the organisation and performance data was shared at relevant sub-committees, board meetings and operational meetings. Reports to the board were comprehensive and included relevant safety and improvement data so that they could effectively manage performance.

Executive and operational leads had effective oversight of the local health economy. They were active in local networks and provided leadership across the region in relation to end of life care and the strategic direction of services.

There were leadership development opportunities for staff, with training, supervision and support available. We saw clear succession plans for leaders approaching retirement, including the development of successors over time to ensure services were in safe hands.

### Vision and Strategy

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

The vision for the service was to make every day the best day possible for patients and families in South Devon. A five-year strategy had been developed in partnership with all relevant stakeholders, including staff, volunteers and healthcare colleagues from external organisations. There were clear strategic aims such as delivery of high quality 24/7 care; to be the community specialist palliative care provider of choice, extending the reach of care services, empowering and educating the local community, and, building a sustainable future by diversifying funding streams.

The strategy focused on objectives such as building talented teams, leading the agenda on palliative and end of life care across South Devon and working in partnership, and building and enterprising culture to develop new income streams and reduce waste.

Strategic initiatives had been developed across clinical, community and commercial operations. This included the development of superfluid staff who worked across inpatient and community services, providing flexibility to meet the changing needs of patients and the service. 'Non-cancer plus' aimed to increase the provision of specialist palliative/end of life care for patients with non-cancer life limiting conditions. Other initiatives included developing a building that was fit for purpose in the future, expanding hospice at home, establishing a community hub and to build on collaborations with partners to provide a more integrated offer in the community. Progress of the strategy was regularly reviewed by the senior leadership team and board of trustees.

## Culture

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

There was a clear focus among staff teams and leaders to provide high quality care. The needs of patients and their families were central to the ethos of the service. There was assurance that patients and their families could raise concerns, and these were taken seriously. Patient stories were used to support learning and improvement, including, on occasion where patient experience fell below expected standards.

An organisational learning strategy provided a basis for development within the service. There was a focus on personal growth and the development of a values-based development culture. Staff had been involved in workshops to develop the values of the service; respect, honesty and integrity, generosity of spirit and team player. Staff we spoke with told us they felt valued and listened to by leaders.

A career framework had been established in 2018, created specifically for the hospice to support career progression. The hospice supported staff members to progress their careers. For example, through the recent succession planning for the director of patient care role.

The hospice had adopted a restorative practice approach to enable teams and individuals to work well together. This focused on conversations to improve relationships, ensure everyone has a voice, support effective problem solving and create a non-blame environment. Managers within the service had been trained in restorative practice skills.

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The hospice provided support to staff caring for patients at the end of life, including the provision of compassionate leave when affected by their own bereavement.

Staff understood the duty of candour and apologised to patients when things went wrong. An audit of duty of candour practices was carried out annually and demonstrated that practice was in line with requirements.

Staff we spoke with told us they felt able to raise concerns. There was a whistleblowing policy and a freedom to speak up guardian to support and guide staff to speak up where they have concerns. The policy detailed how staff could raise concerns both internally and externally to other agencies.

## Governance

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

There was a well embedded governance structure to ensure organisational, team and individual responsibility and accountability. Clear goals and ambitions were set out within the organisational strategy. Senior leaders and trustees worked together to deliver the strategy. Individual trustees chaired each of the service's sub-committees with cooperative leadership from relevant members of the senior management team. This ensured overarching accountability as well as appropriate challenge and scrutiny between strategic and operational delivery.

Rowcroft Management Board meetings were held every three months, the executive team met monthly, the senior management team met formally every month and informally every week. Sub committees included clinical, non-clinical, finance, strategy and remuneration. Monthly reports from each of the sub-groups went to the board of trustees and the executive management team.

We reviewed meeting minutes from all groups and saw that performance, staffing, finance, quality and patient safety information, and performance against the strategy was discussed at each level. Committees received and reviewed the minutes and actions of related subcommittees.

Levels of governance and management functioned effectively and interacted appropriately. Governance within the hospice was overseen by the board of trustees and executive management team through the quality and governance framework. The quality and governance framework provided a clear structure for reporting on a range of metrics. This included key performance indicators that were reported internally to the management board and externally to commissioners.

There was a programme of clinical and internal audit to identify areas of risk and improvement and actions were taken to improve performance. There were business continuity plans in place to ensure continuity of care in the event of an emergency, this included an outbreak plan in response to the COVID-19 pandemic.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

# Hospice services for adults

There were clear arrangements for identifying, recording and managing risks. Risk assessments identified and escalated relevant risks and issues and identified actions to reduce their impact. Risk registers were regularly reviewed and updated.

Service leads understood service's main risks, and these matched the risks identified on the hospice's risk register. Control measures were in place. For example, clinical staff shortages were consistently identified by staff we spoke with as one of the higher risks. Action to address this included offering competitive terms and conditions, the creation of flexible roles and development opportunities and working collaboratively with other organisations to address staffing shortfalls, such as exploring the use of apprenticeship programmes. The risk register covered all areas of the service. Risks were rated by the potential impact on safety. Actions were taken to put in control measures to reduce the impact of the risk.

There were effective lone working arrangements to keep staff safe. Risks relating to lone working had been assessed. Staff working in patient facing roles had received training in conflict resolution. A personal alarm system was in use. Buddying arrangements were in place, for example, for the hospice at home team working at night, ensuring that lone working was minimised.

Performance data was analysed and presented at both committee and board meetings. There was evidence of board influence over performance management and recommendations to service leads. For example, in relation to deeper exploration of incidents on the inpatient unit.

An annual quality account was published on the Rowcroft website, sharing information about the quality of services provided with patients, families and the wider public.

## Information Management

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

The service collected a variety of data and analysed it to understand performance, make decisions and improvements. Information was collated and shared with staff, patients and visitors. Patient safety and experience data was displayed on the inpatient unit and included accidents, incidents, errors and patient experience. Benchmarking data was submitted to Hospice UK and data was shared with other South West providers and commissioners.

There were effective arrangements to ensure that notifications were submitted to external bodies as required. Service leads were aware of their responsibilities to monitor the use of data, including breaches and report these appropriately. Notifications to external organisations were clearly identified when the need arose, and these were appropriately submitted. Relevant managers were aware of their reporting responsibilities.

Information technology systems were used effectively to monitor and improve care. For example, the hospice had implemented an electronic patient record system that was aligned with primary care services in the region. This enabled sharing of information. Hospice at home and community staff implemented new technology in order to undertake video appointments during the height of the pandemic, triaging patients to ensure that face to face visits were only undertaken when necessary. A web-based incident management system had been implemented to enable smarter reporting of patient safety and quality issues.

# Hospice services for adults

Data management audits were undertaken, including those relating to consent to share information, data quality and the process for information shared with patients' GPs. Information governance meetings were held to ensure systems were effective. Any breaches to information standards were reviewed by the group.

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Leaders had a shared purpose and collaborated internally and externally to provide effective services. Engagement with staff, patients, their families and other agencies was central to decision making within the service.

Staffing groups were represented at a staff consultation and community committee and staff could raise concerns anonymously with their representative. A 2019 staff survey highlighted that the majority of staff felt proud to work for the service, were happy with the standard of care, enjoyed their work and working with colleagues, were clear what was expected of them and felt they were able to make a difference. The proportion of staff responding positively to whether they would recommend the service to their friends and family was 97%. Some issues were also highlighted, for example, that communication between teams and with senior managers could be improved and that some staff felt that personal and career development opportunities were not always available. Leaders evaluated the results of the survey and took action to improve. A repeat survey had not been carried out during the pandemic but a further survey was planned for 2022.

The senior management team (SMT) had developed improvement plans, including devising a learning strategy that focused on career development and providing opportunities for staff and volunteers. We saw action plans had been developed, with timely actions including strategies for personal growth, succession planning and the potential development of apprenticeship roles. Leaders had devised a competency framework that incorporated organisational, team and individual competencies. We saw actions had been implemented to establish and develop this system. For example, through agreed competencies for registered nurses and other staff groups. Other action that addressed issues identified in the survey, included the development of restorative practices to improve communication between teams. Examples of communication between staff and leaders included clear communication from the SMT to the board, with messages to share with staff agreed at every board meeting.

The service engaged well with patients, staff, volunteers, the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively. This included specific activities where stakeholder involvement was embedded into processes. Examples included organisational values and strategy development, the development of the inpatient unit and the future care model for the service. We saw that workshops had been held with involvement from representatives from all staff groups, volunteers and bereaved carers. The service's 'what matters to you' approach to developing the care model and delivering care ensured that engagement and involvement was sufficiently prioritised and central to decision making processes.

Service leads consistently engaged with external partners and agencies. Rowcroft was represented at strategic and operational levels within the local health economy.

## Learning, continuous improvement and innovation

# Hospice services for adults

**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 hospice leads were committed to improving high quality end of life and palliative service provision within the local community, working as strategic and operational partners across South Devon.

There were positive collaborative partnerships with commissioners, NHS providers, independent and local services. The director of patient care regularly met with the local NHS Trust chief nurse to collaborate on improving the system for people with end of life care needs. The director of patient care and medical director were members of the locality end of life care board. The director of patient care was operational lead/deputy chair for the Devon end of life care workstream. These relationships supported patient flow through the end of life care services across the region with shared learning and improvement a priority.

Internally, improvements included the expansion of the hospice at home team during the pandemic, working collaboratively with NHS partners to increase the provision of end of life care in people's homes. The result was an increase in hospice at home capacity from 8 to 15 patients a day. This enabled more patients to be cared for at home at a time when many were reluctant to access inpatient services due to the risks associated with COVID-19. Other improvement projects included the development of respiratory and heart failure services, using self-management and multidisciplinary interventions to help improve patients' quality of life. The hospice were actively involved in pilot studies to improve the quality of care across the region. This included a collaborative advance care planning brief intervention pilot with additional training to improve the use of advance care planning with patient at the end of life.

Leads of the service were committed to improving services through training and innovation. The service was committed to providing regular training opportunities to staff. We saw information about education sessions for clinical staff, and others, which had been delivered during the pandemic. The hospice took a lead role in developing training initiatives for other providers, often leading to innovations in end of life care across the local health economy. This included a 2019/20 bespoke training package for domiciliary care workers. The aim was to increase the confidence and competence of care workers in the community providing end of life care in order to reduce inappropriate admissions to hospital. Project evaluation showed increased confidence of domiciliary care workers in supporting patients at the end of life in their homes.

A traineeship in end of life care programme for staff working in acute and mental health settings focused on training, support and shadowing opportunities to improve end of life care in non-hospice environments. Outcomes from this programme included innovations in the trainees' work settings. Examples of improvements included the creation of bereavement and loss resources in an older people's mental health setting and the introduction of end of life care comfort measures for patients, and wellbeing support for staff on a COVID-19 ward.

Staff were supported to attend and present research at conferences. This included poster presentations and speaking opportunities at the 2019 Hospice UK conference on the heart failure and spiritual care projects.

The hospice participated in relevant national and local research projects. Recent projects included working with hospice clinicians in the use of information to estimate survival of palliative care patients and a study of oral care experiences for patients receiving end of life care.



## Hospice services for adults

There were internal systems to support improvement and innovation work. Staff were able to influence board decisions through a 'bright ideas' standing agenda item at board meetings. Examples included suggestions from staff to improve. This included the use of technology to help staff in the community better identify the location of patients. Staff also made suggestions about the design of the inpatient unit which had been adopted into the design brief.

As well as a comprehensive approach to using quality and safety metrics, we saw that patient stories were shared, to improve practice. These provided an opportunity to hear directly from people and their relatives about their experiences of using services. We saw that stories were incorporated into training programmes to illustrate high quality end of life care and the impact of this on patients and their families.