

University Hospital Southampton NHS Foundation
Trust

Countess Mountbatten House

Inspection report

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Ratings

Overall rating for this service	Good	
Is the service safe?	Good	
Is the service effective?	Good	
Is the service caring?	Good	
Is the service responsive?	Good	
Is the service well-led?	Good	

Overall summary

Countess Mountbatten House provides treatment and care to adults with life limiting conditions. The hospice

also supports the families of the patients who use the service. The hospice is part of the University Hospital Southampton NHS Foundation Trust, and this was the first inspection of the service.

Summary of findings

Countess Mountbatten House is a 25 bed unit, providing specialist end of life care and support for patients and families. There were 22 patients receiving care at the time of the inspection.

The day care unit (the Hazel Centre) supports patients living in the community. There is a dedicated nursing and bereavement team working closely with the clinical nurse specialist, led by consultants at the hospice, and those in the community. Patients benefit and receive care and support from a dedicated multidisciplinary team, including counselling, physiotherapy and occupational therapy teams.

There was no registered manager, as the hospice is part of the trust and does not require a registered manager. A matron was in day to day charge of the hospice. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The hospice had a dedicated staff team with clear visions and values. Staff commented “we work as a team and all pull together”, in order to achieve best outcomes for the patients. Patients and their relatives described the care and treatment they were receiving as “excellent care”. Staff we were told were “very caring” and patients said “they (the staff) can’t do enough for you”. Care and support was provided in a caring, compassionate manner, and the patients’ privacy and dignity were respected.

There were arrangements to assess risks, such as falls and pressure injury, to ensure the safety of patients. Care plans had been developed following assessments by physiotherapy for patients identified as high risk of falls. These provided guidance to staff in order to manage these risks in a consistent way. The staff rotas showed that there were consistently enough staff with the skill mix to provide safe and consistent care.

The CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS are a code of practice to supplement the main Mental Capacity Act 2005. Staff were clear about the actions they would need to take if they needed to evoke the DoLS to

protect the rights of patients. We were given an example of how staff had ensured the safeguards were initiated and assessments carried out by appropriately trained professionals.

The service had developed ways of ensuring that staff received the training they needed to deliver a high standard of care. Staff had been trained and appointed as ‘champions’. Champions were staff that showed a particular skill or interest in reducing falls, and providing end of life care and infection control, and acted as role models for other staff. Staff told us that they had received training which was appropriate to their roles.

There was a strong commitment and support for the patients and their relatives, before and after death. Patients were treated with compassion and care. They were put at the centre of their care through ongoing consultation and involvement of their relatives and multidisciplinary team, so that care could be tailored to their individual needs.

There was strong clinical leadership at the hospice. There was a clear governance structure from unit level to the trust board. Members of the board made quarterly visits to both the hospice and community services. However, the process to seek patients and their relatives’ views was not fully developed and the trust needed to work with its partners to improve the provision of bereavement and hospice at home services.

Areas for improvement

Action the hospice should take to improve:

The hospice needs to ensure that:

- Staff have training in the use of the electronic patient record system to enable them to access information as needed.
- Strategies are developed to provide support for the families of those who were cared for by the service in the community.
- The hospice at home service is developed with partners, as an integral component of community end of life care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Patients told us they felt “very safe and well looked after”. The service was clean, well maintained, and infection control procedures were adhered to by all staff.

Staff had completed training and understood their responsibility in protecting patients in their care.

There were sufficient numbers of staff, with the right competencies, skills and experience available to meet the needs of the patients.

The staff followed their processes for assessing risks, such as falls and pressure injury, to ensure the safety of patients.

Medicines were appropriately managed and patients received their medicines as prescribed, including medicines for effective pain control.

Good



Is the service effective?

Care plans had been developed which were aligned to National Institute for Health and Care Excellence (NICE) guidance and evidence-based practice for end of life care.

Following the withdrawal of Liverpool Care Pathway (LCP), the trust had commenced the Achieving Priorities of Care document pilot, which aims to develop an end of life pathway.

Patients and their relatives expressed a high degree of satisfaction with pain control to ensure patients comfort. Patients received appropriate support with diet and fluids, including supplements in order to meet their nutritional needs.

Staff had the necessary training and skills to provide specialised care and support to a high standard. The hospice provides 24/7 specialist palliative (end of life) care service for patients with advancing cancer. Following the inspection the trust told us they are providing support to an increasing number with non -cancer diagnoses.

Some staff were designated 'champions' and provided guidance in specific areas of care and peer support. Multidisciplinary working was well established and enhanced the delivery of seamless care.

'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were used appropriately. Where a person lacked capacity to make decisions we saw that the Mental Capacity Act (MCA) 2005 best interest decisions had been made. The Deprivation of Liberty Safeguards (DoLS) were understood by staff, and appropriately implemented for patients' protection.

Good



Is the service caring?

Patients and their relatives told us the staff were kind, caring and provided “excellent care”.

We observed care was provided in a caring, sensitive and compassionate manner. Patients and their relatives were involved in their care and treatment.

Relatives were supported to stay close to their loved ones, and care was provided in a holistic way, and took into account their spiritual and psychological needs.

Good



Summary of findings

The team of volunteers and chaplaincy provided good support and help to the patients, their relatives and the staff.

Is the service responsive?

The service was responsive.

Patients' individual needs and choices were taken into account and arrangements were in place to meet their care, spiritual and religious needs.

There was good access to beds at the hospice, and community support provided advice and weekend visiting for urgent cases only. Calls were directed to the hospice due to limited support out of hours.

Patients with non-malignancy requiring management of symptoms control were treated in the community by the community palliative medicine team. The trust had identified currently there are no facility to admit patients for symptom control and they are looking at developing this service.

The day care service provided valuable support to patients and their families. This included therapy sessions and regular carers group meetings.

The palliative care team worked cohesively with the clinical nurse specialist in ensuring seamless service when patients are discharged into the community.

There was a complaint process, which was followed, and people were able to raise their concerns with the staff.

Good



Is the service well-led?

There was a strong nursing leadership; the chief executive was approachable and the board made quarterly visits to the hospice and to the community team.

There was a clear governance structure from unit level to the board. Staff were clear about incident and statistic reporting through their electronic reporting system, and how this was used to inform practice improvements across the trust. Staff said there was also good medical leadership with a consultant palliative clinical lead, who led the hospice team.

Staff were passionate about care, and their visions and values, of putting patients as main focus of their care.

The process to seek patients and their relatives' views was not fully developed. Questionnaires were being developed to seek views of patients and relatives, as this was not happening to support service development and improve outcomes for patients.

A bereavement service had been provided by the hospice until a few months ago, but funding for this this had stopped. There was a trust wide bereavement service based at Southampton General Hospital that covered the hospice. Further work was needed with partners to ensure bereavement services are established as an essential component of palliative care to support bereaved relatives in the community.

The hospice did not provide a hospice at home service. There was a palliative care support service provided by a neighbouring community trust. The hospice management needs to work with partners to develop a hospice at home service as an integral component of community end of life care, bringing the skills, ethos and practical care associated from the hospice into the home.

Good



Summary of findings

Arrangements for the monitoring of the storage of medical gases, used by the Hospice, should be improved to ensure it is safe and secure.

Countess Mountbatten House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 10 December 2014. The inspection was announced, as this was part of a wider inspection of the University Hospital Southampton NHS Foundation Trust. The team inspecting this location consisted of an inspector, a specialist advisor who was a specialist nurse, experienced in caring for people receiving end of life care, and a pharmacist inspector.

Prior to the inspection, we requested information from the trust and this was provided in their pre inspection pack.

This is a document which provides some key information and data about the trust. We reviewed the document and other information we hold about the trust, including previous inspection reports.

We spoke with 11 patients, who included some who were living in the community, five relatives, and 19 staff including nurses, community nursing specialists, doctors, health support workers, domestic staff, pharmacist and volunteers, as part of our inspection. We looked at four care plans, records of medicines, records relating to the management of the service, information provided by the trust and local stakeholders.

We would like to thank all staff, patients, families and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Countess Mountbatten Hospice.

Is the service safe?

Our findings

Patients and their relatives expressed a high degree of satisfaction about the care and support they received at the hospice. They said, “I feel safe here” and there was “nothing to worry about”. Relatives told us they were “in good hands as all the staff know what they are doing”. They said there were enough staff around and “they make sure I am safe”. A relative commented they felt “safe” to leave their relatives there.

Medical gases were stored securely within the Hospice. Staff were aware how to isolate medical gases. FP10s (prescription forms) for drug prescription were available for use as this was a remote unit. Pharmacy staff delivered the prescription medicines by hand. These were signed out of the pharmacy and couriered by pharmacy staff, but they were not signed for on receipt at the hospice. This was brought to the attention of matron during the inspection. The service should review the procedures records and audit of controlled stationery.

There were enough staff with the skills and expertise to provide safe and consistent care and staffing levels were reviewed to ensure care was delivered safely. The team consisted of specialist palliative care nurses and doctors. We observed a ward handover meeting attended by the multidisciplinary team, and there was a holistic approach to care. Information shared and discussed between the team included family concerns, changes in patients’ conditions and plans of care. Staffing levels were reviewed daily, and information was shared with the clinical lead and consideration given to the acuity of patients. Staff followed their internal process and escalated to senior management to cover any staff shortages which they said worked well. The duty roster showed the planned staffing levels were achieved, and shortages were covered by their own staff, who were familiar with the patients and provided continuity in their care. There were currently two vacancies for band 5 nurses and two for healthcare assistants; recruitment was in progress and interviews planned.

There were three end of life care facilitators in the palliative care team, and the community nurse specialists provided seven day cover. Staff told us they felt supported and had received mandatory training relevant to their roles. Staff had been trained in non-invasive positive pressure ventilation (NIPPV). They had not admitted any patients requiring this treatment recently. The trust had been pro-

active and an action plan developed for physiotherapy staff to provide support to staff on admission of any patient requiring this procedure. Patients will be planned admissions in normal working hours.

Incidents were recorded on the electronic reporting system, and reviewed by the matron and by the clinical lead for end of life care. These were discussed at the monthly multi professional group meeting and actions shared with the relevant staff. Staff told us incident reporting was everybody’s responsibility and the electronic system was “user friendly”. Incidents of grade three pressure ulcers were analysed through route cause analysis. An action plan was developed and discussed at staff meetings. Consideration was being given if their procedures needed updating and lessons learnt.

Arrangements were in place for the safe management of medicines. Drug charts were used for individual patients were clearly completed, and all other drugs were managed appropriately. During the inspection we saw all medicines were stored safely and according to trust policy. The e-prescribing and medicines administration system and remote prescribing were in use; this ensured clinical screening and dispensing could be undertaken. Patients were appropriately supported to manage their pain with effective management and pain control. This included advice from pharmacists, and equipment, such as syringe drivers, for the delivery of pain medicines.

Patients were assessed for risks such as falls, nutrition and pressure injury, to ensure their safety. The trust was using the falls assessments (SIRFIT) tool, and appropriate care plans were developed to manage this risk. Other measures included a close observation bay, easy access to the toilet, and pressure mats on the floors of people’s rooms. Specific care plans had been developed following assessments by physiotherapy. These provided guidance to staff in order to manage fall risks in a consistent way.

Patients who had been assessed as at risk of poor nutrition had supplements prescribed and these were available to them. Risk assessments, such as the Malnutrition Universal Screening Tool (MUST), were used to identify specific risks associated with poor nutritional status. Where people were identified as at risk, referrals were made to the dietician for specialist advice as required. Skin care assessments were carried out daily, and a weekly pressure ulcer audit was completed. Patients were referred to the tissue viability nurse for advice/treatment.

Is the service safe?

There were arrangements to safeguard patients from the risk of abuse. Staff had completed training in safeguarding adults and could recognise the signs of abuse. Reporting procedures were available, and staff were confident to raise their concerns and report externally if needed. There was a dedicated safeguarding lead who staff could contact for advice and support and they provided additional support to staff as needed.

We spoke with doctors about the new regulation pertaining to the Duty of Candour, and the fit and proper person's test. The Duty of Candour places a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant or moderate harm. This was well understood, and we saw an example where this had been followed when a concern had been identified and escalation process followed for investigation. The discussion with the family was recorded, and they were informed of actions and were satisfied with the action taken.

All areas of the unit were clean and in a good state of repair. Infection control procedures were understood by staff. Hand hygiene gels were available in different areas. As part of infection control processes, registered persons are required to take account of the Department of Health's publication, 'Code of practice on the prevention and

control of infections and related guidance'. This provides guidance about control measures in order to reduce the spread of infection. We found these measures were followed, which provided a clean and safe environment. Equipment in use was clean, and protective personal equipment (PPE) was available and used by staff. Staff had received training in emergency procedures including resuscitation, and the resuscitation trolley and other equipment were checked regularly to ensure they were fit for purpose.

For major incidents a contingency plan had been developed where patients could be evacuated to the education centre and transferred to the main hospital. Designated nurses would also be contacted for help and support.

The 'Dr Foster' data 2013/14 reported 351 deaths for the hospice. Public Health England data showed the percentage of deaths at 7% for the hospice which was higher than the national average.

The involvement of patients and their relatives, including decisions about their 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) status, preferred place of care, improvement and deterioration, are acknowledged as part of daily review.

Is the service effective?

Our findings

The patients and the relatives told us they felt “quite confident” in the staff’s ability to provide care and support. A patient commented, “they know what you need and they never rush you”. Other comments were the care was “excellent” and the staff were “very good and treat you with the utmost respect”. Relatives told us “the care and facility are excellent”. Patients said their pain was well managed and staff ensured they had regular pain control.

NICE guidance, quality standard for end of life care for adults statement 3 states, ‘People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences’. A newly admitted patient record showed that an assessment was carried out by senior staff of the palliative care team prior to admission. This followed the NICE guidance and the hospice’s admission criteria which was introduced in April 2014. Patients and their relatives were offered the opportunity to discuss and review their plan of care to meet their needs and preferences.

Staff, including doctors and nurses, had a clear and up-to-date understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty, these are assessed by appropriately trained professionals. Staff discussed a recent example of how they had ensured the safeguards were initiated and assessments carried out by appropriately trained professionals for the protection of a patient. The social work team from the county council also provided informal training with a multidisciplinary approach, including Deprivation of Liberty Safeguards (DoLS). There was clear understanding of restraint, and we were given example such as the use of bedrails for a patient, as they used them to change their position. The patient said “this is very helpful and I can use this to turn over”. Staff were also designated “champions” as part of their fall’s management strategy in order to learn from these incidents and support staff in fall’s prevention and management.

‘Do not attempt cardio-pulmonary resuscitation’ (DNA CPR) forms were used appropriately. Where people lacked capacity to make this decision, a mental capacity

assessment best interest decision was made by the appropriate people. Where family had been involved as part of the best interest decisions, this was recorded in patients’ records.

During mealtimes we observed patients were supported and encouraged to eat. Choices were offered. Patients completed a daily menu and they said they could have “something else if you don’t fancy what’s on the menu”. Hot and cold drinks and different flavoured supplements were available to patients at all times. Relatives told us, “the food is good” and patients we saw had plenty of choices. Staff confirmed hot food was available at other times and not restricted to set meal times. We were told “you can ring and the porter will bring you a meal which we can heat in our microwave”.

Patients expressed a high degree of satisfaction with pain control. Patients commented “I have no pain”. Another patient told us “the staff are always checking if we are comfortable”. Discussions with family indicated they were satisfied with their loved ones pain management, and the staff were very good at changing patients position and providing pain relief. Staff focus was on keeping patients pain free and as comfortable as possible. Training had been provided in the use of “syringe drivers” equipment for delivering continuous pain control. The staff told us they felt confident in using the devices for the delivery of pain control.

There was an ongoing and regular review of the care and support people received with the person or their relatives as appropriate. Where changes were identified, care plans were updated and the information disseminated to staff at handover and other times. For example, staff discussed changes in a patient whose pain control was not adequate. Action was taken, pain control prescribed, and advice was sought via telephone from the pharmacist regarding the best route of administering the pain control. All the patients were reviewed daily by doctors, and the staff team worked cohesively, sharing information and planning care to achieve best outcomes for the patients.

Following the withdrawal of the Liverpool Care Pathway in June 2014. The Achieving Priorities of Care document pilot commenced within the trust in August 2014, and the trial took place on seven wards. This is a pilot of a new individualised end of life care plan to replace the Liverpool Care Pathway. Countess Mountbatten House took part in the pilot for a week in September 2014 as a hospice

Is the service effective?

environment in the NHS. The trust was using feedback in preparation for the second pilot. A patient who had been transferred from the main hospital was using the Achieving Priorities of Care document, their individualised end of life care plan, as part of the phase two pilot, which was due to commence in January 2015. Feedback was sought from staff and suggestions made for the new end of life care plans to include a section to demonstrate that people's spiritual needs had been assessed. The chaplains were to write in the patients' records when they had visited the patients. This showed the trust was pro-active and engaged their staff in development of patients' care.

An End of Life 'Principles of Care policy', reflecting the NICE QS13 standards, the five priorities for care, and the Essence of Care standards, had been developed and was waiting ratification, and planned to be introduced in February 2015. Information from the trust care of the dying audit showed the end of life steering group had been established and a strategy meeting planned for the end of January 2015. The trust took into account national guidance and developed strategies according to best practice.

Training was provided in palliative care by the social work lead in the community, and they were aiming to meet all patients and their families within 24-48 hours of referral. Morbidity and mortality (MM) meetings were held fortnightly, and the last MM minutes for December 2014 showed they looked at inappropriate admissions, discharges and deaths occurring 24 hours post admission. These were followed by actions and learning points such as timely transfer from other providers and feedback provided in order to improve practice and encourage better outcomes for patients. The nursing staff education team was working with St Christopher's Hospice to further develop dementia care. There were also good community care home engagements with the education team and specialist palliative care community nurses, effecting shared learning and support.

Care is funded with costs of 90% provided by the NHS and 10% by the charity. The charity enhances the service provision through volunteers providing support, such as transport, gardening, equipment, and assisting patients and their families. There were approximately 100 volunteers, who received an induction training, including health and safety, and hand hygiene. We received positive feedbacks from these staff about the training and support,

feeling valued and being part of the team. Patients and relatives were complimentary about the volunteer service and support they received including transport in order to be able to visit their relative.

Consultant palliative medicine advice and support was available 24 hours a day, seven days a week and some of this was offered through their on-call system. Consultant provided day-to-day supported by a specialist registrar, two part-time speciality doctors and two GP trainees at the time of the inspection. This meant medical staff were available to provide continuous care and treatment for patients.

There was an appraisals system for the staff and they felt closely supported. They said they found clinical supervision "very beneficial". This meant patients received care from staff whose practices were monitored and additional support or training provided as needed. Student nurses were positive about the support they received and had allocated mentors as part of their placement in the unit. They told us "the staff are very supportive" and they were enjoying working as part of the team.

The palliative care clinical nurse specialist team were well qualified, and nursing staff undertook regular training to maintain their skills. A clinical psychologist provided monthly clinical supervision to senior staff. They were planning to expand this facility to the multidisciplinary team and nursing staff. There was support and supervision for staff in the community. Staff felt closely supported with feedback from managers and peers. A staff member said it was "understanding what is important for those I care for".

There was a designated room at the hospice that had space for up to three deceased patients, which meant they did not have to be transferred to the main mortuary at Southampton General Hospital. Staff said this worked well and relatives were supported by staff they were familiar with. Arrangements were made locally, and patients were transferred to the care of their preferred undertakers.

Accommodation was available on site for relatives so they could remain close to their loved ones. A relative told us "this is fantastic as this is the first sleep I have had in two days".

An electronic patient record system had been developed, and there were plans to use this from April 2015 for patient reported outcomes measures. Assessments were uploaded on the electronic system used in the unit; however, senior nursing staff could not access this directly as they had not

Is the service effective?

received the appropriate training. The clinical lead said the administrative staff could provide this information and medical staff had access to the patient record system out of hours. The electronic patient record had been developed with King's College Hospital. The plan is to use this for

patient reported outcome measures (PROMS) from April 2015. The clinical lead said training in the use of the electronic patient record system will be provided to nursing staff.

Is the service caring?

Our findings

People approaching the end of life were offered spiritual and religious support appropriate to their needs and preferences. Patients and their relatives told us the staff were “very caring and can’t do enough for you”. Other comments were “they (the staff) are always there when you need them” and “nothing is too much”. A patient said “sometimes all you need is someone to hold your hand” and the staff were there to provide this. We observed the staff supporting patients in a caring and compassionate manner. A relative who was distressed was supported with compassion and care by a nurse and the chaplain.

A bereavement interview took place within 24 hours after a person died. This provided support and advice to family, such as obtaining the death certificate, the process to register a death, and the opportunity to seek views and discuss care and “anything we could have done better”.

The National Institute for Health and Care Excellence (NICE) quality standard for end of life care for adults statement 6 says, 'People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences'. A chaplaincy service was available to the patients and staff. There were two chaplains working for the trust, and one of them visited the hospice three times a week and chaplaincy service could be accessed seven days a week.

NICE guidance statement 12 states 'The body of a person who has died is cared for in a culturally sensitive and dignified manner'. The chaplain had developed links with the local council of faith for information and support for patients and their relatives. The hospice had a volunteer from an ethnic minority group providing support to patients. There were effective arrangements and assistance was provided to patients in accessing spiritual care and support from multi denominational faiths practitioners.

Patients and their relatives told us that staff were caring, treated them with respect, and promoted their privacy and dignity. Relatives commented that this was “never a

problem” and all the staff were “very good” at protecting the patients privacy and dignity. Staff treated patients with compassion, and ensured patients privacy was respected, such as curtains being drawn when providing care, or simply when they were administering their medicines. A staff member commented “we are all focused on ensuring our patients’ privacy and dignity”. The hospice participated in the trust wide Friends and Family Test and consistently had one of the highest response rate and 100% of responded would recommend the hospice to others.

During the inspection staff provided emotional support to a distressed relative in a respectful and caring way. Relatives were supported and kept informed of their loved ones care and any changes. A visitor told us they felt fully involved, as their relative was living with dementia and could not participate in their care. Care records showed next of kin had been involved as appropriate. These plans clearly stated how they wanted to be supported during the end stages of their life. A relative told us “the doctor explained everything so clearly to us” when a decision was made not to continue with active treatment.

Patients told us about the alternative therapy which was available for patients, to help relieve stress, manage pain and improve wellbeing. A patient talked about a massage which they enjoyed; “it was so lovely and relaxing which sent me off to sleep”. Staff said they were always looking at ways of relieving stress and anxiety, and commented “you have one chance to get it right”.

The patients were supported to maintain important relationships. Relatives told us there were no restrictions in place when visiting their relatives, and they received “very good” support from the staff. Patients and their relatives were supported by a team of volunteers, who offered support with transport and assistance with meals. There was a 'tea bar' facility run by volunteers, where hot and cold drinks and snacks were available for family and friends. A relative told us this was such a good service, where they were “able to come away and have a drink and gather your thoughts”.

Is the service responsive?

Our findings

Patients commented they found the hospice care and the care received from the community nursing team extremely helpful and supportive, and they received good written information. For example, a patient said it “couldn’t be better if I paid for it”. Some of the comments included “everybody is so kind and understanding”. Another relative told us, “the doctors explained everything and the following day went through all we had been told to make sure and this was good”. Patients told us they were aware of whom to contact out of hours and found the staff responsive. They told us they had symptoms control and very good liaison with the GP. Another patient commented “I think a few of the hospitals could learn a thing or two”.

The hospice has the facility, nursing and medical support to enable them to admit patients day and night. They admitted an average of four patients per day. The team consisted of a community nurse specialist team, social work team, chaplaincy, a therapy team of physiotherapists and occupational therapists, and a bereavement service. The readmission rate was low, and beds were held for 24 hours occasionally for discharges which were considered 'risky'. These were cases where the patient had requested to go home. Patients benefited from this, as they could be readmitted. Staff told us their ethos was “care has to be patient led” and patient’s choices were accommodated. A relative said that a patient had been transferred quite late at night, and they felt this was carried out efficiently and “everything was done well and we are so pleased to be here”.

The service was responsive to patients who had limited mobility. The design of the building had level access which allowed for beds and adapted chairs to be wheeled outside, weather permitting, for patients to enjoy the gardens. The communal areas could also accommodate beds, where patients could spend time with their friends and families, and not feel restricted or isolated to an area.

Currently, patient admission criteria included non-cancerous palliative care needs and end of life care. Patients with non-malignancy requiring management of their symptoms were treated in the community by the community nursing specialist team. Palliative medical consultants saw non-cancer patients as outpatients, and these patients could be admitted for terminal care if required. Staff told us there was currently no facility to

admit patients for symptom control, and with diseases other than cancer, the trust is looking at developing this service. Patients with motor neurone disease (MND) had access to the service. A heart failure service business case had been put forward to increase nursing staffing and the medical input, with a plan to start in 2015 if successful. This meant the trust was responsive to identified gaps in care and development of services.

All new referrals are triaged by a consultant, and assessed by either a community nurse specialist or a palliative medicine doctor. Patients were also assessed at the nurse-led clinic in the Hazel centre. This included providing phone support for new referrals. The staff team recognised that providing support to patients to remain in the community, free from symptoms, is a vital part of their role. They used the ABC tool, such as (A) referral means contacts with patients were made within 24 hours. Patients were referred to multidisciplinary teams (MDT), including staff such as from physiotherapy, occupational therapy, the psychology clinic, and complementary therapies. The Macmillan citizen advice bureau service was available, together with welfare and benefit support for patients and their carers.

Patients and their families and carers were involved and offered information, in an accessible and sensitive way in response to their needs and preferences. Information included the variety of services, such as volunteer assistance and chaplaincy services. In November each year, a Memorial Service is held for the families of patients who have died during the year.

Following feedback from the staff, the chaplaincy ran 17 focus groups last year, and 110 staff from the trust’s multidisciplinary team attended. A paper was presented to the trust’s board which recommended the formation of a 'compassion operational group' and work streams. They would be looking at reflective practice, holistic care and communication. A 'spiritual care competency passport' was implemented, which was assessed by a nurse and a chaplain, to support staff and build confidence in discussing spirituality with patients.

Staff followed the trust’s policy in meeting the diverse needs of the patients they care for, and followed their equality and diversity policy. The hospice’s staff had access to multidisciplinary teams, such as the learning disability and mental health teams, for support and advice. Information was available in different formats and from a

Is the service responsive?

language service. The trust employed a diverse staff team, and they also provided support for patients and their relatives, such as acting as translators in order to ensure effective communication and support which staff said worked well.

The hospice reconfigured the wards during 2014 with the provision of two side rooms equipped and suitable for use by patients with motor neurone disease, and bariatric patients in order to meet the needs of these patients' group.

The Hazel Centre, a day centre attached to the hospice, provides a service for patients in the community within Countess Mountbatten House, and is open for two days a week. It provides an environment that aims to promote independence and wellbeing. Staff ran psychology clinics on Tuesdays, providing peer support; a course consisted of 12 sessions occurring every two weeks. There was a therapeutic clinic as part of an empowerment programme, with a relaxation and a nutrition session. A carers group was held every fourth week. Patients were positive about the support they received, and found staff approachable and appreciated the open discussions.

Information on how to raise a concern or complaint was available to patients and their families. Relatives said they were confident to approach the staff if they had any concerns. They wanted to stress they were "more than happy" with the care. A relative said the staff were responsive to any of their requests. Comments included "the care is second to none". Staff were aware of the complaints procedure, and would report to matron and escalate as necessary. They said most things were

addressed informally. Complaints were fully investigated, and action plans were developed following two complaints received in the last year, and used as part of learning. The Friends and Family Test indicated 100% satisfaction with the care, support and kindness shown to patients and their families. Comments were "extremely likely" in recommending the hospice as a place for care.

There was evidence of good working relationships between the hospice and the community specialist team. The hospice was developing a shared post with the young people's hospice, Jack's Place. The community team had an average of 450 patients; the palliative medicine consultants saw patients as outpatients and had the facility to admit non cancer patients to the hospice for terminal care. The discharge protocols and processes had been developed to ensure patients were at their preferred place of care when receiving palliative care with better outcomes for patients.

There was evidence of joined-up working between the community and inpatient teams. A relative told us they were involved in the decision when their relative was transferred from the intensive care ward to the hospice. There was no one who had made the transition for children to an adult ward; however, staff told us they had clear protocol which was followed. All patients were seen by the community team prior to discharge and shared 'knowing' of the patients. Calls were directed to the hospice due to limited support out of hours which staff said worked well. Patients in the community were positive about their discharge planning and the continuous support they received.

Is the service well-led?

Our findings

Patients and their relatives were positive about the care, treatment and support they received at the hospice. Patients did not make any suggestions on potential improvements to the service provided. Staff said they were well supported, and they worked well as a team locally. The hospice does not require having a registered manager as this is part of the trust. There was a matron and a clinical lead who were responsible for the day to day management of the service.

The hospice does not provide a hospice at home service. There is a palliative care support worker service provided by a neighbouring community trust. The feedback from hospice staff indicated the aim to keep people out in the community, to enable them to receive end of life care at home, was not well resourced and strategies were under-developed. Further work was needed with partners, commissioners and providers, to develop initiatives and schemes, such as hospice at home.

Staff said there was “frustration” regarding the bereavement support in the community. A bereavement service had been operating, but funding had stopped. There was a trust wide bereavement service based at Southampton General Hospital that covered the hospice. Further work was needed with partners to ensure bereavement services are established, as an essential component of palliative care, to support bereaved relatives in the community.

The hospice took part in the Family and Friends Test and had high response rates. There was a lack of recent surveys to seek more detailed views of patients and their families. Staff told us that patients’ questionnaires, such as the 'VOICES' survey, were “well overdue”. The questionnaires were being developed as there was currently no formal audit of patient’s views to evaluate the care provided.

Medical gas cylinders were not securely stored within the external gas store and were exposed to the weather, Whilst the medical gas store was operated by another provider; there had been no monitoring or action to ensure the medical gas cylinders used by the hospice were safely and securely stored.

Nursing staff felt there was a strong nursing leadership, and the chief executive was approachable and they followed her blog. Board visits occurred on a quarterly basis to the

hospice and the community team. There were mixed reports on the visibility of board members by the community nursing specialist (CNS) team, as staff did not feel they were 'core business', and there was a feeling of acute care versus community care. CNS staff commented this could be improved by increasing their presence at meetings. However, others found the blog from the chief executive informative and felt “very well supported” by the local team and that peer support was “excellent”.

There was a clear governance structure from unit level to the board. Staff were clear about incident and statistic reporting through their electronic reporting system, and how this was used to inform practice improvements across the trust. Staff said there was also good medical leadership, with a consultant palliative clinical lead, who led the hospice team.

Staff reported they were “proud of an open and no blame culture”, and learning from incidents. The visions and values included “putting patients first and pulling together”. A staff member said “our main focus is patient’s care”. Comments from staff included “loves working for the organisation” and “never enjoyed a job so much”. This was evident throughout the inspection and the positive comments from relatives and staff. Comments included “the staff are marvellous and look after you very well”.

There was good understanding of end of life care within the hospice; the palliative care team worked cohesively with the clinical nurse specialist (CNS) team in the community, providing support to patients and their families. The joint workings continued across the hospice, the CNS team, and the hospital. This made transfer of care from the hospital to the community service, including the hospice, effective, and aiming for best outcomes for patients. To ensure continuity of care, patients were assessed by the hospice’s team, and documents such as Achieving Priorities of Care were transferred with patients.

The patient-led assessments of the care environment (PLACE) for the hospice in 2013 showed they achieved a 100% for cleanliness; food and hydration scored 93.42%; and privacy and dignity received 97.22%, which was higher than the national average in all areas. We observed the service was clean and hygienic, choices were available, and patients were supported appropriately. All these contributed to good outcomes for patients, receiving care in a person centred manner.

Is the service well-led?

The hospice provided a care home education service, supporting staff within care homes to assist and improve palliative and end of life care in care and nursing homes. This was initially established to support nursing homes in the area, and now also include care homes. The CNS team had developed a 'six steps to end of life care' programme, with links to 75 care and nursing homes. The group met bi-monthly, building relationships, providing support, and sharing knowledge. The annual report for 2013/14 showed 68% of the nursing homes had received some input from the team by March 2014. A steering group meets three times a year. The group consists of stakeholders from the local council and care commissioning group (CCG), and oversees the strategic development of the education team's work. This work has a positive impact in the care people receive in the wider community such as care and nursing homes.

The link nurse groups worked closely with the nursing homes to keep them updated on care matters, and also

providing support in development of protocols, tools and training, such as advanced care planning and the use of "syringe drivers" for end of life care. The team has continued to work with a number of nursing homes in their catchment to implement the Gold Standards Framework (GSF). This framework aims to develop a practice-based system, to improve and optimise the organisation and the quality of care for patients and their carers in their last year of life. The clinical lead told us this was an area they were very proud of and continue to develop.

We recommend the provider works with partners, following good practice guidance, to scope and provide a hospice at home service.

We recommend the provider develop strategies for bereavement support for the families of those who were cared for by the service in the community.