

## The Lewis-Manning Trust

# Lewis-Manning Hospice

### 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 ●

# Summary of findings

## Overall summary

This unannounced comprehensive inspection took place on 14 and 16 December 2016. At the last inspection completed in November 2013 we found the provider had met all the regulations we reviewed.

Lewis-Manning Hospice provides day services for up to 15 people a day, who are living with long term conditions and/or a diagnosis of cancer. They provide people with one day a week programme for 12 or 16 weeks dependent on the person's medical condition. In addition, the hospice offers 'better breathing' and 'lymphoedema' clinics and support programmes for people with head and neck and ovarian cancers. The hospice also has a purpose built in patient unit but this was not yet operational at the time of the inspection.

There was a registered manager in post who was also the chief executive. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had an understanding of The Mental Capacity Act 2005 and made sure people gave their consent before providing any care and support. However, people's consent was not recorded for staff to administer their medicines and this was an area for improvement.

People received care and support in a personalised way. Staff knew people well and understood their needs. People's care needs were assessed and planned for. However, there was not a consistent way to review outcomes, achievements or goals at a point when action could have been taken to address this. The management team confirmed that immediate action would be taken to review and address this.

Staff were caring and treated people with dignity and respect. People and staff had good relationships and they were relaxed and comfortable with staff. People participated in individual and group activities and therapies during their visit to the day hospice.

People felt safe whilst at the day hospice. Staff had received training to enable them to recognise signs and symptoms of abuse and how to report any concerns. Risks to people's safety were assessed and managed so that people could be as independent as possible. The building and equipment people used was regularly serviced and well maintained.

Most people managed their own medicines. The medicines that staff administered were administered, managed safely and stored securely. People received their medicines as prescribed.

People told us there were always staff available to help them when they needed support and they were supported promptly by staff who were friendly and caring.

Staff received an induction, core training and specialist training specific to their roles so they had the skills and knowledge to meet people's needs. Staff were recruited safely. There were plans to provide training for the volunteers at the service.

People told us they enjoyed the food at the day hospice. Specialist diets were catered for and people were able to make choices about the food and drink they had. Staff and volunteers supported people sensitively with their meals and drinks.

The culture within the service was open. There was a clear management structure and people and staff felt comfortable raising any issues. There were systems in place to monitor and drive improvements in the safety and quality of the service provided. However, some of the quality audits had not been completed but plans were already in place to address this. The management team acknowledged and took immediate action on any areas for improvement identified during the inspection.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Medicines were managed safely.

Staff knew how to recognise and report any allegations of abuse.

We found staff were recruited safely and there were enough staff to make sure people had the care and support they needed.

Any risks to people were identified and managed in order to keep people safe.

### Is the service effective?

Good ●

The service was effective.

Staff received training to ensure they could carry out their roles effectively.

Staff had an understanding of The Mental Capacity Act 2005 and the importance of seeking people's consent before helping them.

People were offered a variety of choice of food and drink. People who had specialist dietary needs had these met.

People accessed the services of healthcare professionals as appropriate.

### Is the service caring?

Good ●

The staff were caring.

Staff were cheerful and kind, treated people with patience and were constantly aware of their needs.

People and staff enjoyed each other's company.

Staff understood how to provide care in a dignified manner and respected people's right to privacy.

### **Is the service responsive?**

The service was responsive.

Care plans were in place and gave information about people's care and support needs and staff followed these.

Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People knew how to make a complaint as there was a complaints procedure in place.

**Good** ●

### **Is the service well-led?**

The service was well led.

Observations and feedback from people and staff showed us the service had an open culture.

Feedback was regularly sought from people and staff.

There were systems in place to monitor the safety and quality of the service. Improvement and development plans were in place.

**Good** ●

# Lewis-Manning Hospice

## 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.

This inspection took place on 14 and 16 December 2016 and was unannounced on the first date. There was a lead inspector, a pharmacist inspector, a hospice care specialist advisor and an expert by experience in the inspection team. An expert by experience is a person who has had a family who has used this type of service in the past.

We spoke with 11 people attending the day services over the two day inspection, one bereaved relative who was also a volunteer, 10 staff including the registered manager, operations manager medical director and nursing, healthcare, catering and medical staff. We observed the morning handover on the second day of inspection.

We reviewed four people's care records, eight people's medication records, four staff files and records relating to the management of the service, such as health and safety monitoring and quality audits. In addition we reviewed the policies and procedures in place in preparation for the in-patient unit that was planning to open during December 2016.

Before our inspection, we reviewed all the information we held about the service. This included the information about incidents the registered manager notified us of. In August 2016 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted a commissioner prior to the inspection and sought the views of 15 professionals involved in the service following the inspection. We received feedback from five health care professionals.

Following the inspection the provider sent us their improvement and development plan.

## Is the service safe?

### Our findings

People told us they felt safe at the day hospice. Professionals also said people had fed back to them they felt safe at the service. People had told them this was because they knew there were trained staff who were able to support them no matter what their illness was.

There was information displayed about how people and staff could report any allegations of abuse. The staff had all received safeguarding training as part of their induction and on going training. All of the staff we spoke with were confident in recognising the types of potential abuse and how to report any allegations.

During our inspection we looked at the systems in place for managing medicines, and spoke with staff involved in the administration and management of medicines.

Some people brought their medicines into the day hospice, and were responsible for taking them themselves if it was safe for them to do so. Some medicines were looked after and given by the nursing staff. There were safe systems for checking that these medicines were correct and for storing them on the unit. Nurses recorded when medicines were due and when they were given to people.

Staff were able to access up to date information on the safe use of medicines. Comprehensive policies and procedures were available for staff and these were kept under regular review. Staff received training on giving medicines, and a system of competency checks had been introduced to check that nurses could give medicines safely.

Any medicines incidents were recorded, and there were reflections and actions recorded to help reduce the risks of similar incidents happening again.

We looked at the new systems which had been set up in preparation for the new in-patient unit, which was due to open soon. There were appropriate storage and recording systems set up. There was a service level agreement with the local hospital pharmacy department, who have been working with the hospice medical and nursing staff to prepare and review policies and systems ready for the unit to open.

Risks to people and the service were managed so that people were protected and their wishes supported and respected. People's risk assessments covered areas such as mobility, falls, communication, moving and handling, and skin integrity. There was focus on positive risk taking at the day hospice. For example, one person who had swallowing difficulties had been advised by professionals that they should have their fluids thickened. However, the person chose not to have their drinks thickened and understood the risks. The person's wishes were recorded and fully risk assessed in their care records.

All incidents and accidents were recorded. The registered manager and medical director had reviewed each accident or incident. This was to identify what had happened and actions the staff could take in the future to reduce the risk of reoccurrences.

Environmental risk management systems were in place for the day hospice. There were maintenance records for servicing of equipment, fire systems, boilers and the building. Audits were undertaken to make sure all equipment and the building were checked and serviced as required. Robust systems were in place for the maintenance of equipment such as hoists and bathing equipment.

People, professionals and staff told us there were enough staff to meet people's needs. People's dependency needs were assessed to make sure the day hospice had sufficient staffing to be able to meet their needs. There was a low staff turnover at the day hospice and there was a consistent staff team. Additional nursing and healthcare assistants had also been recruited in preparation of the opening of the in-patient unit. These staff worked in the day hospice as extras whilst they were waiting for the in-patient unit to open.

Recruitment practices for staff and volunteers were safe and relevant checks had been completed before staff worked unsupervised at the service. These checks included the use of application forms, Nursing and Midwifery Council (NMC) checks, an interview, reference checks and criminal record checks. This made sure that people were protected as far as possible from staff and volunteers who were known to be unsuitable.

## Is the service effective?

### Our findings

People received effective care from staff. They told us the staff were skilled and knowledgeable about their needs. One person said about the staff, "They're all fabulous they know what they are doing".

There was a clear system in place that showed what training staff had completed and what training courses they were due to attend in order for them to keep their knowledge up to date. Staff told us the training covered a range of topics and provided them with the relevant skills to carry out their roles. Records showed staff received training in all the core subjects such as; safeguarding, basic life support and first aid, fire awareness, assessing mental capacity, consent and Deprivation of Liberty Safeguards, moving and handling, food safety, infection control and information governance. Staff also received additional training specific to their role. For example, nursing staff received training in medical gas safety and equipment training for syringe drivers. Some of this training was in preparation for the in-patient unit opening.

The registered manager told us there was a plan in place to provide volunteers with core training to make sure they had the skills and knowledge to support people who used the service. They anticipated this being completed by March 2017. They had already provided volunteers with a handbook that included key information and policies that were relevant to them. In addition they were planning to recruit a volunteers' lead who would be responsible for the coordination of volunteers.

Staff told us they were well supported and received regular supervision sessions with their line managers and had an annual appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). There were systems in place for making any applications once the in-patient unit was open (if required).

We checked whether the day hospice was working within the principles of the MCA. Staff had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and observed that they had a good understanding of people's capacity to consent to care.

People told us that staff always gained consent from them before providing them with any care and support. We observed informal and verbal consent being obtained by staff before they assisted people. Staff knew who required support to make decisions because of their communication needs and they were given time to take in the information and make a decision. However, people's consent was not recorded for staff to administer their medicines and this was an area for improvement but plans were already in place to address this.

People's nutritional needs were assessed prior to them starting at the day hospice. This included details as to their preferences, any specialist diets, whether food needed to be a different texture, needed fortifying with creams and milk powder or whether the person had a safe swallow plan in place. People spoke highly of the meals provided at the day hospice. One person said, "The meals here have been outstanding", another said, "The chef does a fantastic job", and a third person told us, "Meals are very good".

People were given two choices of hot food and other alternatives were also available if they did not like what was on offer. Where people had very specific dietary needs the chef was prepared to meet them. Staff and volunteers offered people drinks and snacks throughout the day.

Volunteers and staff supported people with their drinks and meals. The chef had recently introduced a new menu and consideration had been given to the effects of chemotherapy, specific health conditions and other drug therapies that impacted upon people's taste and their ability to eat certain foods.

People's health needs were met and they were supported to access healthcare. Staff worked closely with community health professionals, including community nurse specialists, and made referrals to people's GP's and district nursing services when needed. For example, one person had developed a pressure area which was identified by staff at the day hospice. They contacted the person's district nursing service who visited the person whilst they were at the day hospice.

Health professionals told us that the hospice provided the type of support to people that was difficult to source elsewhere. Professionals told us people benefited from the additional services provided by the day hospice such as physiotherapy, complementary therapies and the 'lymphoedema' and 'better breathing' clinics.

Lewis-Manning hospice was purpose built. The day hospice was situated on the first floor and was accessible by lifts and stairways. There were communal spaces with specialist pressure relieving recliner chairs, a dining and arts area and private rooms for therapies, clinics or relaxation. There was a bedroom people could use if they became tired and wanted to lie down or rest. There was specialist assisted Jacuzzi bath for people to use with staff support. There was easy access to outside balcony areas and the gardens which were shared with the in-patient unit.

## Is the service caring?

### Our findings

People were happy with the care and support they received at the day hospice. One person said, "The support and one to one care is superb", another said, "I come here once a week, It's intangible, all the little things they (staff) do make a difference. I've got to know the others who come the same day as me. It's a very social time".

One person wrote a letter to the service it included, 'Lewis-Manning and all the staff have found a special place in my heart, since coming here has shown me the positive side of having cancer, if I did not have it I would not have met so many lovely people and had so many opportunities. It changed my thinking from a negative to a positive. Coming here has given me joy and peace.'

A bereaved relative told us the day hospice had been invaluable to them as a family and that being part of the carers group had given them additional comfort and support.

Health professionals told us the feedback they received from people was always very positive. They said people fed back to them about how 'incredibly caring' the staff were.

We observed staff interacting with people in a friendly and caring manner. Staff were laughing and joking with people throughout the day. People appeared to like this and were responding in a positive way. Staff took time when communicating with people and did so in a respectful way.

People's independence was encouraged and people told us their confidence had increased since using the service. For example, one person who was registered blind who had needed staff support when they first started using the day hospice was walking independently at the end of their programme. Another person was not eating and was socially isolated before accessing the day hospice. Following their 12 week programme, the person was eating and drinking, had gained weight and had returned to their volunteering job.

Staff understood and responded sensitively to the needs of people. This included supporting people to prepare advance care plans and make their wishes about their end of life needs clear to their relatives and professionals. Care records showed that advance care planning had been put in place where people were willing to discuss their needs. One person said, "I have been able to talk to family about things I didn't think I would be able to discuss, like my wish to not be resuscitated and getting my house in order. I have been able to focus on those things with my family." Staff understood that discussing with a person how they wished to be cared for at the end of their life was a sensitive matter. They told us they would be led by the person who used the service in when and how much detail they would discuss this.

People felt their privacy and dignity was respected. Staff supported some people to have a bath using the specialist bathing equipment at the day hospice. Staff made sure people's privacy and dignity was maintained during personal care. If anyone needed treatment or any complementary therapy it was carried out in a room away from the main area of the day hospice in private.

People were also able to use a variety of rooms at the day hospice where they could enjoy privacy and time by themselves or with staff. Staff received training in diversity, equality and human rights which they put into practice when they supported people from different backgrounds. Information and resources were displayed and readily available for people from different minority groups. For example, information was displayed and readily available about planning ahead for 'Your treatment and your care' for the LGBT (Lesbian, Gay, Bisexual and Transgender) community. This information was produced following the identification of palliative care shortfalls for this group of people in national research.

Arrangements were in place to be able to support people's spiritual and faith needs if needed at the day hospice via the spiritual lead and the chaplain at the local hospital. Contacts had been made with other local faith groups in preparation for the in-patient unit opening.

## Is the service responsive?

### Our findings

People told us they received personalised care and support from staff. One person said, "I didn't think I would get much out of it at the beginning, but I have been really surprised, I enjoy coming. We set out goals at the beginning and have nearly met all those now".

We attended a morning handover where each person coming to the day hospice that day was discussed. Staff summarised the person's health and social care needs and identified what week people were on in their programme. They allocated a staff member to spend time with the person and giving them the opportunity to talk in private if they wished. Each person was offered the opportunity to spend one to one time with staff during the day if they wanted to.

People's needs were assessed prior to them attending the day hospice and a care plan was developed. People's care plans reflected their individual needs and wishes. They contained information about people's needs such as personal care, mobility and support needed with eating and drinking. The plans also included their physical and emotional wellbeing as well as their medical diagnosis.

People attended the service for a 12 or 16 week programme dependent on their medical condition. The 12 week programme was offered to people with long term conditions and they could re attend after a break of six months. The 16 week programme was offered to people with a diagnosis of cancer. People and staff told us they discussed what they wanted to achieve whilst using the service in the first few visits and they understood the programme was time limited. People and staff met each week to discuss how they were feeling and if they had any new concerns or issues. However, there was no way of recording or reviewing the person's goals, outcomes or achievements until they had almost completed their 12 or 16 week programme. Two weeks prior to the completion of the programme staff discussed with people whether to extend the programme or discharge them. This meant there was not any earlier review of whether the service was meeting the person's outcomes, achievements or goals at a point when action could have been taken to address this. Following discussion with the day services lead and registered manager they agreed to implement a care plan review system for reviewing people's needs wishes and goals at an earlier point in their programme.

When people started at the day hospice they were asked about their interests and hobbies. One person told us they were asked what they wanted to do whilst at the day hospice. We saw people participating in individual and social activities they said they liked. People participated in quizzes, games and arts and crafts. People told us they valued being able to chat with peers and to give their family carers a break. People told us staff understood their conditions and they were able to sit quiet and rest if they wanted to.

The complementary therapist worked two and half days a week. During the inspection they gave people hand massages. People could also have a full aromatherapy massage in the complementary therapy room.

The physiotherapist provided a group session for everyone in the day hospice main lounge and also offered individual sessions in the physiotherapy suite. People had access to specialist physio and gym equipment in

the physiotherapy suite.

A creative therapist worked at the day hospice two days a week. People told us they enjoyed creating art works and trying new crafts whilst at the day hospice. One person said, "I have undertaken activities, I have made a lot of silk scarves, so have Christmas presents for the family".

Staff referred people to other agencies and support groups so they continued to receive support when their programme at the day hospice finished. For example, staff worked closely with Citizen's Advice Bureau in relation to benefits advice. Staff had researched and made a referral for one person to attend another specialist day service when they finished their programme at the day hospice. This was so they did not become socially isolated as they had been before they started to use the service.

We saw that information was provided to people about the complaints procedure when they came to the day hospice. The complaints procedure was displayed on the notice board. People knew how to raise any concerns and complaints and did not raise any with us.

There had not been any formal written complaints received since 2009. However people were confident their complaint would be dealt with appropriately.

We followed up on a concern that had been raised directly with CQC that was not raised as formal complaint with the day hospice. There was no system for recording people's verbal concerns and how these were addressed so any learning could be shared with the staff team. The registered manager and operations manager agreed to implement a system for recording peoples' verbal concerns and what action had been taken in response.

## Is the service well-led?

### Our findings

People, volunteers and staff told us they felt the service was well led. There was a clear management structure at the hospice. The registered manager was also the chief executive. There was a board of trustees and there were regular board meetings with the chair and board members of Lewis- Manning hospice. They were supported by an operations manager and director of nursing/matron. However, the director of nursing/matron post was vacant at the time of the inspection. In addition there was a lead nurse for the day hospice and they were also the lead nurse for the inpatient unit that was due to open later in the month. On a day to day basis the day hospice was run by the lead nurse and the nursing team.

Staff and volunteers told us they knew what was expected of them in terms of their roles. Staff said all of the managers and leads were visible and they were approachable. There were monthly staff briefings and a daily handover. Staff all sat together at the end of each day to debrief and provided each other with any emotional support they needed. Staff also had access to an external counselling service.

The service had appointed a 'freedom to speak up guardian' so staff could raise any concerns or issues independently of the provider and managers. The freedom to speak up guardian then fed back any issues or themes to the executive team and board whilst protecting the staff's identities. Staff knew how to whistleblow and the different ways they could also access the freedom to speak up guardian.

Feedback was sought from people, their relatives and staff via surveys twice a year. The 'friends and family test' and a suggestion box were available in the reception area. Action was taken in response to any feedback from people and staff and there was a standard agenda item at board meetings of 'You said we did'. The feedback gathered from people who used the day hospice in August 2016 was positive. The results of the 'friends and family test' between August and October 2016 showed that people were extremely likely to recommend the services provided by Lewis-Manning hospice.

There was a carers group held on a monthly basis at the day hospice. This group was currently facilitated by the members of the carers group some of whom also volunteered at the day hospice. We received feedback that the carers who attended the group were bereaved relatives rather than relatives of people who were currently using the service. There were some concerns raised with us that because the group was not being facilitated and promoted by trained staff or volunteers, current carers may not be aware of the group and how to access it. However, this had already been identified and was also an area for development identified in the improvement and development plan. The timescale for this to be met was June 2017.

Trust and board members visited the day hospice unannounced to complete quality assurance visits and to seek the views of people and staff. These visits fed into their quality assurance processes and ensured trust members had the opportunity to meet with people and staff.

The hospice worked closely with other organisations so that they maintained up-to-date practice and provided quality care to people. For example, the support groups for people with head, neck and ovarian cancers were set up in partnership with MacMillan cancer support. Lewis-Manning also worked very closely

with the local hospital hospice in setting up and developing the in-patient unit.

There was an improvement and development plan in place that was regularly updated and reviewed. The plan considered the five key questions we ask and included timescales for completion. For example, there was a plan to implement an audit of the self administration of medicines systems and records in the next three months.

The registered manager acknowledged that following the retirement of the director of nursing/matron in the summer there had been shortfalls in the completion of some quality assurance audits. This included care record audits. However, there was a plan in place to restart these and to cover the post from January 2017 with an interim director of nursing until a new director of nursing/matron could be appointed.

The records kept about people were accurate and reflected the care and support provided to people. They were stored securely in the day hospice office. However, there were some areas of the care records that were not consistently recorded in. This meant that when the care records audits were restarted the records may be difficult to audit as they were completed differently. The nursing staff told us they were in the process of reviewing the care plans and records in use. The registered manager told us and the improvement and development plan identified that action was to be taken immediately to address this.

Professionals involved with the service fed back there were sometimes delays in the ways referrals could be made and information shared as to who is undertaking what tasks with people. For example, advanced care planning. This was due to incompatible communication and computer systems. The registered manager and operations manager were aware of this and told us they were investigating new computerised systems that could be compatible with their health colleagues systems.