

Dorothy House

Dorothy House Hospice Care

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

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as outstanding 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.
- People received outstanding care from highly motivated staff who developed exceptionally positive, caring and compassionate relationships with them. Staff gave patients enough to eat and drink and gave them pain relief when they needed it. The service had an open and positive culture that placed people at the heart of everything they did. Staff treated people with sensitivity, dignity and respect.
- 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. Key services were available seven days a week.
- Staff treated patients and their loved ones with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest. Families and those that mattered to the person were supported to spend quality time with them.
- Services were planned and tailored to meet the complex needs of individual people, and the local population, in partnership with the wider health economy. The hospices' services were delivered flexibly, by a responsive and passionate multidisciplinary team, providing choice and continuity of care for patients, their families and carers. The hospice planned and worked to improve awareness and access to palliative care for hard to reach communities. The service made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service needed to make improvements in their medicines management.

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Outstanding



Summary of each main service

Our rating of this location stayed the same. We rated it as outstanding because:

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- People received outstanding care from highly motivated staff who developed exceptionally positive, caring and compassionate relationships with them. Staff gave patients enough to eat and drink and gave them pain relief when they needed it. The service had an open and positive culture that placed people at the heart of everything they did. Staff treated people with sensitivity, dignity and respect.
- 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. Key services were available seven days a week.
- Staff treated patients and their loved ones with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest. Families and those that mattered to the person were supported to spend quality time with them.
- Services were planned and tailored to meet the complex needs of individual people, and the local population, in partnership with the wider health economy. The hospices' services were delivered flexibly, by a responsive and passionate

Summary of findings

multidisciplinary team, providing choice and continuity of care for patients, their families and carers. The hospice planned and worked to improve awareness and access to palliative care for hard to reach communities. The service made it easy for people to give feedback. People could access the service when they needed it.

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service needed to make improvements in their medicines management.

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Summary of this inspection

Background to Dorothy House Hospice Care

Dorothy House Hospice is a registered provider of specialist palliative and end of life care for people, over the age of 18 years, irrespective of diagnosis. Dorothy House Hospice is registered for 10 beds, the inpatient unit had eight single rooms and one double room, all with en-suite bathroom facilities. The service provides inpatient care for people needing help with complex symptom management, pain control and end of life care. The service also provides home care

People are referred to the hospice by health professionals, in liaison with their GP or hospital consultant or they can self-refer.

The service had a dedicated day patient unit so they could provide more day services nearer to people's home.

Dorothy House Hospice has 788 volunteers working in the hospice and across charity shops. Of these, 463 are retail volunteers and were not part of this inspection. Of the 325 non-retail volunteers there are currently 133 active patient facing volunteers, the others were involved in fundraising or volunteers with the service's enabling teams. However, the charity shops were not part of this inspection.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 09 June 2022.

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

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

The service was registered to provide: Treatment of disease, disorder and injury.

How we carried out this inspection

We carried out a comprehensive inspection of the service under our regulatory duties. The inspection team comprised of a lead CQC inspector, a pharmacy inspector and a specialist nurse in palliative care and was overseen by a CQC inspection manager.

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.

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>.

This inspection took place on 09 June 2022 and was unannounced.

Summary of this inspection

Outstanding practice

- We found the following outstanding practice:
- Staff consistently went above and beyond to help patients achieve their goals, for example by supporting patients to travel with their families, creating lasting gifts and mementos and sourcing people with rare skills to complete life-time projects.
- Staff used technology innovatively to provide patients with a virtual reality experience, taking them into the realms of enjoyment and discovery.
- Staff supported children and young people to explore their feelings and prepare for bereavement. Young people had been supported to develop a manifesto for schools to facilitate difficult conversations. Staff supported one young person, who won a national award for their work supporting other young people who were bereaved.
- Staff worked alongside other agencies to provide palliative care to people who might be considered 'hard to reach', such as the homeless and people living in shelters.

Areas for improvement

- The provider should ensure that patients receiving medicines by transdermal patches are monitored appropriately.
- The provider should ensure that patient group directions (PGDs) are legally valid to allow staff to administer medicines.
- The provider should ensure that medicine audits are accurately reflecting practices within the hospice.

Our findings

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

Are Hospice services for adults safe?

Good 

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

Mandatory training

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

Medical and nursing staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. All staff completed a range of mandatory training which included fire safety, infection control, safeguarding, moving and handling, Mental Capacity Act, equality and diversity and clinical information governance. Some of the courses had 100% completion rate, such as moving and handling at work and risk assessment for managers. Where training statistics were not 100%, the provider had training courses arranged and staff were made aware of the need to complete all training.

Staff also completed role specific mandatory training. For example, staff working with medicines had to complete training for drug calculations. In addition, registered staff completed an end of life care module and advanced communication training.

The registered managers monitored compliance with mandatory training and staff were alerted when they needed to update their training. Staff confirmed they were given enough time to do training.

The registered managers ensured staff could access online training appropriate for the service. Staff told us they were able to request additional training, and this would be provided for them.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.



Hospice services for adults

Medical and nursing staff received training specific for their role on how to recognise and report abuse. The service had clear safeguarding processes and procedures. Staff and volunteers were trained to safeguarding level two for both vulnerable adults and children and records showed most staff had completed this. The service had a safeguarding lead who was trained to level four. Although not required at this level, fifty percent of staff had completed safeguarding level three training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to an up-to-date safeguarding policy. Staff we spoke with were able to clearly articulate signs of different types of abuse and the types of concerns they would report or escalate to the registered manager. The service had made one safeguarding referral to the local authority in the quarter from January 2022 to March 2022. However, the service had provided care and support to people who identified as being at risk but did not meet the threshold for a safeguarding referral, for example if they felt suicidal.

Staff followed safe procedures for children visiting the ward.

The provider had a recruitment policy which stated all staff had to have a Disclosure and Barring Service (DBS) check before starting their employment at the location. All staff had an up-to-date DBS check. We reviewed staff personnel files and all staff had proof of identification, full employment history and an up-to-date curriculum vitae on file. The service had obtained two references for all staff in line with their policy. We also saw employment offer letters, evidence of induction training, qualifications, and professional memberships were kept on file.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on the inpatient unit and transporting patients after death.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve infection prevention and control (IPC) practices if needed. The hospice had a champion for IPC who was available to provide support, advice, training and updates for staff. An audit programme was used to increase and maintain standards and help prevent the spread of infection. We reviewed minutes from committee meetings and could see it was an effective way to monitor, promote and maintain infection prevention and control standards at the hospice.

The service undertook quarterly audits of hand hygiene. These showed staff achieved 100% following the five moments of hand hygiene guidance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. The service had appropriate handwashing facilities and sanitising hand gel was available. Staff had their arms bare below their elbows and washed their hands before and after each patient contact. Personal protective equipment such as latex-free gloves and aprons as well as antiseptic wipes were readily available for staff to use at the service. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

In the twelve months before the inspection there had been no incidence of healthcare acquired infections at the location.



Hospice services for adults

Environment and equipment

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

The service had enough equipment to care for patients safely. Patients could reach call bells and staff responded quickly when called.

Some patients attended a day patient unit for blood transfusions. The fridge used for storing blood had broken down in January 2022. The clinical lead had investigated the best options for either replacing or repairing the fridge. At the time of our inspection, red transportation bags were used which maintained the correct temperature for blood for four hours. A longer-term solution was being sought.

Environmental risk assessments were completed such as detailed risk assessments about the fire risks related to the use of oxygen. Staff completed specific training about safe storage and how to change oxygen cylinders in accordance with the medical gases policy. Where people were using oxygen, hazard signs were on display outside their rooms warning about the flammable risks. No smoking was permitted within the service, and a covered gazebo smoking area was provided outside, so people/visitors could smoke away from the building.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

People were protected because risks for each person were identified and managed. Comprehensive individual risk assessments were completed, in relation to people's risk of falling, malnutrition and dehydration, and about moving and handling risks. Detailed care plans identified measures taken to reduce risks as much as possible. For example, on how to reduce a person's risk of developing pressure ulcers, including details of pressure relieving equipment, the need for regular repositioning and skin care.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Every patient was assessed for their risks of falls, nutrition and venous thromboembolism (VTE), also known as blood clots. The clinical team had monthly reports so they could have oversight of the reporting processes.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Clinical staff told us they followed the hospice sepsis policy but did not need to use NEWS 2 on every patient. The National Early Warning Score (NEWS2) is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis, in hospitals in England. However, when transferring patients between services, staff used the same language as the NEWS 2 tool.

Nurse staffing

The service had enough nursing and support 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 and agency staff a full induction.



Hospice services for adults

Patients were safely cared for by sufficient numbers of skilled and experienced staff. The service employed 54 people full time within the patient and family services team, 142 staff part time and 50 bank staff. Staff roles included advanced nurse practitioners, senior and junior sisters, nurse specialists and registered nurses. Other staff roles included a physiotherapist, an occupational therapist, a specialist dietician and a senior social worker. A psychological support lead was available, together with a chaplain and spiritual care co-ordinator. A bereavement service co-ordinator was also available.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The provider used a tracker to identify how many staff were needed. This meant managers could adjust staffing levels daily according to the needs of patients. The service had an escalation procedure where the inpatient unit staff could bring in additional staff if there was a sudden absence or if a patient's needs or dependency increased. Twenty-four hour advice and support was provided by a team of doctors. The duty rota showed recommended staffing levels were maintained.

Out of hours there was an on-call executive team member to escalate staffing concerns if needed.

To support nursing staff, Monday to Friday there was a multi professional team of therapists, doctors, Ward clerks, housekeepers, social care staff, chefs, maintenance staff and other support staff and volunteers on the unit at different times. This was not replicated at weekends or bank holidays at present. Staffing was discussed prior to weekends and bank holidays at the daily meeting.

Managers made sure all bank staff had a full induction and understood the service.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service employed a medical consultant who was also one of the registered managers and a speciality doctor. The service also employed a medical director, and a motor neurone specialist practitioner. Motor neurone disease is a condition where parts of the nervous system become damaged, causing progressive weakness. The service also employed specialists for lymphoedema, which is a long-term (chronic) condition that causes swelling in the body's tissues.

The medical staff matched the planned number. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

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. We reviewed patients' notes and found them to be completed in full and were up to date. They included relevant risk and clinical assessments including escalation



Hospice services for adults

and ceiling of care plans, known allergies, nutritional and pain assessments, medical and nursing clinical management plans and pathways, and were linked to the integrated palliative outcome scale (IPOS) phase of illness and advance care planning. Communication with patients and their families was clearly documented throughout the records. Records were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records.

The service had an up-to-date information governance policy, and a data retention policy. The registered manager was the information governance lead for the service. The service was registered with the Information Commissioner's Office (ICO).

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. The service were not using patient group directions in line with legal requirements.

Staff followed systems and processes when prescribing, ordering, administering, recording and storing medicines. Medicines were supplied by a local NHS trust. A pharmacist visited the hospice four times a week.

However, we found the service was not using patient group directions (PGDs) in line with legal requirements. PGD's are written instructions to help services supply or administer medicines to patients, usually in planned circumstances. The service suspended use of PGD's immediately and began a review of their processes and protocols.

Staff followed current national practice to check patients had the correct medicines, this was completed by doctors on admission to the hospice and then checked by the pharmacist.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We could see that medicines had been individualised for patients such as what time they wished to take their sleeping tablet. We found on one occasion that it was not documented when a discussion with a patient had taken place about stopping a medicine. Following our inspection, the service immediately looked at the process to allow notes to be written at the same time as the consultation to ensure all conversations were captured.

Prescribing was clear, safe and appropriate to be able to respond to symptoms that patients may experience during their stay including making sure patients had adequate pain relief. People who were receiving medicines by syringe pumps (where medicines are delivered continuously by infusion through the skin) were regularly monitored and the syringe pump devices were regularly checked to ensure they were in working order.

Staff completed medicines records accurately and kept them up to date. However, there was no monitoring of patients who were receiving medicines that were not controlled drugs through the skin through a patch. Action was taken immediately, and transdermal charts were put into use for any patient receiving their medicines in this way.

Staff stored and managed all medicines and prescribing documents safely. There was a procedure and storage facilities in place to allow people to self-administer their own medicines if they wished. Emergency medicines were available, and the service had a procedure so that a critical medicine was immediately available in the event of a bleed. If necessary, supplies of medicines could be obtained via the local chemist. Prescription stationary was safely stored and controlled.



Hospice services for adults

At discharge, there was a comprehensive checklist to make sure patients received all the necessary documents and medicines. This included a medicines planner which provided a list of their medicines and how to take them.

Medicines were prescribed off-label (where a medicine is used for a condition or purpose other than for which it has been approved) and occasionally unlicensed medicines were used within the hospice. This means the use of these medicines is not covered by the manufacturer. This prescribing was guided by standard practice within palliative care but currently there was no information given to patients about this. This had already been discussed at the Medicines Management Meeting and had been identified to be included in the patient information pack and on the website.

Staff reported medication incidents and near misses. Incidents were then reviewed at Medicine Management Meetings. There was evidence that actions had been completed and learning shared with hospice staff, such as the implementation of an audit looking at blood glucose monitoring when a patient was admitted to the hospice if they were receiving medicines that could lower their blood sugar.

The service conducted medicine audits, but some of the prescribing did not meet the standards in the audits as the audit did not examine the 'as required' prescriptions. Immediately following our inspection, the service agreed to undertake two separate audits covering prescribing and administration and to repeat these quarterly.

The service had not actioned a National Patient Safety alert appropriately ensuring people who took steroids were adequately informed and carried an alert card. This should have been completed by 13th May 2021. The provider responded immediately, and a new process was implemented to ensure patients have an emergency steroid card and the audit amended to reflect this.

On the inpatient unit staff had received medicines training and their competency was regularly checked. A training need had been identified for hospice at home carers and work was currently being undertaken to support carers with medicines in patients' homes.

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.

Accidents and incidents were reported with action taken to reduce risk of recurrence. For example, following a person becoming aggressive the service completed a thorough review. This included considering what medicines were available, clear signage for the police so they knew where to go, staff training how to manage an incident out of hours and having a panic button that alerted the police but did not ring everywhere to disturb other patients. A member of staff on each shift was designated to take the lead in the event of any incidents.

All accidents and incidents were recorded, such as if patients developed pressure ulcers or had a fall. Accidents and incidents reported were discussed during monthly team meetings and reviewed by the Health and Safety and Clinical Governance Committees to agree any additional actions needed. The hospice participated in the Hospice UK national inpatient benchmarking project, so accidents and incidents were compared to similar services, to highlight any areas of concern.



Hospice services for adults

There was evidence that changes had been made as a result of learning from incidents. For example, after one incident at night the lack of security personnel overnight was added to the risk register. Staff were consulted and agreed a security camera by the door would be beneficial. This action was completed.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. In line with their duty of candour, the service made the person involved and their family aware of the outcome of the investigation, lessons learned and the improvements implemented.

The service had no never events. Managers shared learning with their staff about never events that happened elsewhere.

Managers debriefed and supported staff after any serious incident.

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. The head of governance and quality managed a central database of policies and procedures for the hospice that enabled tracking of policy review dates. A process was in place for policies to be updated with any new or amended guidance. We reviewed a range of policy documents held by the hospice.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory training. Patients had an individualised plan of care which reflected their personal needs.

The hospice undertook a comprehensive range of audits throughout the year to ensure healthcare was being provided in line with standards. The hospice used the audits as a quality improvement process to improve patient care and outcomes through systematic review of care against explicit criteria. Each person admitted to the hospice had an individual assessment of their personal care, level of pain, nutrition, moving and handling, and pressure area care needs.

The service completed audits to ensure the hospice was dementia friendly. Staff on the inpatient unit used a well-known evidence-based questionnaire which helped people to self-report their physical, emotional, social and spiritual needs. This enabled people to identify their main concerns, any symptoms or worries so staff could help meet those needs. For a person experiencing a lot of psychological distress about their family, staff arranged family support counselling to help them.



Hospice services for adults

At handover meetings, staff routinely referred to the psychological, emotional and spiritual needs of patients, their relatives and carers. All members of staff at the handover were able to contribute to the discussion, including allied health professionals and spiritual care staff.

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.

We found sponge sticks were used for oral care. This was considered poor and unsafe practice due to a risk of choking if the sponge came off the stick. Senior staff responded immediately and informed all staff about the situation. Current stocks were disposed of and more appropriate oral care products were ordered.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff who supported people with specialist nutrition and hydration needs were trained to do so. People were supported to eat and drink what they wanted for as long as they wished. They were asked about their food preferences, allergies and any specific dietary needs. If a person needed a special diet, the chef discussed their individual requirements with them. People could choose their meals from a menu, including their preferred portion size.

Mealtimes were protected, so no visitors or doctor's ward rounds were permitted, which meant people could enjoy their meal without interruptions. Food served was attractively presented to tempt people with poor appetites. If a person didn't wish to eat the main course offered, they were offered an alternative, such as salad, jacket potato, omelette or sandwiches and relatives could bring in favourite foods. Out of hours, staff had access to a kitchen and could prepare snacks such as cereals, toast, soup, yoghurts, rice pudding, jelly and ice cream.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff prescribed, administered and recorded pain relief accurately.

Pain was a common symptom experienced by patients cared for in the hospice and its services. Clinical staff discussed pain and pain relief with patients during admission to the inpatient unit. This was documented in the patient's record. Patient pain levels were then regularly reviewed, and staff gave pain relief in line with individual needs and best practice. Nursing staff were taught how to assess pain and where necessary used syringe pumps for effective pain relief. Anticipatory medicines were prescribed for patients who needed them.

Staff monitored patients for distress cues, for example patients who because of cognitive impairment or physical illness had limited communication. Staff also regularly assessed patients' ability to tolerate oral medicines with alternative administration routes prescribed if necessary, such as intravenous infusion.



Hospice services for adults

Patients received pain relief soon after requesting it. One patient was receiving anticipatory medicines through a syringe pump and this was reviewed on admission and the following day. The syringe pump was continually monitored to ensure the correct amount was being administered and the site where the needle was inserted was checked.

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 had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The service completed two national audits and 40 internal audits in the year April 2021 to March 2022. Managers used the results to benchmark themselves with Hospice UK against other adult hospices. Audits included falls, medicines errors and pressure ulcers. Results showed the service had fewer instances of patients with pressure ulcers and fewer medicines errors, but a higher rate of patients' suffering falls. Managers responded with an action plan to reduce the number of falls. Actions they took included setting up a group of staff with reducing the rate of falls as their priority. Changes made included renewing the falls policy and testing a new bed which alerts staff when people move. The service completed an annual audit to look at how many patients died in their preferred place of death, this showed between 90% of people died in the place of their choosing.

Managers and staff used audits to improve patients' outcomes. For example, the service improved the rates for testing patients' blood glucose levels. The service aimed to test the blood glucose levels of all patients with diabetes or those taking steroids on the day of their admission.

People received effective end of life care based on best practice evidence. Staff had link roles to champion best practice. For example, in skin care and prevention of pressure sores, falls prevention, nutrition and hydration and infection control. A nurse had introduced a bespoke end of life pressure ulcer risk assessment tool, which helped staff identify factors that might make people more at risk of skin breakdown. This ensured staff were using best practice skin care which minimised people's risk of developing pressure ulcers.

As well as being accredited with Investors in Volunteers, the service was also accredited to the Armed Forces Covenant and Working for Carers.

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.

Hospice staff had a range of skills and experience, and received access to thorough training, updating and opportunities for ongoing professional development. All new staff including bank staff and volunteers underwent a thorough induction, which gave them the skills and confidence to carry out their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were champions within the service who actively supported staff to make sure people experienced good healthcare outcomes leading to an outstanding quality of life.

The service benefitted from training staff to become champions, such as a dementia champion, a learning disabilities champion and a falls champion. The role of a champion is important for informing staff of updates and improving quality of care.



Hospice services for adults

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff from band 6 upwards benefitted from external coaching. A confidential counselling service was provided for staff, which some staff really appreciated. A training needs analysis looked at the future training needs of hospice staff and identified additional skills needed so staff could take on extra roles. For example, clinical skills to support people having more treatments in day services, such as blood transfusion, and prescribing for nurse specialists. Also, to provide healthcare assistants with additional skills and competencies to support people at home with more complex needs. For example, people with artificial feeding tubes.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The provider had developed a bank of internal clinical supervisors. All doctors had external one-to-one clinical supervision.

The clinical educators supported the learning and development needs of staff. The education department worked closely with the University of the West of England, so nursing staff could gain additional qualifications at degree and master's level.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

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

Links with health, complementary and social care services were well established. Where people had complex/continued health needs, staff always found ways to improve their care, treatment and support by identifying and implementing best practice. One patient told us, "I didn't realise the things they could do; it helps me feel like I'm fighting back." Another patient told us how the clinical care they received had got them walking again and said, "I've had all sorts, from acupuncture to young people's groups and they really help people with life-changing illnesses."

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. A consultant reviewed patients on admission. Patients were reviewed daily by the medical team. The service provided five consultant sessions at a nearby hospital.

Hospice staff understood the importance of working together to provide seamless care for people. People's care was reviewed daily or more often by nursing and medical staff and treatment plans updated as their needs changed. Comprehensive discussions took place about the care of each person and those of close family members. Physiotherapists and occupational therapists helped people experiencing difficulties with mobilising, falling and breathing difficulties. This included arranging equipment to help them be as independent as possible, such as mobility equipment, moving and handling aids and electric beds. This meant people's care and treatment was actively managed.

Seven-day services

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



Hospice services for adults

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. The service had two registered managers, one of these was a consultant and was the medical director. The medical team included three other consultants, two advanced practitioners and one GP completing six month's training. A volunteer doctor was available one day a week.

The hospice provided a 24-hour, 7-day a week palliative care advice line for patients and their carers and for health professionals such as GP's, district nurses and hospital staff. Nursing staff provided advice on symptom control and management of pain relief and the doctor on duty was available for more complex queries. Data showed the service was well used and has continued to grow.

Health promotion

Staff gave patients practical support to help them live well until they died. Staff made sure patients were comfortable and able to be as pain free and symptom free as possible

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.

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Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Each person's mental capacity to make their own decisions and consent to their care was regularly assessed and reviewed, as their condition changed. Staff consulted relatives, staff and other professionals in 'best interest' decisions about the person's care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Patients were consulted and involved in all care and treatment decisions.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff respected people's wishes, set out in advance care plans, even when the person was no longer well enough to communicate them.

Staff clearly recorded consent in the patients' records.

Clinical and nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.



Hospice services for adults

Are Hospice services for adults caring?

Outstanding



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

Compassionate care

Staff and volunteers were highly motivated and treated patients and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond expectations to meet their individual needs and wishes. Patients and their families were truly respected and valued as individuals.

All staff, including volunteers, were aware of the importance of providing compassionate care and the impact their actions had on the patient and their families during this time of their lives. Support was always given by caring and empathetic staff who put patients and those close to them at the heart of everything they did. All conversations and observations, without exception, with staff during our inspection demonstrated this. Big and small acts of kindness were embedded in how staff looked after patients, whether it be arranging a wedding, picking flowers from the hospice gardens to put in a patient's bedroom if they liked fresh flowers or holding a patient's hand when they were scared.

People experienced a level of care and support that promoted their wellbeing and meant they had a meaningful life. One person we spoke with told us, "They've been life-savers, they've sorted everything out for me making sure I understand, but I'm in control."

Staff consistently endeavoured to provide compassionate care tailored to patients' individual needs and wishes, particularly for those approaching the end of their life. Staff wanted to make end of life care as good as it could be for the patient and their family or carers and went above and beyond to achieve this. For example, one patient wanted to make the most of the time they had left with their family and young children. The patient had a bucket list of things they wanted to do, these included attending a stag weekend, visiting a well-known amusement park in Europe and having a cruise with their family. Staff worked to optimise pain control and issued enough medicines for the person to travel, along with a supporting letter from the person's GP. The patient and family were supported by the family support team throughout their travels.

Staff were able to give us many examples of where the service had gone above and beyond to meet patients' needs and wishes. One patient who was in the last days of life was desperate to say a final goodbye to their beloved horse. Staff arranged for the horse to visit the hospice and go into the patient's room where they said farewells. Another patient was a carpenter whose life's work was a beautiful ornate door they'd carved. Staff found a carpenter with the skills to finish the patient's work and arranged for them to meet. Hospice staff would work together to achieve outcomes for patients, often with tight timelines. Staff told us no matter how large or small if they could make it happen safely, then they would try their hardest to achieve it.

The service was taking an innovative approach to support patients' wellbeing. For example, the service was using technology to develop an immersive virtual reality, with the aim of exploring how patients' care could be enhanced. Patients living with pain, nausea, anxiety and boredom and living with life-limiting illnesses could be taken away from this into a world of relaxation, enjoyment and discovery. The project aimed to increase access to day hospice services for patients within their own home.



Hospice services for adults

Patients said staff treated them well and with kindness. Patients described the exceptional quality of the service by commenting, “I’m a walking miracle example of the care they’ve given” and, “I’m over the moon, really surprised at the level of service they give.”

Staff treated patients in a holistic manner and worked together to improve all aspects of their life. They spoke about the importance of setting small manageable goals for people, such as watching a favourite film or having massage. Staff told us about other ways they personalised the service for patients, for example, by arranging ‘date nights’ for couples with a special meal, film or a takeaway.

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. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. People’s privacy and dignity was always considered. Staff always knocked before entering a room.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and their relatives and consistently took account of this when providing care and treatment.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The hospice provided a comprehensive bereavement service for people and families, which included individual or group sessions and a ‘drop in’ bereavement support two days a month.

Staff gave patients and those close to them help, emotional support and advice when they needed it. A children and young people’s team were doing exceptional work supporting children and young people facing bereavement. Qualified children's therapists supported children and young people to explore and express their feelings, prepare for their loss and find ways to cope with the changes in their lives. They offered one-to-one sessions, workshops and advice to anyone caring for or supporting children and young people. A range of approaches were used including play therapy, memory boxes, life stories and creative arts. A staff member usually met with the child and their parents initially to find out about each child and explain the various ways in which they could support them. For example, helping families to tell children a loved one was dying, to say goodbye and make lasting memories. A dedicated room called ‘The Den’ was filled with a variety of toys, games, pictures, books, a dolls house, and arts and crafts designed to appeal to children of different ages.

The patient and family support team offered emotional support to the individual and families who may be struggling with how to cope with the challenges of serious illness and the changes it brought. Support was offered on a one-to-one basis, with family or in groups. They undertook anticipatory grief work and identified coping strategies, which included working with patients and their wider families. The team offered bereavement support to bereaved relatives and friends



Hospice services for adults

before and after the death of their loved ones. This included individual counselling or group sessions. We saw positive feedback from service users for the support that was provided which was summed up in the following comment, “Staff are just brilliant. Nothing is too much trouble and they’ve gone above and beyond to help me make the best of my time with my young family.”

The hospice social worker role was multifaceted. It included advising on benefits and advocacy services and supported patients and their families with accessing these as required. Through their experience and training they were skilled at recognising families in distress and facilitating difficult conversations. Patients and their families spoke highly of the support offered and how it had alleviated stresses at an extremely difficult time in their lives.

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. Staff were trained in communication skills and compassionate behaviours and excelled at giving people information and explanations, and sensitively managed difficult and challenging conversations. One person said, “They make the most difficult conversations easy; they’ve certainly got good communication skills.”

Staff had provided support for young people who were bereaved to express what they needed in a manifesto for schools. This meant the young people had been enabled to have difficult conversations in a supportive environment with other young people having the same experience and did not have to have the conversation on their own with their schools.

Friends and family could visit at any time, a family room with overnight accommodation was available, so relatives could take a break, make a drink or snack, and get some sleep.

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.

People said staff treated them with dignity and respect, which was confirmed by 100% positive response in the most recent survey. People and relatives said staff were always popping in to check they were comfortable, pain free and check if they needed anything.

The hospice used ‘Life Stories’ as a way of supporting people to leave personal messages, letters or keepsakes for those they loved and cared about and to create memoirs. People were able to record what mattered most in their lives, on CD/DVD, through poetry, drawing, photographs or memory boxes. Each person decided what stories they wished to tell and who would be able to access them. One person told us how much it meant to them to have been supported to create pottery pieces for their children, so they would always have something to treasure.

Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. We saw this in one to one interactions between patients and others involved in their care. Staff displayed warmth and appropriate levels of intimacy. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Staff were supported by the patient and family support team, which included the counselling and pastoral teams, to reflect on how they cared for patients with compassion. Staff were extremely complimentary of these teams and the support they gave the patients and their families but also the support they gave to the staff.



Hospice services for adults

People were supported to have a comfortable, dignified and pain free death. Following death, a temperature-controlled room called 'Orchard View' meant relatives and friends could spend time with their loved one and staff could continue to support them. Family representatives could design bags to use for taking their loved one's belongings away after they had died. Regular memorial services were held which provided opportunities for friends and relatives to come together and remember loved ones.

The service adapted through COVID-19 to continue to provide bereavement support virtually or through schools. Dorothy House services aimed to have a shared understanding of the needs and capability of the whole family (adults and children) and take them into account during assessment, planning and delivery of services. The Bereavement Service actively promoted the principle of 'THINK family'. THINK family means to meet the full range of needs within each family they are supporting or working with.

The hospice received overwhelmingly positive feedback, the data collected showed the hospice had received 528 compliments and thank you cards in the past year.

Are Hospice services for adults responsive?

Outstanding



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

Service delivery to meet the needs of local people

The hospice, and its multidisciplinary team, proactively planned its services and provided care in a way that took into account and, quickly and responsively, met the preferences and needs of local people and the communities it served. The hospice, and its team, worked with others in the wider system and local organisations to plan individualised and highly responsive care that promoted equality, including for those with protected characteristics.

Patients received exceptionally personalised care tailored to their individual needs, wishes and preferences and responsive to any changes. Patients and relatives appreciated that staff involved them in regular reviews of their care. Patients told us that staff listened to them and involved them in the development of their care plans. Patients were supported, if they wanted to, to develop an advance care plan, which captured their preferred place of care and death, views about resuscitation and any ceiling levels of treatment. This meant their wishes were known and could be carried out. Patient's relatives told us they had been encouraged by staff to voice their opinions, which made them feel their views mattered.

Managers planned and organised services, so they met the needs of the local population. The service employed nurse specialists who were often people's first point of contact with Dorothy House. Nurse specialists were highly experienced registered nurses with expertise in specialist palliative care. They provided advice on symptom control and they offered an opportunity for patients to talk about any fears and anxieties, to discuss advance care plans and preferences for future care. They gave advice and support to patients in GP practices, at home, in Dorothy House clinics, in community hospitals and in residential and nursing homes. Nurse specialists also supported families and carers, including during the early days following a bereavement.

The service provided an information hub to provide up-to-date end of life and palliative care resources for patients, carers, family members and healthcare professionals.



Hospice services for adults

The hospice improved end of life care for people living with dementia. A dementia working group mapped their service against the Southwest Hospitals Standard in dementia care, and sought expert advice from the King's Fund and incorporated the recommendations of A Patient Led Assessment of the Care Environment (PLACE) to make the hospice environment more 'dementia friendly.' For example, signage around the hospice was replaced with word/symbol signage so it was more easily visible to people with perceptual difficulties. Other improvements included purchasing music such as 'bird song' to promote people's sense of well-being. These improvements reflected best practice evidence of what works best for people living with dementia.

A nurse-led contact centre prioritised all referrals to the hospice community services. People could be referred to the service by a health and social care professional or they could self-refer. Families and friends of people with a life-limiting illness could also make referrals. A nurse did an initial assessment and developed care plans with people to meet their needs. Referrals to the inpatient unit were managed by the medical team in consultation with the nursing team and the referrer, usually the GP or consultant.

Dorothy House Hospice provided support to adults with a progressive, treatable but not curable life-limiting illness or with severe frailty, and their family (including children) and carers. Services provided included physical, psychological and/or spiritual support. The service also provided teams in the community. Dorothy House hospice also offered people with long term conditions such as motor neurone disease or chronic obstructive pulmonary disease admission to the inpatient unit for short periods of respite. This meant various professionals could visit them, review their care and give their main carer a break and a rest.

Facilities and premises were appropriate for the services being delivered. The in-patient unit had 10 rooms with en-suite bathrooms. Each room provided a calming environment with a hoist, and roll chairs with easy access to the grounds where families could enjoy the landscaped gardens. Patients could enjoy the jacuzzi bath whilst listening to relaxing music.

A family support team provided significant practical, emotional and bereavement support to people and families, which helped them adjust to the impact of people's illness. For example, helping people apply for benefits, advising them about their rights and supporting them with housing and equipment needed to help the person maintain their independence at home. Patients and their families benefitted from their expertise and close links with other agencies such as social services and housing.

Physiotherapists and occupational therapists supported people to maintain their health and retain their independence for as long as possible. For example, providing support and advice with mobility and assessing people's needs for equipment such as electric beds and mobility aids. Therapists used 'tool kit' approaches to teach people to self-manage symptoms such as breathlessness and fatigue through relaxation techniques. The service had a rehabilitation and exercise facility called The Sulis Gym, which enabled people with life limiting conditions to exercise in a safe environment.

A variety of groups and services such as 'The Same Boat' were held for people affected by the diagnosis of a life-limiting condition. A four-week programme helped people with energy conservation, sleep, diet, and offered an array of complementary therapies. A wide range of activities and crafts were provided by the Creative Therapies Team, such as 'Sewing bee' and 'Creative keepsakes.' This provided a personalised opportunity for a person and their family to work together creatively to make beautiful works of art. Options included painting, ceramics, plaster cast hands, decorative boxes and card making. The creative process helped and supported the family coming to terms with their situation by developing a piece of art together that was meaningful to them.



Hospice services for adults

People received co-ordinated person-centred care when they used or moved between different services through outstanding partnership working. Hospice staff linked with several groups, organisations and networks, for example, domestic violence forums, and child bereavement groups. The service had raised awareness of young people's needs and developed services with them closer to home. They engaged with young people and their carers/families and sought their views. They formed a young people's group and two young people created a manifesto for schools which helped with difficult conversations.

The hospice had extended the work they had already done to improve equity of access to palliative care and end of life services for hidden groups of people such as the homeless, travellers and prisoners. A working group looked at the issues facing some marginalised groups and developed partnerships with relevant statutory and charitable organisations to enhance their end of life care. They established closer partnership working with health, police and housing and voluntary organisations such as the YMCA. Work had been done to embed this work with prisons and the homeless and look at ensuring the resilience of this service.

One member of staff had a specialist interest in supporting the homeless, using their expertise as a palliative care nurse alongside people who found themselves homeless, in shelters, on the street and/or being supported by other local charities. This approach provided support to those living on the street, in temporary accommodation or in homelessness shelters and staff attended monthly multi-agency meetings. Homeless people often had complex healthcare needs related to drug and alcohol abuse and were reluctant to engage with healthcare professionals.

Meeting people's individual needs

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

The service had 10 Community Palliative Care Teams who covered a 700 square mile area. These teams provided physical, psychological and spiritual support. The specialist palliative care teams included doctors, nurses, therapists, carers and counsellors and saw patients at home, in a clinic setting or in a care home. They worked closely with GPs, community nursing teams, hospital staff and other healthcare professionals to ensure a high standard of care and support.

Staff had training to be able to support patients with complex needs such as learning disabilities, mental health concerns and dementia. Clinical staff told us, if needed, they would liaise and involve relatives, specialist practitioners in the local community and from the local trust who were already involved in the patient's care to make sure they supported patients appropriately and to make sure there was continuity of care. The service worked collaboratively to develop a reciprocal education programme with a local charity for people with learning disabilities. Dorothy House staff had provided training to the learning disabilities charity and a date had been set for the charity to provide training for Dorothy House staff. about meeting the needs of people with a learning disability.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A working group had looked at how to improve the environment to be dementia friendly. The service used a 'reminiscence interactive therapy activities' system (RITA), which offered digital reminiscence therapy for patients with dementia. The hospice environment met the needs of patients living with dementia.



Hospice services for adults

The service had completed a service review in 2021 and identified seven tasks to improve effectiveness, patient, family and carer experience and quality. One of these was a group to improve the referral pathway to ensure there was a clear, inclusive referral pathway for Dorothy House services. Dorothy House staff worked with community teams to develop new processes and stakeholders were all aware of these.

Dorothy House had started running joint specialty clinics, to enable people to benefit from joined up care for patients, families and carers. A joint clinic with an oncology service started in February 2022 and this was being evaluated with a view to expanding to other cancer and non-cancer clinics.

The Community Clinical Development Manager led a project working with commissioners and other stakeholders which ensured patients, families and carers received a 72-hour rapid response. This initiative provided high-quality rapid response home care services. It prevented unnecessary hospital admissions and enabled people needing end of life care to be discharged from hospital more quickly. The service also worked with local CCGs to provide continuing health care for patients in their own homes. This meant patients dying in their own homes experienced continuity of care.

Patients in receipt of palliative care were able to access blood transfusions in a timely way because staff at the Dorothy House day service could administer blood transfusions for them. This meant these patients had been enabled to access palliative care earlier and saved them having to travel to a hospital for their blood transfusion.

The provider's website provided a helpful resource that informed, trained and supported patients, their families, carers and health practitioners to provide the best end of life and palliative care. The range of information available included guidance about managing breathlessness at home, anxiety and fatigue. A series of recordings promoting relaxation were available. A series of videos guided patients through exercises to help relieve symptoms and cope in isolation.

The provider's chaplaincy strategy recognised that today's society is diverse and increasingly interfaith as well as including many people of no professed faith. This strategy was aligned to the NHS Guidelines: Promoting Excellence in Pastoral, Spiritual and Religious Care (2015) which sets out to 'respond to changes in the NHS, society and the widening understanding of spiritual, religious and pastoral care'. Chaplaincy, with no affiliation to any one religion or belief system, is recognised as including not only religious care, but non-religious pastoral and spiritual care. It emphasises the needs of those 'who do not hold a particular religious affiliation' (NHS England, 2015: 6) and the assertion that 'patients and service users have a right to expect that chaplaincy care will be experienced as neither insensitive nor proselytising' (NHS England, 2015: 9). One patient told us, "The chaplain was brilliant. I've just planned my funeral and he's been amazing, he explained how things could be and I didn't realise I had so many options."

The service had a multi-faith room known as 'The Beacon'. This fit the provider's strategy about being a light in the community. Books of many faiths were available, including a Bible, the teachings of Buddha and a Koran. There was also a Qibla compass, to indicate the direction to face to perform prayers. In Islam, this direction is called qibla, and points towards the city of Makkah and specifically to the Ka'ba. Crocheted blankets were also available for people who wanted to sit in comfort and enjoy the peace of the room.

Staff had undertaken multifaith training and were knowledgeable about how to meet people's spiritual, religious and cultural needs. A resource folder on the inpatient unit provided information for staff on a range of faiths and beliefs such as Buddhism, Judaism, Christianity, Islam and a multifaith calendar highlighted important dates. Where people had dietary restriction related to any religious or cultural beliefs, these were catered for. All were welcome to use the quiet room set aside where daily services were held, and which provided a quiet and tranquil space to spend time for quiet reflection.



Hospice services for adults

Support was personalised to meet the communication needs of the person. Services available included translation and interpretation services, a wide range of 'plain English' literature and information leaflets, pictorial resources, the use of technology to support patients and family who were unable to communicate verbally due their condition such as Eye Gaze and use of iPads and tablets.

People's individual needs were met by the environment at the hospice. The building was light and airy, with suitable adaptations for people with disabilities such as corridors suitable for wheelchair access, grab rails fitted and height adjustable Jacuzzi bath and wet room facilities. People had spacious ground floor rooms, so those confined to bed could access the outside space outside through wide patio doors.

The service had suitable facilities to meet the needs of patients' families. A room was available for families to stay overnight.

Where staff were working in people's homes, a risk assessment was completed to identify any risks both outside and inside the home. This ensured the person's home was a safe place for the hospice staff to work.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

The hospice had effective processes to manage admission to the service. Referrals came mostly from GPs, specialist palliative care nurses, community clinical nurse specialists and the local acute NHS hospital. Patients could refer themselves if they had been diagnosed with a life-limiting illness. The hospice was able to meet the needs of patients who would benefit from the service at the point they needed it.

Patients who needed to be admitted were discussed in the daily meetings. Data showed the service had shortened the length of time patients waited to be admitted because they had a better understanding of who needed to be admitted. This had reduced the number of people going into hospital. The service also looked after people in their own homes. This helped people maintain their preferred place of death. Records showed 90% of patients died in the place of their choice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The provider had worked with a local hospital to create a companion role, so a patient dying on a ward could have someone sitting with them.

Staff supported patients when they were referred or transferred between services. There were discharge processes to ensure patients could be safely discharged home to their preferred place of death, wherever possible. These included liaising with other hospice services such as occupational therapy team and pharmacy to ensure an appropriate care package was in place.



Hospice services for adults

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.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

People and relatives said they had no concerns or complaints about the hospice. A compliments, concerns and complaints leaflet outlined the ways in which concerns could be raised in person, by phone or e mail or using suggestion boxes. It included details of Healthwatch and advocacy services.

The registered manager investigated complaints and identified themes. A complaint's register logged complaints received, and showed actions taken and any lessons learned. In the third quarter from October to December 2021, there had been two complaints and two concerns raised. These were investigated and closed in a timely manner in line with the complaints policy. Staff were open and honest with people when things went wrong and were committed to learning from people's experiences. Full explanations were given about the investigation, its findings and any actions being taken to address concerns. Learning from complaints was discussed at executive level and any actions or changes as a result were shared with staff. Complaints were reviewed by the Clinical Governance Committee, to ensure they were dealt with rigorously.

In the same quarter, 147 compliments were received, predominantly for the family support team, the inpatient unit, nurse specialists and the hospice at home service. The service also received 57 electronic reviews between October and December 2021. Only one of these reviews was not five stars. This was a one-star review with no comment to explain why; the provider had asked for more information so they could address this.

The induction programme included dealing with complaints, which all staff had completed. All staff knew who to contact if they received a complaint.

Are Hospice services for adults well-led?



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

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.

There was compassionate, inclusive and effective leadership at all levels. Dorothy House Hospice was led by a dynamic and purposeful senior executive team and board of trustees. There were two joint registered managers, one of whom was also the medical director. Executive clinical leads led the hospice and inpatient services and outreach services and community teams. In the inpatient unit, medical leadership was provided by the registered manager and another consultant and there was a nurse manager and deputy.



Hospice services for adults

The leadership team promoted strong values of person-centred care and worked in partnership with other organisations providing end of life care for patients to receive best practice. The nominated individual had been invited to talk at national events and had made presentations at Hospice UK events. The medical director had also made presentations at regional events. The service had written a strategy for the end of life care alliance, to improve care for people in their last 1000 days.

All trustees were accessible, and it was not unusual to see them in the building. They held a monthly coffee break for anyone in the organisation to join in. Trustees were selected according to a skills matrix to use their expertise to develop the organisation.

Business continuity plans were in place. Managers checked the efficiency of plans by running scenarios, for example staff were told to deal with a situation such as the oxygen exploding. Managers learned that practicing scenarios was better than staff completing theoretical paper training. As a result of this scenario being run, changes had been made. The specification for the oxygen storage had been adapted and was now made of brick with a roof and solid doors. Staff were trained to deal with piped oxygen.

Vision and Strategy

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 service promoted their vision as, “Our vision is for a society where death is a part of life.” The service embodied this vision in their mission, which was to ensure that everyone had access to outstanding palliative and end of life care.

The provider engaged with stakeholders, patients and families to understand their views of the service. Feedback from patients and families was overwhelmingly positive and thankful for the support and services Dorothy House Hospice had provided.

The service identified the challenges they faced in delivering the strategy, these included a growing, elderly population with complex care needs and a need to do more for increasing numbers but with less public money.

The service worked with care homes looking at how to support them. The provider told us 9.8% of referrals came from care homes. The service provided teaching and education for care home staff. The service had a care home link twice yearly for educational days and networking, where care home staff could choose the topics they wanted covered. This had stopped throughout COVID-19, but staff were working towards providing this service again. The provider was looking at further ways to support care homes by having more presence with community teams.

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.



Hospice services for adults

Leaders had an inspiring and shared purpose and strived to motivate staff to succeed. All staff promoted a positive culture that was open, inclusive and empowering. The registered managers set high standards of caring for staff and told us how they nurtured staff to ensure low turnover. This also enabled them to build on the experience in the team. Staff were committed to care that placed people at the centre of the service.

Staff told us they felt supported, respected, and valued by their managers. They enjoyed coming to work and were proud to work for the service. Staff told us there was strong collaboration, team-working and support between staff and a common focus on improving the quality and sustainability of care and people's experiences. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. Staff completed equality and diversity training. Staff were encouraged to raise concerns openly and without fear of reprimand.

The provider worked to identify talent and invest in future leaders and key specialists. This was to enable succession planning, through a new performance and development review process. The programme was informed by qualitative research undertaken over three months, which included the executive team and 23 colleagues from clinical and non-clinical teams. The focus was to identify current development needs and the skills, and mind-set the service wished to foster. The development topics were mapped against the World Economic Forum's 'The Future of Jobs Report' and the CIPD's universal skills framework.

Staff had regular meetings where they were able to bring together staff views, raise questions and support information being shared across the teams they represented through a staff forum called 'Our Voice'.

The well-being of the workforce remained a top priority for the provider. Staff had various ways they could access support such as free counselling, through coffee break sessions and on Dot2Dot. Leaders were very mindful that the current economic climate may be causing concern for some staff, so they offered financial wellbeing sessions which included subjects such as pensions, retirement planning and debt advice.

A further initiative for staff well-being was a "Really Well Being" programme. The key features included Live Well (optimising lifestyle habits), Feel Alive (physical-mental-social health) and Do Good (perform well with purpose). This programme was being offered to 30 staff and the provider was hopeful that the programme will enable staff to become wellbeing champions.

One in 10 staff had declared a disability, however many staff had not declared their ethnicity or sexual orientation. Work was underway as part of the provider's Equality, Diversity and Inclusion Strategy and action plan to address appropriate data collection.

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.

We found a clear line of governance to communicate information throughout the service, and to escalate and cascade information up and down lines of management and staff. Staff were clear about their roles and understood what they were accountable for and to whom. Staff could describe the governance processes for incidents and complaints and how they were investigated.



Hospice services for adults

The service had a governance framework in place through which the hospice was accountable for continuously improving their clinical, corporate, staff, and financial performance. The board of trustees and the executive management team through the governance management framework oversaw governance within the hospice. The framework and supporting policies provided the structure for managing and reporting on a range of auditable metrics.

The hospice had groups where specific operational issues were discussed, such as the patient safety group, the infection prevention and control group and medicine management group. We reviewed minutes from these meetings and saw they were effective and included the set of decisions, outcomes and next steps or action items.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

Management of risk, issues and performance

An effective system of quality assurance checks at service and provider level ensured continuous development and improvement of people's care. Staff 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 compromising the quality of care.

Staff improved service quality and safeguarded high standards of care by creating an environment for excellence service to flourish. All staff were fully committed to patient safety. The service had an effective risk register and the Clinical Audit and Quality Improvement Group had oversight of this.

Although the Clinical Audit and Quality Improvement Group had a rigorous and reliable audit programme to provide assurance of the quality and safety of the service, audits had not identified the issues we found. Local audits, such as clinical and compliance audits were undertaken regularly to monitor performance.

The Clinical Audit and Quality Improvement Group produced an annual report April 2021 to March 2022. This contained information about two national audits and six audits against NICE guidance Dorothy House participated in. These audits included 'Care of Dying Adults' which scored 100%. Audits were used to drive improvements, for example audits followed up whether staff were recording the discharge packs being given out.

The board of trustees had effective oversight of the quality and safety of care which enabled them to make sure decisions were in keeping with the strategy and values of the hospice and progress was delivered. Safety of the workforce was also paramount. For example, the provider used a phone application for staff who were lone working which meant staff could instantly access help.

Dorothy House had a strong 'no blame culture' and this ensured staff had confidence to report accidents and incidents. All were investigated and staff had specific 'debrief' meetings involving all relevant staff when needed. A Clinical Quality Lead had oversight of all clinical incidents and accidents and reported to CCGs. This person allocated appropriate staff members to undertake investigations, supported them with this and saw the process through completing investigations, Duty of Candour and staff learning and feedback.

The service was able to quickly respond to unplanned shortages of staff. The service held a daily "sitrep" meeting at 0845 each morning to review staffing levels on all clinical services and used this information to move staff to cover where sickness caused low staffing levels.



Hospice services for adults

The service had a contingency plan with identified actions to be taken in the event of an incident that would impact the service. For example, extended power loss, severe weather events, short notice staff sickness and equipment failure. The contingency plan included contact details of relevant individuals or services for staff to contact.

The executive team supported leadership and management development at every level. Management and leadership education and training was provided in house and by accessing external courses, expertise and support.

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 high quality data and used this information to make business decisions. For example, the service benchmarked themselves against other hospices for staffing levels. The figures gave assurance that Dorothy House staffing for the in-patient unit benchmarked well against other hospices.

The service had policies and procedures to promote the confidential and secure processing of information held about patients. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant, having been scrutinised by all staff in quarterly quality and safety reports.

We saw appropriate and accurate information was effectively processed, challenged and acted upon. Key performance, audit, and patient feedback data was frequently collated and reviewed to improve service delivery.

The service was up-to-date with information governance and had data retention policies. These stipulated the requirements for managing patients' personal information in line with current data protection laws. The service was registered with the Information Commissioner's Office (ICO), which is in line with 'The Data Protection (Charges and Information) Regulations' (2018). The ICO is the UK's independent authority set up to uphold information rights.

The service was committed to continuous learning from accidents, incidents, complaints and from training. At monthly meetings staff received feedback about any issues that had arisen in their own and other areas. The service had introduced a Duty of Candour register, to demonstrate the hospice was fulfilling its legal duty to inform and apologise to people, if any mistakes in their care led to significant harm. The registered manager sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly.

Engagement

There were consistently high levels of constructive engagement with patients, staff, equality groups, the public and local organisations to plan and manage services. The service engaged well with patients, staff and the public to plan and manage appropriate services and collaborated with partner organisations effectively.

The service worked in partnership with other organisations to make sure they followed current practice and provided a high-quality service. They strived for excellence through consultation, research and reflective practice. They also showed how they had sustained their practice and improvements over time.



Hospice services for adults

There were many examples that demonstrated personalised commitment and attention to patients. This ranged from ensuring high-quality support for the patient and their loved ones, to empowering them to apply for awards. One young person who helped Dorothy House Hospice to help other children facing loss and bereavement was supported to apply for and received the Diana Award. The Diana Award is recognition for outstanding young people who go above and beyond to create and sustain positive social change and is awarded in memory of Diana, Princess of Wales.

The hospice had developed strong collaborative partnerships with local Clinical Commissioning Groups, Health and Wellbeing Boards, and other health and social care providers. They demonstrated a commitment to developing joined up, innovative, flexible services and to developing sustainable models of care that improved the health and wellbeing of local people.

The provider worked closely with Bath and North East Somerset, Swindon and Wiltshire (BSW) Clinical Commissioning Group, who were the NHS commissioners for most of the Dorothy House area. In September 2020 they started working with Dorothy House, Salisbury and Prospect Hospices, as part of a BSW Palliative and End of Life Oversight Group, to develop their new palliative and end of life care strategy. Building on collaboration between the hospices, the intention is to deliver a system-wide approach to end of life care.

Working in partnership with a hospital, staff provided satellite treatment clinics at hospice locations so patients with life limiting conditions, could have their outpatient treatments nearer home in a more relaxed setting. For example, blood and platelet transfusions for people with blood related cancers and treatments to benefit women with advanced breast cancer. These initiatives were in accordance with the Ambitions for Palliative and End of Life Care (2015) framework for local action and the recommendation of the King's Fund Place based systems of care (2015).

The service was proactively identifying the topics patients would need to ask questions about. The service engaged with people through social media to provide Dorothy House podcasts, which gave people the opportunity to have an informal chat. The Dorothy House podcasts enabled difficult conversations about death and dying. The provider's website had videos which addressed topics such as death as a part of life, living life well, peaceful death and supported bereavement; these provided a useful source of information.

Staff were consulted and involved in changes, through local team meetings, a staff newsletter, and a staff consultative committee. Suggestion boxes were available for staff and volunteers, which were reviewed regularly by the executive team and responded to through the staff intranet.

The provider had a lone-worker application on their phones to give them additional security. This application meant staff could be tracked if they went missing and the service could speak with the member of staff's family.

The provider engaged an external company to undertake a staff survey, aligned to the wider Hospice UK survey in 2021. By doing this the service was able to compare their results with 34 other hospices across the UK. Responses showed some improvements over previous scores, particularly in enjoying work (90%), working with people in the charity (92%) and making a difference (86%). The executive team noted there was however a worrying score for the question 'I never feel overwhelmed by stress at work' with a negative outcome of 66% (including neither agree/disagree). The executive team aimed to focus on staff wellbeing over the next year and develop a series of events to support physical and mental wellness, as well as ensuring staff know how to access the wide range of resources available to them. The executive team noted take up was currently low for some existing resources.



Hospice services for adults

The service provided a newsletter three times a year which kept people and supporters of the hospice up to date with developments. This included fundraising events planned, and stories about people's care that raised awareness of the services offered by the hospice.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement. The service was committed to improving services by learning from when things went well or wrong, and promoting training, research and innovation. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of service delivery and care.

Dorothy House Hospice was committed to improving the quality of services offered to patients and their relatives. All staff were actively encouraged to think of ways to improve their service. During our inspection we were told of many ways' improvement had been made and of further developments to the service. For example, the service was investing in 'cuddle beds' for the in-patient unit. The cuddle bed did everything a normal hospice bed did and one more extraordinary thing. At the touch of a button, the cuddle bed widened into a double bed, so patients and their families and friends could all get on a bed together and have a cuddle or movie nights.

Staff were enabled to develop their own clinical practice and share their expertise by taking part in a number of research projects. The service had a member of staff who was head of research, supported by a research nurse and small research team. Patients were invited to take part in the questionnaires. When people were referred to the service, they were asked if they were happy for their data to be used for research.

The service was involved in a clinical trial with a university for people with motor neurone disease, to optimise their nutritional needs. Staff worked with a university to evaluate patients living with lung diseases. The project involved collecting information about patients' experiences and information will be presented at a national conference. The service was involved in a survey of the population to understand mental health needs and how to provide bereavement support. Another project involved working with other hospices to understand the impact a change in delivery of care made to patients. When the reports are ready to publish these will include clinical recommendations which other services will benefit from. The service had completed a survey for people who had cancer in the spine to capture clinical practice and opinion. Staff were currently involved in research to understand when to switch devices off for people who have a device to help their heart. how to improve care of people with dementia.

The service developed training courses to benefit other services. Bath University asked the service to develop a training package for end of life care for care homes. As a result, the education department listened to what staff said they needed and developed and formulated a standard care course called The Tulip Standard: Essentials of Care. This training addresses the training needs for bands two, three and four and incorporates aspects of the Care Certificate as well as end of life and palliative care core skills. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Additionally, the education team were creating course content for new in-patient unit Band 3 health care assistant development posts, due to commence in July. They were also working on a development course for new band 4 hospice at home posts. Dorothy House staff provided training for a range of staff who worked with patients, such as district nurses, staff who used wheelchair ambulances and people who fitted stair lifts to help support them how to have appropriate conversations.



Hospice services for adults

The provider engaged with stakeholders and used the information they received from feedback to improve services. For example, the provider used listening exercises to consider previous research and feedback. The aim of the Listening Project's stakeholder listening exercise was to gather feedback, views and suggestions regarding services from both external and stakeholders to inform the Services Review.

Hospice staff received a range of awards. One member of staff won a Girdler award because staff said, "He has truly made an outstanding contribution to the running of Dorothy House during the most challenging of times and we are deeply grateful for his service." Another member of staff had been nominated for the Nursing Times Awards, due to be held in October 2022.