

Hospice, Isle of Man

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Our findings

Overall summary

We carried out this announced inspection between 31 October 2022 and 3 November 2022. The assessment was led by a Care Quality Commission (CQC) Assessor who was supported by two Assessment managers and two specialist advisors.

This inspection is one of a programme of inspections that the CQC is completing at the invitation of the Isle of Man Government's Department of Health and Social Care (IOMDHSC) in order to develop an ongoing approach to providing an independent regime of health and social care providers delivered or commissioned by IOMDHSC and Manx Care.

The CQC does not have statutory powers with regard to improvement action for services on the Isle of Man, and providers on the island are not subject to CQC's enforcement powers. The inspection is unrated.

The Hospice, Isle of Man, provides a seven-day service for people requiring specialist palliative and end of life care as well as respite care.

The service provides nursing care within the community to support patients wishing to receive end of life care at home, to prevent crisis admission to the Hospice In-Patient Unit or hospital.

The service also delivered respite care for children on an as required basis within the Rebecca House unit of the Hospice. Rebecca House was equipped to receive up to four inpatients should they receive a referral for a child requiring palliative or end of life care.

The Hospice also delivered several community groups and therapies including a psychological support team, young person's support team, bereavement support, pastoral care team, creative

wellbeing sessions, rehabilitation programmes, complementary therapies and lymphoedema services.

People's experience of using this service and what we found

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.

To get to the heart of people's experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our key findings

- The environment was purpose built and its design had considered people's individual needs.
- Staff were focused on the needs of patients receiving care.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

We identified areas of notable practice

- Staff were seen to show a genuinely caring approach to patients, patient and relative conversations supported this.
- There was a strong team working culture, including community support groups and volunteers, that provided a holistic service with patients at the heart of this.

We found areas where the service could make improvements. CQC recommends that the service

- Safeguarding – Not all staff had undertaken the correct level of safeguarding training as compliance figures for safeguarding children level 2 and 3 were low.
- Assessing and responding to risk – There was no sepsis awareness training or specified pathways for staff to follow. Recognised tools were not used to identify deteriorating patients. Falls risk assessments were completed for all those at risk, PEEPS were not regularly reviewed and therefore did not accurately reflect the current needs of patients. Resuscitation equipment was not stored in a way that would make it immediately accessible to staff.

- Cleanliness and infection prevention and control – Separate areas did not have specific cleaning equipment increasing risk of cross contamination.
- Medicines – Medication room temperatures were not monitored to ensure medications are stored within recommended parameters. Medical oxygen cylinders were not always secured to reduce risk of falling.
- Patient care records – Records, such as advance care plans, were not always uploaded onto the electronic system in a timely way meaning staff could not be assured they were delivering care in line with patient preferences.
- Competent staff – Staff did not receive training in the awareness of learning disabilities, autism or mental health.
- Access and flow – There was not a system in place to identify patients in hospital that required hospice care and therefore referrals were dependant on individual capacity to reach out to acute service.
- Vision and strategy- A new vision and strategy had not yet been developed as the service were awaiting the appointment of a new CEO.
- Governance - The service was using guidance that supports best practice, but this is not yet fully embedded across all areas.
- Managing risk - There is no effective accountability within the risk register for example audit
- Raising concerns- The service did not have a Freedom to speak up guardian or an equivalent to which staff could raise concerns about the service.

We have also identified areas we have escalated to the IOMDHSC.

- Respite services had reduced in size and therefore offered limited provision to support the wider system.

Is the service safe?

We found that this service was not always safe in accordance with CQC's assessment framework

Mandatory Training

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

Staff received and kept up to date with their mandatory training, staff had achieved a compliance rate of 98% against the hospices compliance target of 95%.

Mandatory training was a combination of face to face and e-learning depending on the content, for example moving and handling.

The mandatory training was comprehensive and met the needs of patients and staff. This included modules expected to be undertaken by all staff such as, but not limited to, basic life support, fire safety, health and safety, moving and handling, safeguarding, General Data Protection Regulation (GDPR), medication and de-escalation.

Staff also completed further modules categorised as 'essential'. These modules included, but not limited to, dementia, Aseptic Non-Touch Technique (ANTT), syringe pump, introduction to capacity and equality and diversity.

Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities and autism. Managers had identified this and had utilised employed learning disability nurses to create a bespoke training programme to be rolled out in 2023.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have training on how to recognise and report abuse.

Staff were offered safeguarding training relevant to their role but did not always keep up to date with this. Staff were trained to a level of safeguarding dependant on their role, staff at bands two, three and four were required to complete Safeguarding Adults and Children Level 1 training, with band five nursing staff and above required to complete Safeguarding Adults and Children Level 2 training. In addition, staff working within Rebecca House were required to complete Safeguarding Children Level 3 training. The safeguarding lead and admiral nurses had also completed Safeguarding Adults Level 3 training which they had sourced outside of the Isle of Man.

Training compliance figures for all staff showed a 96% compliance with Safeguarding Adults Level 1 and 95% compliance with Safeguarding Children Level 1. Training compliance figures for Band five and above nursing staff showed a 91% compliance with Safeguarding Adults Level 2 and 75% compliance with Safeguarding Children Level 2. Training compliance figures for Rebecca House staff showed that 67% of staff had completed Safeguarding Children Level 3 training.

Both safeguarding adults and children training included awareness of modern slavery and human trafficking but did not include PREVENT training or equivalent to make staff aware of the threat from terrorism and extremism or awareness of female genital mutilation.

Staff were aware of patient's protected characteristics under the Equality Act 2017 and used the tool 'Opening the spiritual gate' to ensure information important to delivering their care was captured.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of working with external agencies in a multi-disciplinary approach to support parents of children with complex needs, including attending strategy meetings, offering emergency respite care and delivering psychological support services.

Staff told us who they would inform if they had concerns and knew who the safeguarding leads were within the service. Staff were supported to make safeguarding referrals themselves with oversight from the safeguarding lead, to ensure that information referred was a first-hand account of what had occurred.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

Staff did not always use equipment and control measures well to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. An infection prevention and control (IPC) audit was provided from April 2022 and showed 100% compliance against standards such as safe handling of waste, environment, disposal of sharps, linen and patient equipment.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff changed into uniform within the service, removed jewellery, were bare below the elbow and washed hands regularly. Hand hygiene audits were completed on a sample of staff monthly and demonstrated 100% compliance with the five moments of hand hygiene.

Sharps bins were clearly dated, and the temporary closure mechanism was in use.

We observed staff cleaning equipment after patient contact, but this was not labelled to show when it was last cleaned.

Equipment used for cleaning was not separated for use into specific areas. For example, staff told us they used one mop for the upstairs of the building and one for the ground floor. This meant there was a risk of cross contamination as the same mops were potentially being used to clean bathrooms, bedrooms, communal areas and kitchens.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

Patients could reach call bells and staff responded quickly when called.

The design of the environment met the needs of patients using the service. The Hospice was divided into community and inpatient areas, these had separate entrances which ensured that visitors accessed the appropriate part of the building. The inpatient area was clinically suitable and ensured that patients received hospital standards of care, whereas the community side was decorated with artwork and allowed for a more sociable feel for group activities and therapies. Rebecca House was suitably designed for children, with individual rooms and both outdoor and indoor communal spaces. The Hospice and Rebecca House had undergone a recent refurbishment of which the staff had been heavily involved in its design. Research had been carried out to ensure that the needs of patients were considered in the environment.

The service had suitable facilities to meet the needs of patients' families. There were communal kitchen facilities for families to use when visiting patients on the inpatient unit. Room also had double doors for families to access the gardens with their loved ones, these had also been used to allow visitation for families during the COVID-19 pandemic. In Rebecca House, a flat had been built for families of children admitted as inpatients. The flat had an open plan kitchen, dining and living space, bathroom and double bedroom and nurse call for if requiring assistance from nursing staff.

The service had enough suitable equipment to help them to safely care for patients. The Hospice was large and had adequate number of inpatient beds, communal areas, rooms for therapies and rehabilitation space. Staff told us that there were sufficient, slings, wheelchairs and hoists and

should they require more they were able to request these by proposing a business case. Rooms within Rebecca House were adapted to meet specialist needs such as having a ceiling track hoist from bed straight to assisted bathroom, high side beds and a room with softened walls, to enable them to accept referrals of children with complex needs.

Staff carried out safety checks of specialist equipment in time intervals relevant to their use, for example fire extinguishers were checked monthly whereas vehicle maintenance was checked weekly. Staff kept an asset register to ensure that routine checks of equipment took place in line with servicing timeframes such as annual portable appliance testing. Syringe pumps were serviced and tested, and staff knew how to report any concerns with specialist equipment.

Staff had attended a legionella awareness course and had a risk assessment carried out by an external agency. The service sourced a contractor from the UK to ensure water samples were taken appropriately. Staff completed regular flushes of taps which used less than twice a week and completed temperature testing.

The service had safe arrangements for the disposal and collection of clinical waste. Rooms where clinical waste and sharps were disposed of were left unlocked and could potentially be accessed by patients or a member of the public.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. The service did not have tools in place to support staff in identifying and quickly acting upon patients at risk of deterioration.

Staff did not use a recognised tool to identify patient deterioration. Patients had a baseline observation taken on admission to the Hospice, staff then used this baseline and admission risk assessments to determine how regularly patients received observations and would increase these in the event of any changes. Patient care records demonstrated that staff appropriately, recognised and escalated patient deterioration.

Staff completed risk assessments for each patient on arrival, using recognised tools, and reviewed these regularly, including after any incident. These included falls, mobility, nutrition and hydration, swallow assessment, pressure ulcer and Waterlow assessments.

Staff did not know about certain specific risk issues to identify patients at risk of these such as Sepsis or Venous Thromboembolism (VTE). Staff told us there was no structured sepsis pathway for inpatient showing signs of deterioration. Staff did not receive training on sepsis awareness, and we did not see sepsis awareness displayed within the environment. We did not see VTE assessment completed in any care records looked at and when asked staff were not aware of the risks of VTE.

Patients at risk of tonic clonic (stiffening and jerking) seizures were not assessed in relation to falling. Three of the paediatric records contained a care plan in the event of seizure activity, but this did not detail how to safely manage a child either during or post fall.

Personal evacuation plans (PEEPS) were not systematically reviewed which meant that patients' needs were not always reflected in their evacuation plan. Two of 4 PEEPS had not been reviewed since 2020 with 1 child's PEEP detailing that they were too young to understand instruction in the event of an evacuation.

Resuscitation equipment was not stored in line with best practice. Resuscitation equipment contained items in line with recommendations from the resuscitation council. These were kept in

zipped bags which could be opened and therefore stored in the medication rooms which were secured with coded locks. In the event of an emergency this could delay staff access to emergency medications. The service had a defibrillator available in the main entrance of the Hospice which was signposted using standard defibrillator signs.

The service had 24-hour access to a clinical psychologist of which all patients were able to access either upon requests or from referral from staff. Staff discussed the psychosocial needs of patients during handovers to discuss as an MDT what support was required.

Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers looked at the staffing establishment in advance and adjusted the number of inpatient beds they could offer dependant on overall staff available. At the time of this assessment the Hospice had reduced bed occupancy from 11 to five inpatient beds and one respite bed.

Managers could adjust staffing levels according to the needs of patients. The staffing establishment was broken down into the integrated care services consisting of the inpatient unit and hospice at home service and the children's hospice in Rebecca House.

The number and grade of nurses and healthcare assistants needed for each shift in the inpatient unit was determined by bed occupancy and patient acuity. Community staff were based at The Hospice inpatient unit and would travel to patients requiring or preferring care at home.

The number of nurses and healthcare assistants matched the planned numbers, however staff felt that the Hospice at home service required more staff as it could be difficult to reach all patients across the Isle of Man requiring support at home with the current staffing establishment of one registered nurse and one healthcare assistant. Staff told us this had meant them spending entire days driving between two homes to provide time critical symptom management which had proven difficult, and that if there had been more people requiring home care at during that shift they would not have been able to provide this.

Rebecca House staffed shifts dependent on requests for respite hours. Parents requested respite hours in advance and once received, days and times were staffed according to demand and dependency. These hours were then offered to parents and asked to confirm whether they would be accepting the hours so that staff could be utilised elsewhere if not required in Rebecca House. Respite requests were predominantly at weekends and the children's service would close on dates without any respite requests.

The service had low staff turnover rates and focussed on the upskilling and retention of current staff.

The service did not use agency nurses used on the wards.

The service used a limited number of regular bank staff to support permanent staff members when required.

Records

Staff did not always keep detailed, up-to-date records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.

Patient assessments were comprehensive, and all staff could access them easily using an electronic system. We reviewed 13 patient records and saw risk assessments and documentation of care provided was complete.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic system was integrated and secure and allowed for patient information to be passed easily between the acute hospital and the Hospice.

Staff used admission forms to gather the initial patient information to assist with clinical admission decision making. Four records of patients currently receiving care in the inpatient unit did not include the patients advance care plans, a planning document offering people to opportunity to plan their future care and support whilst they have the capacity to do so. All records documented that information had been given and discussion had with patient about Advance care planning these had not then been collected and uploaded to the system.

Records were personalised for each patient based on the outcome of their risk assessments and opening the spiritual gate documentation.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were up to date, fully completed and stored securely. Patient care records were stored in the office in the inpatient unit, accessible only to staff.

Access to records was audited monthly with a member of staff and patient selected at random to ensure that records had been accessed or had access to appropriately. Six months of audits demonstrated that records had been accessed only by expected persons.

Staff did not always lock office doors, within offices were boards with patient identifiable information. During our assessment we accessed some offices without anyone present which risked unauthorised access to confidential information.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff reviewed each patients' symptoms, medicine choices and non-pharmacological measures at safety huddles and handovers daily and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date, however medication administration records (MAR) within the adult inpatient unit did not include a list of staff signatures making it difficult to identify which staff member was signing the administration.

Staff did not always store all medicines safely. Temperature checks of fridges were taken daily to ensure medicines were stored between a recommended 2 and 8 degrees, but managers did not audit temperature checks to ensure any discrepancies were escalated appropriately. Room temperatures were not monitored to ensure that medications stored at room temperature remained between the recommended 15 and 30 degrees. Staff reported the room to be hot in the summer.

Medical oxygen cylinders were not always secured to avoid the likelihood of falling.

Controlled drugs (CD's) were stored securely, with patients own CD's stored separately to that of the hospice supply. CD's were administered and counted by two members of staff. All medications were within their expiry date.

Staff learned from safety alerts and incidents to improve practice, medications incidents were reported using the electronic system, DATIX, and learning completed through reflective practice. Medication incidents were discussed at the medicine's management group and the service involved a pharmacist when creating action plans to improve medication management.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw an example where a patient experiencing anxiety did not wish to be sedated despite a disrupted sleep pattern. Nursing staff discussed this with the doctor who reviewed the medical options for the patient and involved them in discussion about potential changes to their medications.

Incidents

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

Staff received training in how to report incidents using the DATIX system and when to apply Duty of Candour, a piece of UK legislation that ensures providers are open and transparent with people who use services. Staff could describe what would be deemed as an incident and how they would escalate concerns in line with provider policy.

The service had an incident management policy and staff were aware of their roles and responsibilities in relation to the investigation of incidents.

Staff described a 'no blame culture' where reporting incidents was seen as an opportunity to learn.

We saw examples of learning from incidents for example there had been several medication errors, this was addressed by staff members receiving update training and additional supervision being put in place.

Managers held team meetings following incidents to discuss the feedback with staff and look at improvements to patient care. Learning was shared with staff through emails.

Managers shared learning from other services using a safety and learning bulletin.

Is the service effective?

We found that this service was effective in accordance with CQC's assessment framework

Evidence-based care and treatment

The service provided care and treatment based on evidence-based practice. Staff did not always have all the relevant information to protect the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice.

We saw that procedures referring to patient needs, such as safeguarding and managing care of the dying adults in the last few days of life, were in date, regularly reviewed and referenced best practice guidance.

A staff member employed by the service was a member of the National Guideline Development Group for Care of the dying Adult and was involved in the development of the National Institute of Care Excellence (NICE) guideline NG13: Care of dying adults in the last days of life. The member of staff shared and embedded best practice guidelines within the service and kept practice up to date as they were involved in guidance reviews.

The service was a member of the Palliative North West steering group, the group host a programme of clinical audit, guideline development and education that the service took part in when able.

Staff assessed people's emotional spiritual and social needs using the 'opening the spiritual gate' documentation. Staff received training in assessing these needs to ensure that what was important to patients was accurately identified including their religious and moral beliefs, people important to them and what they would like to happen to them after the end of their life.

Patients were given information about, and the opportunity to discuss, their advance care plan. These were not always uploaded in a timely way which meant staff could not be assured they were delivering palliative and end of life care in line with patient preferences.

Recommended summary plan for emergency care and treatment forms (ReSPECT), where a patients' individual choices and preferences are captured, were beginning to be trialled in the Isle of Man. The service had been approved to be a part of the pilot. Currently one paediatric patient had a ReSPECT document in place.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff used a screening tool to monitor patients at risk of malnutrition and tailored care plans relating to needs identified. Patients were weighed weekly to ensure any weight change was included in the assessments of patient's nutritional needs.

Specialist support from staff such as dietitians was available for patients who needed it.

Dietary needs were detailed on the nursing and kitchen whiteboards, in handover information and on patient's bedroom doors to ensure all staff were prompted to remember any specialist requirements.

Staff supported patients with oral care delivery daily in terms of comfort and hygiene. Staff also taught loved ones how to use mouth care kits to hydrate patients' tongue, cheeks and lips safely and encouraged this being delivered hourly.

The service did not routinely record fluid intake to monitor fluid imbalance, fluid input being less than output, in patients at risk of fluid imbalance, such as those requiring a urinary catheter.

Pain relief

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

Staff asked patients regularly about their level of pain but did not record this using a recognised tool to monitor this.

We observed patients receiving pain relief was received shortly after requested.

Staff discussed patients' pain and any changes at handovers and MDT meetings as well as escalating any changes in presentation immediately to medical staff.

Staff prescribed, administered and recorded pain relief accurately.

Patients were observed to be and told us that they were comfortable and at rest during our visit to the hospice.

Patient outcomes

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

The service participated in relevant national clinical audits such as Ketamine, interventional pain and breakthrough pain as part of their membership with the Pallaborative North West group.

The service monitored outcomes to ensure patients including preferred place of care and death and advanced care planning to ensure there were positive for people using the service.

Managers analysed the data behind outcome measures to improve the service. Managers had identified that completion preferred place of death was sometimes unknown for patients and that Advanced care plan completion was at 34.7%. They had begun an initiative to improve the number of patients that completed the Advance care plans recognising that this documentation captured where patients preferred place of death was.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment, for example a hand hygiene champion had been appointed to action improvement identified in infection prevention audits.

We saw the provider submitted data to Hospice UK and used this as a benchmark in which to monitor some patient outcomes.

The service had adopted Outcomes Assessment Complexity Collaborative (OACC) a global patients outcome programme to measure the effectiveness of care planning for patient priorities and symptoms, in 2019. The service achieved an adoption rate of 75% and in 2022 were undertaken a review to see if they were ready to adopt the outcomes as business as usual and close their participation in the project.

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.

The clinical educators supported the learning and development needs of staff; a basic life support training was being held for staff at the time of our assessment.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff also attended various MDT and handovers to discuss patient needs and any changes.

Managers did not identify any development needs their staff had and instead relied upon staff raising if there were any gaps in their knowledge or if they required more training. However, we saw several examples of staff professional development being promoted such as through funding for non-medical prescribers' course and leadership courses.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge through use of the clinical passport. The clinical passport had been developed for each band of employee and contained a comprehensive programme of competencies, observations and skills that would upskill them ready for development into the next banding of role. There were no completion dates for passports and staff completed competencies when they felt confident and competent with the understanding that progress on the passport would be discussed at their next annual appraisal.

Managers identified poor staff performance promptly and supported staff to improve through reflective practice, training and additional supervision.

Managers recruited, trained and supported volunteers to support patients in the service.

Volunteers worked in multiple areas including the community. A lone worker policy was in place to support volunteers and there was a system for volunteers to gain advice and support if required. Several volunteers had worked with the hospice for many years

Multidisciplinary working

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

Staff worked together to ensure patients information was shared. Managers had introduced staff meetings such community meetings and handover to ensure key information was known to all staff.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed an MDT and saw that it was well represented by all members of the hospice and external teams including social work, physiotherapists, occupational therapist, pharmacy, safeguarding, medical and nursing team staff members.

The service had built good working relationships with other agencies to care for patients and jointly worked with GP's, care and nursing homes. They sought information from national organisations such as Hospice UK when required.

The electronic record system used at the hospice was the same as the acute hospital, this made it easy to communicate patient information when transferring services.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had leaflets and displayed information promoting healthy lifestyles throughout the building.

Staff conducted annual assessments of people's health needs and offered them health advice and support based on this.

The service offered a range of support to patients through community groups, psychological support team, young person's support team, bereavement support and pastoral care team, creative wellbeing sessions, rehabilitation programmes and lymphedema service. Complementary therapies such as aromatherapy, massage, reiki and acupuncture were also offered.

Consent

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The Isle of Man government do not currently have legislation equivalent to that of the Mental Capacity Act 2005, this meant that the island does not have a court of protection, who make decisions on financial or welfare matters for people who can't make decisions at the time they need to be made, or Deprivation of Liberty Safeguards (DoLs), a procedure that protects a person's rights if you become deprived of your liberty and lack mental capacity to consent to arrangements. However, we saw that staff were respectful of people's choice and demonstrated an understanding of when people had capacity to consent to care and treatment.

The service gave staff training on the introduction to capacity to ensure staff had an understanding as to when patients were able to make their own decisions about their care.

Staff gave an example of supporting people to make informed decisions and informed them of the potential risks of this. For 1 patient wishing to be discharged home, there were potential barriers to this however, staff had discussed these with the person and supported them and their family to overcome these by offering psychological and occupational therapy.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There was an in-house social worker that staff escalated any patients to they thought may not have or have fluctuating capacity. Staff discussed the important of knowing patient's wishes and continuing their independence if possible. We observed staff discussing the best times of day to have discussions about care with patients due to fluctuating capacity.

Staff clearly recorded consent in the patients' care records. Documentation including referral forms asked patients whether they consented to their referral into the service.

Staff understood the Gillick Competence and adopted this when children in the Rebecca House service turned 16. A formal competency assessment took place to assess a child's ability to make future decision about their care when moving into adult services.

Patients told us that they were asked for consent before any care intervention.

We reviewed do not attempt to carry out cardiopulmonary resuscitation forms (DNACPR) and saw that these were appropriately completed.

Is the service caring?

We found that this service was caring in accordance with CQC's assessment framework

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patient's wishes and information about what was important to them was collected using the opening the spiritual gate documentation on admission.

We observed a hospice at home visit, staff treated patients and their relatives with respect and sought consent throughout, including during more complex procedures such as a syringe driver change.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The location of rooms for private discussions such as consoling or consultation with parents were considered, these were at the entrance of different areas so that families did not have to pass others when upset

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

The service provided training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service offered an MDT of wellbeing resources to anyone using the service and discussed the emotional wellbeing of each patient daily to monitor whether they would benefit from psychological support. Wellbeing resources and complementary therapies were also extended to those close to patients.

The service had sourced external companies to make keepsakes for those who had lost a loved one. Relatives and loved ones were able to make stuffed toys out of their children's clothing, they were also able to have a heart shape cut out of a necklace, the heart would then be buried in the hand of the deceased whilst their loved one wore the necklace.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Relatives told us they had been involved in conversations about patient care and decisions weren't made without everyone's involvement.

Staff talked with patients, families and carers in a way they could understand, and ensured that where people required equipment to communicate, such as glasses or hearing aids, these were detailed in their care plans.

Staff supported patients to make advanced decisions about their care. Advanced care plan information was given to patients and documented in their notes when they had discussed this. Patients told us they were supported to have difficult conversations about future planning and the importance of this. We found advanced care plans were not always uploaded to the electronic system in a timely way to ensure all staff were aware of people's advance wishes.

Staff supported patients to make informed decisions about their care.

Patients and their loved ones gave positive feedback about the service.

The service had considered the environment to ensure that patients could be near their loved ones at the end of their lives. There were two bedrooms allocated for relatives of those in adult inpatient services, pull down beds available for relatives to fit in any patient bedroom. Reclines chairs in all rooms and a 'cuddle bed' had been ordered. The family flat within children services allowed relatives to stay on site when caring for their child but also gave them the space and privacy they needed as a family.

Loved ones were able to donate a symbol of a leaf or butterfly to the 'Tree of Life' within the Hospice. They could choose whether this was displayed on the tree within the main entrance or chapel and could write a bespoke dedication.

Is the service responsive?

We found that this service was responsive in accordance with CQC's assessment framework

Service planning and delivery to meet the needs of the local people

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

Managers planned and organised services, so they met the changing needs of the local population. During the COVID-19 pandemic the demand for hospice care within the home increased and the service adapted staffing accordingly. Following this, inpatient and community services were combined, integrated care services, to ensure patients were treated in line with their preferences and there was a seamless transition between services.

Patients using the service received care in individual rooms and did not have ward facilities or potential for mixed sex accommodation.

Facilities and premises were bespoke built for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention including onsite clinical psychologists.

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.

Wards were designed to meet the needs of patients living with dementia. During a recent refurbishment the environment had been planned to meet the needs of patients and their loved ones including but not limited to colour schemes and signage were appropriate for those visually

impaired or with a dementia, sound protecting booths were introduced in communal areas to promote privacy, the height of furniture was able to be adapted to the size of the child being supported.

The service had created the 'your time, your place' group for patients and their families living with a dementia ran by admiral nurses, nurses specialising in dementia care. The support sessions included a range of dementia friendly activities including chair-based exercise and reminiscence work as well as offering their loved one's peer support, practical advice and wellbeing practices.

Staff understood how to meet the information and communication needs of patients with a disability or sensory loss and captured any sensory impairment in their initial assessments to incorporate these into their personal care plans.

The service had access to information available in alternative languages, or interpreters, if required but did not routinely display these in the service as they would not be relevant to the demographic of the local community.

Staff gave patients a choice of food and drink based on their cultural preferences collected on initial assessment to the service.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The service had one patient waiting for inpatient care at the time of assessment.

The service had eligibility criteria for admissions and a defined ceiling of care. Staff told us they reviewed admissions on an individual basis and prioritised admissions based on urgency of needs using the patient's diagnosis, their current environment and preferred place of care and death to determine order of admission.

All community patients were discussed at the community nurse specialist handover. Staff discussed any ongoing or changes needs of patients and the level of care they were receiving to pre-empt patients that may require admission into the inpatient unit.

Occupancy levels were reduced from 11 beds to 6 due to staffing levels meaning that patients could wait longer than anticipated to receive inpatient care.

Staff discussed patient needs with medical staff during handover to ensure patients received timely review.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff started planning each patient's discharge, where appropriate, considering any social care, environmental and medical needs. Staff did not discharge patients at evenings or weekends.

Staff supported patients when they were referred or transferred between services. Staff followed emergency procedures if patients required emergency transfer into A&E. Staff also attended wards at the acute hospital to identify any possible patients that may require hospital transfer. We found that this approach was not robust as it depended on individual staff members capacity to visit the acute hospital.

Learning from complaints and concerns

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

Patients, relatives and carers told us they knew how to complain or raise concerns and received a guide which detailed this information when accessing the service.

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 which detailed how managers would investigate complaints and identify themes.

The service had not received any formal complaints and had identified learning, amending their admission criteria, from one informal concern received.

Is the service well-led?

We found that this service was well led in accordance with CQC's assessment framework

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.

The leadership structure consisted of trustees which met 4 times a year, a strategic leadership team (SLT), operational delivery group lead who oversaw eight operational groups. Each operational group was led by a member of the SLT.

All members of leadership had relevant checks undertaken to ensure that they had the appropriate requirements to evidence themselves as a fit and proper person for a director's role.

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

Executive and operational leads had effective oversight of the local health economy. They were active in local and national networks. They provided leadership across the region in relation to end of life care and the strategic direction of services. Leaders recognised the challenges and priorities faced by the hospice.

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. Not all staff understood the vision and strategy.

The service had a 2018-2023 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 well-coordinated 'hospice influenced care' with patients at the centre of this. Leaders and staff understood and knew how to apply them and monitor progress.

The vision for the service was to support people well at the end of their lives by using three commitments to deliver five goals. These goals included supporting people to be independent, reach more people earlier with earlier access, share, learn and educate, drive innovation for better care and be sustainable and fit for the future.

The aim was to build a hospice culture based on and driven by shared values. The overarching values were 'caring, working together, respect and professional.' We observed staff demonstrating these values in all aspects of their role.

The service used a strategy was supported by a 5- year action plan, with an annual business plan to achieve this developed each year using measurable outcomes that could be monitored. Care delivered during our assessment supported that the service was achieving the current vision.

The service had not developed a future vision and strategy as they were awaiting the appointment of a new chief executive (CE). As the service was still recruiting for a new CE there was a potential risk about the timely release of a new vision and strategy.

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.

The service had a positive culture where staff worked together well as a team, for a shared goal, and were felt supported to do so. Staff were encouraged to develop and empowered to take autonomy over their decisions.

There was a whistleblowing policy but no freedom to speak up guardian to support and guide staff to speak up where they had concerns.

Staff we spoke positively about the service and told us they were proud to work there. They felt supported and worked within the hospice values. They were involved in the development of the values which were currently under review.

There was a staff involvement group where staff from different departments within the hospice contributed to the development of services and had a forum to be heard. There were opportunities for career development with leaders and those aspiring to lead had completed leadership training in the last year. There were additional training opportunities and dedicated competency frameworks for staff to develop their careers.

Staff wellbeing was a priority for the hospice. The service had a people and culture strategy which broke down staff experience into six elements. These included the joining experience for staff, enjoying their role, belonging, health and wellbeing, development and appreciation. Each element had outcomes and gave leaders actions to ensure staff felt valued. Staff could access support from the in-house psychologist if needed.

Staff could attend the Hospice and me group which was a staff support forum to ensure their voices were communicated to senior leaders.

Governance

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

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

Governance within the hospice was overseen by the board of trustees and management team through the governance framework.

The service had a patient care dashboard which identified how the service had performed against its KPI's including, preferred place of death recording, preferred place of death achieved, patients with an advance care plan, referral response time, achievement against OACC assessments and response to family/carers support questions. The service had achieved a 64.8% performance overall which fell within a 'great' range of performance.

There was an audit schedule which included external opportunities to participate in audit and internally identified audits. Clinical and other internal audits were overseen by the Clinical Improvement Group (CIG), these included regular audits and evaluations undertaken throughout the year to support quality assurance such as medication, nutrition and infection control.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were not always arrangements for identifying, recording and managing risks. Risk assessments were in place to identify and escalate relevant risks and issues and identified actions to reduce their impact, but these did not include Sepsis and VTE risk assessments which were relevant to patients using the service.

Audits of patient care record content and quality did not take place within the hospice and therefore had not identified the issues identified in relation to assessing risk such as falls risk not being identified or PEEPS requiring review.

Staff raised risks to their service leads who understood the risk escalation process and had access to systems and data to allow them to manage and identify risks.

There were effective lone working arrangements to keep staff safe for those travelling into the community. Risks relating to lone working had been assessed.

There was a business continuity plan that detailed processes and actions to be implemented at a time of unplanned disruption.

The service had taken to reduce some services based on contracting and a reduction of need for services such as lymphoedema, day centre and inpatient respite services for which the service now offered one bed. Leaders had not undertaken quality impact assessments to identify the effects a reduction in services could have on patient experience and safety.

The service had a risk committee as part of their governance structure. The reporting system allowed for data to be extracted for review and analysis. There were committees that sat alongside the risk committee and risks specific were owned and discussed by these committees, for example financial risks would be overseen by the financial committee. Risks were then scored and escalated to board appropriately dependant on their rating.

There were 14 risk registers held by the service including but not limited to, financial and clinical risk registers. The risk registers included mitigating actions and scored the level of risk by likelihood and impact. We saw that these risk registers still included risks identified from as early 2014 and although were identified as complete without need for review, but not removed from the registers. As risks increased to a risk rating of nine or above, risk would escalate to the overall strategic risk register, which allocated risks ownership to the relevant committee to take action, and to the board.

Performance data was analysed and presented at both committee and board meetings.

Information Management

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

The service collected a variety of data and analysed it to understand performance, make decisions and improvements. Information was collated and shared with staff, patients and visitors.

Benchmarking data was submitted to Hospice UK and data was shared with other providers and commissioners. The service performed well against other hospices of a similar size and used benchmarking information to improve patient experience, such as creating a task and finish group to review pressure ulcers seen on admissions with relevant system partners.

Information technology systems were used effectively to monitor and improve care. For example, the hospice had implemented an electronic patient record system that was aligned with the acute hospital.

The hospice had updated its website in 2022. It was user friendly and contained clear signposting to the service and its resources.

There were effective arrangements to ensure that notifications were submitted to external bodies, such as the registration and inspection team at the department of health and social care, as required.

Engagement

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

Leaders had a shared purpose and collaborated internally and externally to provide effective services.

Staffing groups were represented at the “Hospice and me,” staff engagement group. This gave representatives from each area of the hospice to give and receive updates and feed these back to their staff teams. Staff also received information about key updates such as any new or changes to policy.

The service had a ‘One Hospice’ staff bulletin to communicate key safety information with staff.

Staff attended a variety of meetings which were structured and had a clear role, this included the community nurse specialist handover, where the CNS team shared community updates with inpatient services and identified any potential admissions or requirements for staff support, handovers between shifts, nursing and medical staff handovers to prioritise medical review and

MDT which involved internal representatives from all areas of the hospice and an external doctor from Supportive Care UK (SCUK).

Hospice representatives attended relevant external MDT's, such as at the acute hospital to identify if there were any patients that could benefit from hospice services, and whether advice and information could be shared between services to support patients.

Managers sought feedback using the 'What matters to you' questionnaire. Feedback from the survey was analysed and the findings used to improve the patient experience. For example, the service had incorporated how to raise a concern in the patients guide to hospice, following a low result in how many people had receive information on how to raise a formal concern.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The hospice was part of Project ECHO. This was a collaborative learning tool designed to enable health and social care professionals to connect with each other globally. ECHO communities worked together to share and benefit from each other's learning and knowledge.

The service had sought the services of SCUK who offered out of hours telephone advice by specialist palliative consultants and weekly remote specialist palliative care advice at the weekly board round and MDT meeting.

The service had developed clinical passports to support staff in developing their competencies to progress to their next banding of clinical practice. Manager recognised the importance of staff retention as the pool of recruits could be limited given the geography of the island and therefore encouraged staff to gain additional qualifications such as nursing medical prescriber and leadership courses.

The hospice participated in relevant local research projects and evaluation of adopted programmes to evaluate and improve the experience of those receiving palliative and end of life care.

Improvements included the expansion of the hospice at home team during the pandemic to increase the provision of end-of-life care in people's homes. This enabled more patients to be cared for at home at a time when many were reluctant to access inpatient services due to the risks associated with COVID-19. The service had since adapted this to make home and inpatient hospice services integrated allowing people to access a service dependant on need and preference.

The service offered psychological support to families when their relative was dying. They took referrals from community nurse specialists, the hospital team and GP services. This support was both on an emotional and practical level including help with advanced care planning and will writing.