Inspection Report 2023-2024

Hospice

Independent Hospital

28 February 2024

Isle of Man Government

DHSC

SECTION A Overall Summary

We carried out this inspection under Part 4 of the Regulation of Care Act 2013 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements, regulations and standards associated with the Act. We looked at the overall quality of the service.

We carried out this announced inspection on 28 February 2024. The inspection was led by an inspector from the Registration and Inspection team, together with a colleague from the inspection team.

Service and service type
Hospice is a registered charity, and the only provider of specialist palliative care on the Isle of Man. Care is provided to anyone with a condition that is terminal or life-limiting.

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

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

- Robust recruitment practices, clear organised documentation and good onboarding and staff training were in place.
- Excellent pastoral care for staff was in place. The ethos of care and concern was reflected throughout the service.
- The atmosphere on inspection was calm, caring and positive.
- Feedback from inpatients was, without exception, excellent regarding the standard of care and dedication of staff.

SECTION B The Inspection

About the service
Hospice Isle of Man provides a service for people requiring specialist palliative and end of life care. Respite care is also provided for children with a terminal or life-limiting condition within Rebecca House.

Registered manager status
The service has a registered manager. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of Inspection
This inspection was part of our annual inspection programme which took place between April 2023 and March 2024.

Inspection activity started on 20 February 2024. We visited the service on 28 February 2024.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR), notifications, complaints/compliments and any safeguarding issues.

During the inspection
We spent time with various staff throughout the inspection. We also had the opportunity to speak with two patients on the inpatient unit. We looked at health and safety records, and viewed various areas in the service.

After the inspection
We received feedback from four staff members following the inspection.

SECTION C Inspection Findings

C1 Is the service safe?

Our findings:
Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. The service requires improvements in this area.

This service was found to not always be safe in line with the inspection framework.

Assessing risk, safety monitoring and management
Personal Emergency Evacuation Plans (PEEPS) were all in place and had been appropriately reviewed. However, the plans were difficult to locate as these were filed under a different name. Some staff fire safety training was out of date. The fire risk assessment was out of date, and the fire policy containing inclusion of the hoist tracking in Rebecca House was not seen. All fire exits were clear and uncluttered. Weekly alarm testing had taken place. Monthly fire equipment checks had taken place, as had monthly emergency lighting checks. The annual three hour emergency lighting testing and fire drills were recorded.

The Electrical Installations Condition Report (EICR) was in place. However the requirement that this should be renewed after one year "for medical areas" had not been actioned. PAT (Portable Appliance Testing) had all been carried out. The legionella risk assessment was out of date. Boiler maintenance was in date. Equipment servicing records were all in place.

Recruitment files of new staff were seen with all checks in place. All staff had three year DBS (Disclosure Barring Service) checks in place. Rotas were clear and legible. Shift leaders were clearly identified. Staff ratios were adapted to meet the needs of patients. Regular bank staff completed additional shifts as required. Mandatory training was seen to be comprehensive and met the needs of patients and staff. Training covered basic life support and anaphylaxis, health and safety, fire awareness, infection control and moving and handling. Mandatory training was a combination of face to face and e-learning, managers were seen to monitor mandatory training and alerted staff when updates to training were required.

Staff were aware of how to make a safeguarding referral and whom to inform with raised concerns. The service maintained a clear process for escalating safeguarding concerns.

A business continuity plan was in place.

Staff followed clear processes to identify deteriorating patients and escalated them appropriately. Staff completed risk assessments for each patient on admission/arrival using an in-house recognized pathway of assessment, this was reviewed regularly, including after any incidents. Risk assessments viewed included falls, mobility, nutrition and hydration including swallowing, pressure ulcer and Waterlow assessments.

Staff regularly reviewed care planning to ensure that the care delivered was specific to the patient's status and changes in condition. The care plans and assessments were

documented on the electronic medical system which enabled all relevant staff to access an updated account of the patient record. Staff had received training on sepsis awareness and there was a clear pathway evidenced and displayed in the clinical room and adjoining areas. Resuscitation equipment was seen to be stored safely within best practice guidelines.

The service had systems and processes in place to safely prescribe, and administer medicines, these also included complex medicines administered via a syringe driver. A syringe driver enables medicines to be given via a compact portable battery operated pump, which supplies a continuous dose of medicine. Medicines, including controlled drugs (CD) and medical gases (Oxygen) were stored safely and securely. All medicines and prescribed documents (MAR Sheets) were evidenced by us and in line with the providers Medicine Policy. The service had medicines policies and procedures covering varying aspects of medicines management. We reviewed four medicine charts which showed that patients received their medicines as prescribed in line with good practice.

The service managed patient safety incidents well, staff were proactive in recognizing and reporting incidents and near misses. Managers ensured that actions from patient safety alerts were actioned and monitored. Staff were aware of how to report incidents, and concerns in line with the services policy. Learning following incidents was completed through reflective practice, and recognition of competencies.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation was evidenced, fully completed and identifiable in the care planning records. Temperature checks of fridges in clinical areas were taken daily and logged accordingly, to ensure medicines were stored at the correct temperature. Room temperatures were also observed as being monitored to ensure that medications stored at room temperature was maintained. Oxygen cylinders were secured to prevent falling; however brackets to secure oxygen cylinders in Rebecca House Clinical room are required to be in place.

Staffing and recruitment

Clinical passports were in place. Staff inductions and training were confirmed to be thorough, and patients spoken to confirm that there were always enough staff on duty to meet their needs. A full staffing review had been undertaken. A dependency assessment tool was in place. Reviews of staff levels had taken place. The mandatory training was seen to be robust and met the needs of patients. Further modules were also undertaken relating to essential skills. Staff were complimentary about how managers acknowledged training needs and supported staff to be proactive in their learning. Safeguarding training was dependent on role. However during inspection it was noted that compliance levels remain low for both Safeguarding Adults and Children Level 1 and Level 2. Staff discussed with us how they would raise concerns and were fully aware of who the safeguarding leads were for the service. Staff were autonomous in making referrals with the safeguarding lead overseeing the process.

Preventing and controlling infection

An infection control policy was in place. The building was clean and tidy on inspection. PPE (Personal Protective Equipment) was available throughout the building. Cleaning schedules were in place. The COSHH (Control of Substances Hazardous to Health) cupboard was locked. Safety data sheets were also in place. Infection control audits had taken place. Waste storage and segregation in color coded bags was seen. Laundry room was clean and well organized. Ward areas were well maintained and visibly clean. Sharp bins were dated, clinical areas were well maintained and organized.

Learning lessons when things go wrong

The Duty of Candour policy was in place. Evidence was seen of actions taken following, for example, medication errors. Medication competencies, supervisions and appraisals had all addressed incidents. Training had also been scheduled for staff. The manager told us, "I have oversight of all clinical incidents and near misses and ensure these are appropriately investigated." Staff learned from safety alerts and incidents to improve and maintain safe practice. Medication incidents were reported through DATIX an electronic in house system. Reflective practice was also in place to improve practice and to identify further learning. There was an incident management policy in place. There had been several medication errors. These had been addressed through Notification of Events forms to the Registration and Inspection team in a timely manner. Team meetings, supervisions and a continued open door policy was also in place to feedback and move forward with identified issues. Updated training and further supervision was also put into place to make improvements moving forward.

Action we require the provider to take

Key areas for improvement:

PEEPS (Personal Emergency Evacuation Plans) are required to be easily located by all staff.
This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Health and Safety

All staff training is required to be in date.
This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

An updated fire risk assessment and fire policy to be in place addressing requirement for Rebecca House hoist tracking to be included.
This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Health and Safety

An updated legionella risk assessment is required to be in place.
This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Health and Safety

Electrical Installations Condition Report (EICR) requirement of retesting of medical areas after one year to be actioned.
This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Health and Safety

Oxygen cylinders to be secured by wall brackets in Rebecca House clinical room.
This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Health and Safety

Inspection Findings

C2 Is the service effective?

Our findings
Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. The service does not require any improvements in this area.

This service was found to be effective in line with the inspection framework.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
Pre admission assessments and care plans were seen on inspection. Robust individual risk assessments were in place. Staff completed risk assessments on arrival, and reviewed these regularly, including after any incident. Care planning was regularly reviewed and was person centered and specific to the patient's status and condition.

Records were clear. End of Life plans were integrated into electronic patient records, and patients confirmed that staff were familiar with their wishes. Patients told us they had chosen to come into Hospice, and they felt at home, "safe and comfortable." Assessments and care reviews took place in a timely manner. Families were involved and made to feel part of the care in the inpatient unit; patients told us; "I am able to see them when I like." Patients told us pain relief was available as needed.

Staff support; induction, training, skills and experience
We saw systems in place for staff training, however, there was a low percentage of staff who had undertaken safeguarding training. Full inductions for new staff were seen, and staff told us they felt they had had enough training to adequately carry out their role. Specific needs training was in place, for example, end of life care, symptom management. Supervisions, appraisals, staff meetings and staff medication competency assessments were all in place. Staff were experienced, qualified and their skills and knowledge met the needs of the patients, managers were seen to action any specialist training requested by staff. There were practice educators present to ensure staff received practical and further training to develop their clinical skills. Supervisions were regular and provided constructive clinical supervision of their work. There was a quiet educational room where staff could undertake mandatory training or e learning when required.

Staff told us their managers were supportive for them to move forward with additional training and education when required.

Supporting people to eat and drink enough to maintain a balanced diet
A nutrition policy was in place. Care plans included dietary needs. Multi-disciplinary meetings took place to discuss patient need.

Menus were seen, and patients told us they had choices about what they had to eat, and were frequently offered drinks. Fortified drinks were also appropriately offered. Specific dietary requirements were catered for. Staff used the malnutrition universal screening tool (MUST) to identify those individuals who are malnourished or were at risk of malnourishment and adapted care plans relating to need appropriately. Staff documented patient's food allergies onto their electronic record system. When speaking to patients they discussed how the food was of an exceptionally high standard.

Inspection Findings

C3 Is the service caring?

Our findings
Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. The service does not require any improvements in this area.

This service was found to be caring in line with the inspection framework.

Ensuring people are well treated and supported; respecting equality and diversity
Patients told us how well they were cared for by staff. The manager told us, "It's important to me to ensure that patients have the time they need with staff and supported to carry out personal care at their own pace." They felt "at home" and were particularly grateful for the way in which families had been involved in their care planning and ongoing care. Patients told us they felt well cared for, and nothing was too much trouble for staff. Staff told us about how they loved their jobs in caring for people; we were told, "I am very passionate about Hospice and Rebecca House, the work we do, and the staff team."

Staff took time to interact with patients and their families and significant others in a respectful and considerate way. Staff were aware of the emotional and social impact that a person's care, treatment or condition had not only on their own wellbeing but on those close to them. When talking to staff it was evident that they supported the families not only in life but at end of life also, remaining supportive, offering bereavement support when required and being a constant part of the bereavement process following a patient's passing.

Supporting people to express their views and be involved in making decisions about their care
Patients informed us they were treated with kindness and were fully involved in all decision making. We saw how religious needs were met in line with a patient's beliefs. Hospice questionnaires were sent out to gain resident views. Staff ensured patients, and those close to them, fully understood their care and treatment. Staff supported patients by answering any questions and providing information so that well informed decisions could be made. Choices of care were made in an honest, open and person centred way. Advanced care planning was discussed with patients and documented in their care plans. Staff were seen to be attentive and responsive to patients and relatives. We observed a family member and patient discussing their care with staff and the relationship was unhurried and responsive. We were particularly touched by hearing how staff in Rebecca House had enabled family members to have a special memory of a child in the Rainbow Room.

Staff were fully appreciative of patient's wishes and respect was seen throughout care planning of personal, cultural, social and religious needs being met. This information was also evidenced within the spiritual gate documentation on admission. We evidenced discharge planning in place where appropriate.

In Rebecca House all young people have an "All About Me" document which outlines communication needs and identifies and tailors care and information provision to their specific needs or preferences.

Inspection Findings

C4 Is the service responsive?

Our findings:
Responsive – this means we looked for evidence that the service met people's needs. The service does not require any improvements in this area.

This service was found to be responsive in line with the inspection framework.

Planning personalised care to ensure people have choice and control to meet their needs and preferences
Emotional needs and support were continually being addressed from initial assessment to admission. The environment enabled difficult conversations to be had in an open environment ensuring privacy and dignity were maintained at all times. Staff received training on breaking bad news and empathy was in place during difficult conversations. Staff ensured patients and those close to them were at all times involved in conversations about their care, and involvement was key in identifying personalized care and planning. Staff enabled patients to make informed decisions about their care. Patients discussed with us how they maintained their own autonomy in their care planning and their needs and wishes were accommodated in a sensitive and professional manner. The service fully appreciated individual needs and took into account patients preferences, staff enabled patients to access resources and services with other providers when needed. Rooms were personalized, photos, mementos were on display, and rooms were spacious and adapted to need.

Communication was adapted to the needs of the individual, initial assessments had evidenced any disability or sensory impairment and processes sought to improve services where required. In Rebecca House all young people have the "All About Me" document which outlines communication needs and identifies and tailors care and information provision to their specific needs or preferences.

We evidenced documentation related to managing the care of dying adults in the last few days of life, these were in date and regularly reviewed in accordance with best practice guidance. Patient assessments contained preferred place of death documentation and the Pastoral Team were involved where required as part of the holistic approach.

Improving care quality in response to complaints and concerns
It was evident that people could give feedback and raise concerns about the care they received free from harassment and discrimination. Copies of the Hospice complaints leaflet were available in both reception areas and on the website. Two formal complaints had been received since the last inspection, and had both been resolved at the time of inspection.

Inspection Findings

C5 Is the service well-led?

Our findings
Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. The service requires improvement in this area.

This service was found to be not always well-led in line with the inspection framework.

Promoting a positive culture that is person-centered, open, inclusive and empowering, which achieves good outcomes for people
A new set of values was in place for staff. The Birdsong annual employee engagement survey providing workshops and moving forward with actions from outcomes. Training had begun and a programmer of incorporating these values into staff practice was underway. Managers were visible and approachable throughout the service for patients and staff, they fully supported staff to develop their skills and to move forward with senior roles. The manager told us they felt supported by senior management, and had regular supervisions. Staff confirmed they had regular supervisions, and felt listened to by management; staff said, "The SLT (Senior Leadership Team) are all fantastic leaders." "I could not have asked for a more supportive environment to work in." Staff particularly remarked on the support from all levels of management across the service.

Regular team meetings were in place across all of the service ensuring consistency and continuity, new values based training in different formats, presentations and training embedded the ethos into staff practice. Clinical auditing was in place overseen by the Clinical Improvement Group (CIG), and a number of other committees such as the Medicines Management Group (MMG) and Senior Leadership Team (SLT), to ensure a compliant quality led service. However, auditing of health and safety documentation was fragmented.

Appropriate insurance cover was in place.

How does the service continuously learn, improve, innovate and ensure sustainability
The vision and continued way forward was to promote a person centred positive culture, empowering the staff to move forward with shared values. Staff told us, "With our new vision and strategy it has become clear on our values and how to achieve them." The Manager had extensive experience of palliative care and worked closely with the clinical teams to support them. They also worked clinically in both the adult and children's services.

Action we require the provider to take

Key areas for improvement:

Regular management oversight of health and safety audits to be in place.

This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Health and Safety

If areas of improvement have been identified the provider will be required to produce an action plan detailing how the areas of improvement will be rectified within the timescales identified. The R&I team will follow up and monitor any actions undertaken.