

## Mary Ann Evans Hospice

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### Inspection report

Eliot Way, George Eliot Hospital,  
Nuneaton, CV10 7QL  
Tel: 024 7686 5440  
Website: [www.maryannevans.org.uk](http://www.maryannevans.org.uk)

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### Ratings

#### Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

### Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by Care Quality Commission (CQC) which looks at the overall quality of the service.

This was an announced inspection. Forty eight hours' notice was given to the provider. This was because the hospice at home service is a community based service and we wanted to ensure the relevant staff were available to talk with us during our inspection.

Mary Ann Evans hospice provides a day care service for people with life limiting conditions, a hospice at home service for people moving towards the end of their lives, and a service to alleviate the symptoms for people with lymphoedema, a condition which can occur after cancer surgery or radiation therapy.

At the time of our inspection a registered manager was employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

# Summary of findings

People who used the hospice and their relatives told us they were happy with the services provided by the hospice. They felt the staff understood their needs and they felt safe.

People's wishes and preferences were taken into account and recorded in care plans. Risk management procedures were in place to ensure people's health risks were identified and plans were in place to manage those risks.

Staff demonstrated a good understanding of the needs of people with life limiting illness. They had received good training and support to meet people's needs.

The organisation worked well with other health and social care providers to ensure people's needs were met.

There were appropriate policies and procedures in place to support people should they ever have a need to complain or raise concerns. When concerns had been raised, they had been dealt with effectively.

There were systems in place to assess and monitor the quality of support provided for people.

# Summary of findings

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

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

People told us they felt staff understood their needs and they felt safe.

Staff were recruited only when all checks necessary to support the safety of people had been completed.

Staff understood safeguarding procedures and knew how to alert the relevant people if there were safeguarding concerns.

Good



### Is the service effective?

The service was effective.

Staff had received training and on-going support to help them provide good quality care.

The service worked well with other health and social care professionals to meet the needs of people they supported.

Good



### Is the service caring?

The service was caring.

People told us staff were caring and kind.

People were actively involved in the decisions about their care and treatment.

We observed people being treated with dignity and respect at all times.

Good



### Is the service responsive?

The service was responsive.

People had their individual needs regularly assessed and consistently met.

Management listened and acted on the views and opinions of people who used the service.

Good



### Is the service well-led?

The service was well-led.

The registered manager and board of directors provided good support to the staff team.

All staff were clear about their roles. They told us there was an open culture at the hospice.

There were appropriate arrangements in place to assess and monitor the quality of the service provided.

Good



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## Detailed findings

### Background to this inspection

The inspection team consisted of an inspector and specialist advisor. The specialist advisor was a registered nurse who had experience of working in hospital and community settings.

We last inspected this service in August 2013. The provider met the Health and Social Care Act 2012 Regulations and was found compliant in all areas inspected.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with seven people who used the service, the registered manager and nine staff. We also spoke with MacMillan nursing professionals who visited the service whilst we were there.

We visited two people who were using the hospice at home service. We spoke with them and their relatives. After our visit we spoke by phone with the relative of a person who had recently used the hospice at home service.

We reviewed four people's care records. We looked at the personnel files for two members of staff to check that they were recruited safely and that they received appropriate training, supervision and appraisal.

We also looked at quality assurance processes and records, and arrangements for managing complaints.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

# Is the service safe?

## Our findings

All people we spoke with felt safe. For example, a relative of a person who used the hospice at home service told us they, “Knew [relation] would be in safe hands, every night they’ve been here I’ve slept.”

We spoke with staff about their understanding of safeguarding people. Staff understood what they needed to do if they had concerns a person was being abused. We saw staff had received training in safeguarding adults and found they had a good understanding of reporting procedures to safeguard people.

The records we looked at demonstrated the provider had assessed the risks relating to people’s care and treatment. For example, one person’s emotional health had been assessed as at risk and a referral had been made to the psychology department to support the person with their emotional and psychological well-being.

Incident and accidents had been recorded and we saw that action had been taken as a result to minimise the risk that similar incidents would happen in the future. For example a staff member had not worked within the medication

policy of the organisation. The member of staff and all staff were reminded of their responsibilities to work with the organisation’s policies and procedures and given a copy of the policy for reference.

People had consented to their treatment and their capacity to make decisions had been assessed by the registered manager. At the time of our inspection all people who used the service were able to make their own decisions. The registered manager was aware of the importance of assessing capacity and making decisions in the person’s best interests if required. This meant the service was following the requirements of The Mental Capacity Act 2005.

We saw, and records confirmed, there were enough staff to support people’s care and treatment in all three of the care and treatment services provided at Mary Ann Evans Hospice. We saw a range of staff were employed to support people’s health, social and spiritual care needs.

There were systems in place to manage the number of people attending the service to ensure there were sufficient staff with appropriate skills and knowledge to meet people’s care needs safely.

Records showed the provider completed all the relevant recruitment checks on newly appointed staff, to support the safety of people who used the service.

# Is the service effective?

## Our findings

We spoke with two people who used the lymphoedema service. One person told us the staff were “Really supportive, they have helped me feel braver”. Another person who used this service told us staff helped them to understand why they needed treatment, “I had a vague idea about what to do, but wasn’t sure for certain. They [staff] explained what needed to be done.” A person who used the day hospice told us they had not been able to walk on leaving hospital and the physiotherapy support they had received at the hospice meant they were walking more freely.

Many of the staff we spoke with had worked for the hospice for many years and thought they worked well as a team. We saw good communication within each team. Staff had received specific training to support them to meet people’s care and treatment needs. For example staff had been trained in end of life care, advanced care planning, bereavement, manual handling, infection control and advanced communication. Where appropriate, staff had been trained in specific health conditions.

Staff told us they felt well supported. There were regular meetings where staff discussed people’s specific needs and how this related to their own skills and knowledge to identify any training requirements. We found there were opportunities for staff to have one to one work meetings and support with the registered manager or other members of the team dependant on what their support needs were.

People who used the day hospice were encouraged to have a meal at lunch time to support them with socialisation and with nutrition. People told us that they told us they enjoyed the food provided and found it appetising. One person told us they had lost a lot of weight whilst in hospital and the day hospice had given them support to gain weight.

We spoke with the cook. They told us they ensured anyone who required a soft food diet had each part of the meal pureed separately so the person could distinguish by the

smells and colour what the food was. They gave an example of one person who had attended the day hospice who had their food pureed. The person enjoyed how the food had been pureed and asked how it had been done and the equipment used. They then used this information to buy the same equipment to use in their own home. The person felt this had improved their food intake at home.

We looked at how people were supported to maintain good health, have access to health care services and receive on-going health care support. We found the service provided people with good information and explanations about their health care and treatment options. For example staff at the lymphoedema clinic educated people about self-help and there were leaflets in the treatment area about lymphoedema and support groups.

People were referred quickly to relevant health care professionals when their needs changed. For example we saw close working relationships with the Macmillan nurses, Marie-Curie nurses and district nurses. Hospice staff attended a multi-disciplinary meeting each week. These meetings included the consultant in palliative medicine, the hospice at home service, and Macmillan nurses. This meant all services worked closely together to provide effective support to people with life limiting illnesses. We spoke with one of the Macmillan nurses who was told us they thought the hospice provided an excellent service to people.

People who used the hospice at home service told us they were involved in their assessments. We were informed staff from the hospice at home team tried to visit patients on the hospital ward prior to discharge to introduce themselves and discuss their needs.

The hospice used a system known as RIPPLE (Realising Individual Patient preferences at Life’s End). This identified people whose condition was deteriorating and for whom home had been identified by the person as the preferred place for care. The system ensured people had a rapid discharge (between within six to 24 hours depending on their condition) so that they could have their preference realised and be at home to die.

# Is the service caring?

## Our findings

We spent time observing communication with staff and people, and speaking with people who used the day hospice service. People told us staff were caring. One person said, “They [staff] were marvellous.” Another told us staff were “Nice, lovely”. A third said, “Nice people, friendly, it feels cosy – I get a coffee and biscuits, it feels homely.”

Good relationships had developed with staff who provided care with kindness and compassion and people told us they enjoyed coming to the service. They told us the staff were, “Lovely” and the service was, “Wonderful”. One person told us they enjoyed coming to the day hospice because it gave their loved one respite from looking after them.

During our visit we saw some people chose to play a games console quiz game, they spoke in smaller groups with staff and they had the opportunity to be involved in craft activities. The complimentary therapist was also available to provide massage to people who wished it. People enjoyed the company of other people and the discussions with staff. The manager told us when people booked in to use the day hospice they would look at what their needs were and tried to book them in on a day where people with similar interests were attending. We saw this had worked well.

We spoke with two people who used the hospice at home service and one person whose loved one had recently passed away. They were all very positive about the relationships they had developed with staff. One person said, “I couldn’t praise the girls enough...they have helped me tremendously...they’re so caring and careful, all of them, there is not one who isn’t.” Another said, “It’s an amazing service...each lady [care worker] is so warm and friendly – not like normal carers...they visited him in

hospital, so personal.” A third told us, “The staff were brilliant, we had a good laugh...they washed her, cleaned her teeth, washed her hair, spent so much time with her, they were brilliant with her.”

Care was individual and centred on each person because staff had a good understanding of people’s needs understood how to provide care with respect to ensure people’s dignity was maintained. For example, at the day hospice we observed one person becoming anxious during meal time. We saw a member of staff was close by and quietly and discreetly indicated to the person that they were there if help was needed to leave the room. The person accepted the help offered. The member of staff told us they knew the person might get anxious and had deliberately positioned themselves close by to be there for support if required.

We saw people were actively involved in decisions about their end of life care. One person had initially chosen to die in hospital as they did not want their loved one to be reminded of them dying at home. Two days before they died, they told the hospice at home team they had changed their mind as they felt they had received the support they both needed. We were told they died peacefully at home with their loved one.

We spoke with the chaplain for the hospice. They told us they were a ‘listening ear’ for anyone who wanted to talk regardless of their faith or lack of faith. They told us they would refer people to the hospital chaplaincy if people of different faiths to Christianity required spiritual support. The chaplain was responsible for the bereavement service. This was made up of a large team of approximately 60 volunteers. Many of the volunteers had received support from the hospice service before their loved ones had passed away and understood the emotional needs of people who currently used the service. Volunteers provided one to one support to bereaved people, and offered social activities to reduce isolation and loneliness.

# Is the service responsive?

## Our findings

All people who used the service told us they received care and treatment which met their individual needs. One person told us, "You can leave an answer phone message and someone will ring within an hour." "If you have concerns they say 'come in and we'll have a look – simple stuff but it works.'" Another said, "If you phone up, they get back to you."

Records of people's care showed us that staff were responsive in meeting people's changing needs, and where necessary had referred them to the appropriate service.

Care and treatment needs had been monitored and reviewed at each visit and where their needs had changed, for example, with pain management, the appropriate professional was contacted.

During our visits to people's homes we saw staff respond quickly and appropriately to provide emotional support to the person and their family member. At the day hospice, we saw a member of staff respond quickly to the increasing anxiety of a person. They did this discreetly so other people's attention was not drawn to the person's needs.

We looked at the yearly patient satisfaction questionnaires for the different parts of the service. We noted that people were satisfied with the service. One person said, "From walking through the front door everyone is very friendly, treatment is excellent." We saw one comment which requested a pool table and darts board for people at the day service to use. These were introduced in response to this request. The 'provider information return' informed us they were looking at giving people feedback cards to help them find out more about people's experiences.

There was an effective system in place so that the provider was aware of complaints, responded to them and used the information to improve the service. For example, we saw a letter was received from a family member in which it informed that messages left on the phone were not being responded to at week-ends. On investigation the provider found that messages were left on the reception phone and not the hospice at home phone. This had been rectified and both the main reception phone and the hospice at home message services were now checked.

# Is the service well-led?

## Our findings

The service had a registered manager in post who was responsible for ensuring the service met its legal requirements. The registered manager was supported by a board of directors which met

once every two months. The minutes of the meetings demonstrated the board considered a wide range of issues such as infection control, clinical incidents, training, improvements in service provision, and analysis of compliments and complaints. We saw the board previously had representation from people who used the service, and were looking at filling the vacant position. This meant the hospice would have representation from people at every level.

To support improvements in clinical care and treatment, the provider had a clinical governance group and a service development group, which met once every two months. We saw that the lymphoedema service would be taking part in a significant clinic trial, and hospice staff had been booked to receive training to enable accreditation as a high quality care provider in end of life care.

The manager of the service told us that whilst they responded to people's care and treatment needs, the recognised they had not previously asked people on

referral to the hospice, what people hoped the service would provide them. They were planning to assess what 'outcomes' people wanted from the service. This showed the provider was being proactive in identifying what people wanted.

Staff told us they had regular staff meetings. We asked staff about the meetings, they told us they felt any issues raised at meetings were listened to and if required taken to the board. Staff confirmed they received annual appraisals about their work.

Staff felt fully supported by the registered manager and the board of directors. They told us the manager reported to them any issues raised at more senior meetings and they felt fully briefed about the management of the organisation. They told us if they raised an issue it would get sorted. Staff felt the service had an "open" culture where staff could talk "freely."

The organisation had links with other organisations which supported and treated people with life limiting illnesses. For example information from the provider told us it was working with Health watch to develop a 'Compassionate Community' scheme, and had recently joined a newly set up multi-disciplinary group which conducted case reviews with the view to learning lessons on the delivery of safe and quality care.