

Sue Ryder

Sue Ryder - Leckhampton Court

Inspection report

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Date of inspection visit:

19 October 2016

21 October 2016

Date of publication:

17 January 2017

Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place on 19 and 21 October 2016 and was announced. We gave the registered manager 48 hours' notice of the inspection because we wanted key people to be available.

The hospice at Leckhampton Court has a 16-bed in-patient unit, a day service and a hospice at home team. It provides support for people over the age of 18 who have life limiting conditions such as cancer, heart failure, lung disease and degenerative neurological illnesses. The hospice at home team helps people to stay at home longer or to die at home if this is their preferred place of death. The service also offered respite for carers. The expert care team included doctors, nurses, health care assistants, physiotherapist, occupational and complementary therapist, social workers, bereavement support workers, volunteer befrienders and spiritual care workers. The various services provided by the hospice worked in conjunction with people's own GP, community district nurses, and other health and social care professionals.

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

A hospice service was provided for end of life care in the last couple of weeks, symptom control, emotional and physical crisis. From the in-patient unit 50 percent of people would go home after a short stay and may return at a later date and 50 percent would die in the hospice. The hospice at home service was mainly provided for people in the last two months of life, however this service had helped people with degenerative neurological conditions for longer periods.

All staff including volunteers received safeguarding adults training and nurses and care staff received safeguarding children training. This meant they would be able to recognise if people and children they came into contact with were being harmed and would know what to do to report those concerns.

The nurses and health care assistants were trained on how to use equipment correctly to safely move and transfer people from one place to another. Any risks were identified and management plans put in place. Any other risks to people's health and welfare were identified during the assessment of care needs and were then well managed. Safe recruitment procedures were followed to ensure that only suitable staff were employed. The service had the appropriate procedures in place to protect people from being harmed.

The numbers of staff on duty in the in-patient unit were determined by the number of people who were receiving care and support and the complexity of their needs. The hospice at home team had a flexible workforce (bank staff) in order to be able to increase capacity and accommodate the demand for their service. The team endeavoured to always meet any referrals for a service and would pull out all the stops to support those in need.

All staff had a programme of mandatory training to complete. This enabled them to carry out their roles and responsibilities effectively. Volunteers also had to complete some of these training sessions. There was a comprehensive induction training programme for all new staff plus a programme of refresher training for all other staff. This ensured they had the required skills and qualities to provide a compassionate and caring service to people and their families. .

On admission to the in-patient unit people's capacity to make decisions was assessed and where possible they were supported to make their own choices and decisions. Staff received training regarding the principles of the Mental Capacity Act (2005) and these were understood. They ensured consent was given prior to providing any care and support. Where people lacked the capacity to make decisions because of their condition or were unconscious they worked within assumed consent but checked with healthcare professionals and family members before providing care and support.

People in the in-patient unit were provided with a well-balanced and nutritious diet. Alternatives were always available in order to meet people's specific needs and an out of hours menu was available for those who needed to eat, outside of planned meal times. People in their own homes were assisted to eat and drink where this was required.

Health and social care professionals referred people to the hospice service when they needed in-patient care, and provided an overview of their medical and nursing care needs. Hospice at home staff received referrals for their service from the district nurses and the person's GP and liaised with them as and when needed whilst they were providing a service. Staff worked in partnership with healthcare professionals and families to be supportive and provide an effective service.

All staff who worked for the hospice had the qualities and skills required to provide sensitive and compassionate care and support to the people they were looking after. The staff developed close working relationships with the people they looked after and their families. The hospice received glowing feedback from families post bereavement and examples of these are detailed in the main body of the report. The hospice service not only cared for the people they looked after but also looked after the staff. Staff were emotionally well supported by their colleagues and the managers.

People's care and support needs were assessed and they were provided with person-centred care. Regular reviews of people's needs ensured their care plans were revised as often as necessary. People were involved in making decisions about how they were looked after and in the case of the hospice at home service, the support their family would find beneficial. There were secure communication systems in place for the hospice at home staff so that changes in people's health status was reported back to the team and to the district nursing services.

The service was well led. There was a team of experienced managers and heads of department in post, all committed to providing a high quality service that was safe, effective, caring and met people's needs. The prevalence of any events such as accidents, incidents and complaints were monitored and analysed to identify trends and enable the service to prevent a reoccurrence. Where things had not gone as expected by families and an individual experienced contentious or complex issues at end of life, the staff looked at the reasons why and looked for lessons they could learn for the future. There was a continual programme of audits in place to drive forward any service improvements needed.

Feedback from people who used the in-patient service, the day therapy service and the hospice at home service was gathered and used to measure how people felt about the care and support they received. All feedback was used to drive forward any improvements. A service user group was set up 18 months ago and

feedback gathered from this group had led to a number of changes being implemented. These are listed in the main body of the report,

The service worked in partnership with other hospice care providers, took part and led on research projects. The partnership arrangements enabled the service to share good practice with other care providers and improve medical and nursing standards of care for people who were at the end of their lives or living with a life limiting condition.

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.

All staff received safeguarding adults and children training and protected the peoples they were supporting from harm. Any risks to people's health and welfare were well managed. Recruitment procedures for new employees were safe and ensured only suitable staff were employed.

People were assisted with and administered their medicines safely. Qualified nurses had the appropriate skills to enable them to administer end of life medicines.

Sufficient staff were employed at all times to meet people's needs. The hospice at home service had a flexible workforce and was generally able to meet all referrals for a service. The staffing levels on the in-patient unit varied depending upon the number of people and their care and support needs.

Good 

Is the service effective?

The service was effective.

People were looked after by staff who were well trained and well supported to carry out their roles effectively. Staff had the qualities and skills to provide compassionate care and support.

Staff understood the importance of obtaining consent from people before helping them. They were aware of the principles of the Mental Capacity Act (2005).

People were supported to eat and drink where this was needed and supported to see their GP and other healthcare professionals as required. There was good collaborative working in place between the different health care services.

Good 

Is the service caring?

The service was caring.

People were treated with the utmost respect and kindness and their dignity was maintained until the end. The staff teams were

Good 

highly motivated to provide a kind and loving service and ensured when people were at the end of their life they had a good death.

Families were also provided with a very caring and supportive service, at a difficult time in their lives.

The service looked after its staff and provided them with emotional support and guidance.

Is the service responsive?

Good ●

The service was responsive.

People and their families received the care and support that met their specific needs. The care and support was adjusted as and when required in response to people's changing needs.

People were listened too and staff were all committed to supporting them if they had any concerns or were unhappy.

Is the service well-led?

Good ●

The service was well-led.

People were highly complimentary about the hospice service. External health care professionals said the service was well organised, well managed and provided service to an extremely high standard.

The service worked in conjunction with other hospice services and educational establishments to influence and improve best practice in palliative and end of life care.

Feedback from people using the services and the families of people who had used the service was gathered and used to drive forward any improvements. People were listened to and all staff, including volunteers, were involved and consulted by the management team.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was announced and was undertaken by one inspector and an expert by experience. An expert by experience is a person who has used this type of service in the past. The previous inspection of Sue Ryder – Leckhampton Court was in January 2014. There were no breaches of the legal requirements at that time.

Prior to the inspection we looked at the information we had about the service. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they planned to make.

We received feedback from five health or social care professionals – we had asked them to tell us about their views of the service. Their comments have been included in the body of the report.

During our inspection we spoke with seven people who were staying in the in-patient unit or using the day service and five relatives. We spoke with four people who had previously used the hospice at home service and one person who was currently using the service. We spoke with 17 members of staff including medical staff, qualified nurses, health care assistants, heads of departments. We also spoke with the registered manager and the Hospice Director.

We looked at paper records and the newly introduced electronic care records for five people, seven

randomly selected staff employment records, training records, policies and procedures, audits, quality assurance reports and minutes of meetings.

Is the service safe?

Our findings

People using the in-patient unit, the day therapy unit and the hospice at home service were overwhelmingly positive about the service they received. Examples of what they told us included the following: "I feel very safe here, the staff are wonderful to me", "My sister is in really good hands", "There are staff around every minute of the day so I know he will be safe for his final few days" and "The nurses are all so gentle with her and very committed to ensuring she is comfortable".

The service had a safeguarding adults and children policy and there were clear reporting protocols in place to ensure any concerns were dealt with appropriately. There was a lead worker identified within the hospice for adult safeguarding and child safeguarding both of whom had received appropriate training. They were supported by the management team and had links with the wider safeguarding services.

Although the in-patient and hospice at home services were not provided to children, the staff could be supporting peoples who had child visitors or children were present in the homes of the peoples they visited. Information was displayed in the in-patient unit informing people, their families and visitors and the staff team on who to contact if there were safeguarding concerns. All staff received safeguarding training covering both adults and children as part of the mandatory and refresher training programme.

All staff we spoke with knew what action to take if abuse was suspected, witnessed or alleged. They said they would report any concerns they had to the one of the managers and were aware they could report directly to the local authority, the Police or the Care Quality Commission.

Safe recruitment procedures had been followed. The measures in place were robust and prevented unsuitable staff from being employed. Appropriate pre-employment checks had been completed. Enhanced disclosure and Barring Service (DBS) checks were carried out for all staff. A DBS check allowed employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people.

A register of all nursing and midwifery council registrations (for nurses) and general medical council registrations were kept and checked on a monthly basis. Staff were required to provide evidence that they had renewed their registration. Regular checks using the online checking service were conducted. A register of all clinical staff who had received the Hepatitis B vaccine as recommended by the department of health was kept and reviewed when new staff started. All staff had access to occupational health services.

All staff including the volunteers received moving and handling training. The service had four members of staff who were accredited moving and handling trainers and they had two yearly update training. These trainers worked on the in-patient unit and were therefore able to observe that correct practice was being followed. The measures the provider had in place ensured people were assisted to move and transfer properly and were not harmed by being moved incorrectly.

For those people on the hospice ward a range of different risk screening assessments were completed and

regularly reviewed. These included a nutritional screening tool, the likelihood of pressure injury to skin and falls and a moving and handling risk assessment. Where people needed to be assisted to transfer or move from one place to another a 'supporting me to move' plan was written detailing the equipment to be used for each task and the number of staff required.

Where specific equipment was in use, for example pressure mattresses and cushions, daily checks were in place of the cabling to ensure the equipment was functioning correctly. Staff had completed bedrails training and the risk assessment tool being used was currently under review. The same risk assessments were completed for people receiving a hospice at home service.

Each person was assessed on admission to the in-patient unit and their falls risk determined. These falls risk assessments were kept in the bedside folder and were accessible to all staff involved in the person's care. A member of staff was the falls lead within the hospice and monitored every incident report to identify any learning that could be shared. A falls group had been formed with the physiotherapist and occupational therapist and they assessed people attending the day hospice who had a recent history of falls.

Each person on the hospice ward also had a personal emergency evacuation plan (a PEEP) prepared. These detailed the level of assistance they would need in the event of a fire in the main hospice building. The PEEPs were reviewed each evening and updated where necessary.

There were processes in place to deal with reactive maintenance of the buildings and services. Service contracts for all equipment were in place and managed by head office. The maintenance person had a programme of daily, weekly, monthly and quarterly checks and actions to complete in respect of fire safety and water safety. The head of support services monitored that these had all been completed as planned. The fire safety risk assessment was last reviewed in May 2016 and the few actions identified had been rectified. Full health and safety checks were completed regularly by the provider's health & safety officer.

Hospice at home staff supported people in their own homes and an environmental safety standards assessment was completed during the initial visit. The aim of these risk assessment was to reduce as far as reasonably practicable the risk of harm to staff, the people and their families. The 'home details' were recorded as part of the overall assessment and included any external and internal risks. All hospice at home staff reported any new risks or emerging risks, to the manager.

The service had a business continuity plan and this was last revised in June 2016. The plan set out what would happen if there was a major or sudden untoward incident at the hospice. The plan covered individual action plans for likely scenarios. These included loss of the hospice building, severe weather, fire, utility failure and disruption to staffing levels.

There were sufficient staff employed by the service. The in-patient unit staff team consisted of the ward manager, ward sisters, qualified nurses, senior health care assistants (SHCA) and health care assistants (HCA). Staffing levels were adjusted as necessary in order to meet people's care and support needs.

The day therapy unit staff team was led by a manager and included nurses, art and complementary therapists, HCA's and volunteers. The service was provided three days a week for up to 15 people a day. Staffing levels were arranged dependent on the number of people attending the unit.

The hospice at home team consisted of a manager, two team leaders (qualified nurses), seven SHCA and 10 HCA's employed on a bank basis. These bank staff informed the team of their availability each month. The service had recently restructured into two teams, team one for those people who could be supported by one

nurse or SHCA and team two, for more complex cases needing two staff. Because of the bank staff the service was able to expand in order to meet demand for their service. The manager worked collaboratively with other hospice at home services if they did not have the capacity to support any newly referred people.

The management of medicines was safe. In the in-patient unit, people's medicines were stored safely in locked cabinets by their bedside. Controlled medicines (known as CD's) or other specific medicines for 'sedation' had separate storage arrangements. There were strict procedures in place for the receipt, administration and disposal of CD's. For those people who were at risk of a catastrophic event (for example a bleed) supplies of 'just in case' medicines were stored securely at their bedside to enable the medicine to be administered quickly in the event of an emergency. There were very stringent procedures in place to sign the medicines out of the treatment room and in to each person's own locked cupboard. The in-patient service had introduced a system of single-nurse-administration-of-drugs (SNAD). This meant the nurses were able to administer medicines more quickly to keep people comfortable.

Medicine supplies were obtained from the local NHS Trust and a dispenser from the NHS Trust visited the service on a weekly basis, checked medicine charts and stocks of medicines. There was a service level agreement in place to supply stock medicines and to respond to requests for medicines. The service kept a stock of certain medicines, for example antibiotics and intravenous medicines. Medicines no longer required were returned to the hospital for disposal.

Any medicines that were required to be kept cool were stored in a medicines refrigerator in the locked treatment room. The temperature of the refrigerator and the treatment room was checked and recorded each day. There was also a refrigerator for the storage of any blood products supplied for named peoples. There was evidence of strict and safe management and checking procedures to ensure that the management of blood products and the safe administration of blood to a person was closely monitored. The service was noted to have an agreement with the NHS and they provided a weekly monitoring visit to ensure compliance as part of this agreement.

The service kept a supply of oxygen concentrator units and oxygen cylinders for those people who required oxygen therapy. Warning signs were displayed where oxygen was in use and stored and each day the PEEP's for each in-patient were updated to indicate this information. A set of resuscitation equipment was located in both the in-patient and day therapy unit.

The service was currently completing a six month trial on the use of 'just in case' medicine bags. People who were discharged from the in-patient unit with 'just in case' medicines were provided with brightly coloured bags to keep those medicines, separate from their regular medicines. The introduction of this initiative allowed the community nursing team easier access to these medicines.

People in receipt of a hospice at home service and the family supporting them were encouraged to retain responsibility for their medicines where possible. Nurses administered medicines when this was needed during their visit. The nurses used the medicine charts completed by the district nurses. There would be a discussion between the hospice nurses and the district nurses regarding symptom control and if needed, the setting up of a syringe driver. All nurses were trained to set up syringe drivers. Health care assistants who worked within the hospice at home team were not involved with people's medicine, but would liaise with the nurses if they needed to report a change in the person's condition.

Is the service effective?

Our findings

People and their relatives told us the service was effective in providing end of life care. Comments included, "Mums death was a good death. We thank the hospice at home staff for achieving this", "She (named person) is very scared about dying but she is being very well supported and is in the best place. The family are being supported too", "My sister said this is the place she wanted to die, not at home or in the hospital", "All the staff know what to do and this is very reassuring. He (named person) is in good hands" and "I cannot stress how marvellously supportive the service is. All the staff are so professional and compassionate".

Staff gave us overwhelmingly positive feedback about their experience of working for the hospice service. They said, "We are all determined to get the service right for everybody. We only have one chance to get it right", "This is a very supportive team" and "I am proud to be part of such a fantastic inter professional team. We share one common interest and are all so passionate about what we do". One volunteer told us they were very much valued as part of the team providing support to people on the wards and those using the day therapy service.

The in-patient unit admitted people 24 hours a day 7 days a week from the community. Health and social care professionals reported the service was fully effective in meeting their aims. They said, "We have regular contact with the hospice at home team when they are caring for our patients, they have excellent skills in caring for the dying and communicating with families", "The service wholeheartedly supports staff with clinical supervision and this enables the service to grow and develop", "The hospice at home team work in partnership with us (district nurses)", "I have always found the staff and volunteers at Leckhampton Court to be very obliging in regards to advice and support that is required. Staff will contact our team directly. I have regular meetings with managers and the link nurses". The Gloucestershire Hospitals NHS Foundation Trust in October 2016 had graded the service as excellent for being an effective educational environment and a safe supportive working environment for the GP trainees.

The service had a programme of mandatory training all staff had to complete, organised and overseen by the practice educator. They were responsible for the mandatory programme, skills development and student nurse placements from the university.

The provider's palliative care training module was an accredited course which ran every two years. It was open to qualified nurses and allied health care professionals. In addition there were stand-alone days for areas such as symptom management. The single stand-alone training days were also available to staff outside of the hospice setting and could be accessed by community nursing teams and care home staff. The service participated in a county wide training programme along with two other hospice services in Gloucestershire.

Newly recruited staff had an induction training programme to complete at the start of their employment. Any new member of staff was supernumerary for the first two weeks and had generic and role specific training to complete, including one corporate induction day. One member of staff we spoke with who had recently started working at the service already had the date planned for the corporate induction day and

was working through their induction modules. They said the induction programme was preparing them to do their job well.

The service organised monthly palliative and end of life care forums on the third Tuesday of each month and all staff were able to attend these. Examples of forums already held in 2016 included palliative care emergencies, research in palliative care, discharge planning at end of life and tissue viability. Staff we spoke with during the inspection talked about the benefit of these forums and said they tried to attend as many as possible. These forums were open to all staff in the hospice and all health and social care staff in Gloucestershire. The forums were well attended by staff external to Leckhampton Court. This meant hospice staff were able to share their expertise in end of life care with other 'general' care workers. One member of staff from the hospice at home service described the forums as "massively valuable" and meant they were able to provide better care to people.

Student Nurses on placement from the university worked in the inpatient unit and their learning needs were fully supported by appropriately qualified mentors. An extension to these placements has been explored along with the provision of a community nurse placement using the day hospice and hospice at home service as well. The University of the West of England (UWE) were visiting the service in November 2016 to discuss the positive feedback from student nurses and to demonstrate to the Nursing and Midwifery Council (also attending) the value of the placements for improving end of life care outside of this service. It was evident the service was a valued placement for new nurses. People not necessarily being looked after by this service would therefore benefit from the good education the student nurses had received at Leckhampton Court.

The consultant in palliative medicine told us the hospice had an important role in education, not only for nurses but for doctors as well. GP trainee's had placements at the service. The service was also at the forefront of hospice research. They employed one part time research nurse who participated in studies which had originated elsewhere plus other 'home-grown studies'. The consultant was a member of the Association for Palliative Medicine of UK and Ireland Science Committee and led on hospice research for them, for example symptom control and better pain management. Following the inspection we were informed the consultant had won The Public Sector Hero Award in the Heart of Gloucestershire Community Awards. He had been nominated by two families for the support and care given when their relatives were receiving end of life care.

It was evident from these examples that this service was rated highly by educational establishments, with the staff team developing the skills of new workers who would then take their learning and experiences, to work in other health care services.

All staff were supported to do their jobs effectively. Performance development reviews were undertaken annually with a further review at six months. All staff had 1:1 supervision support sessions with their line manager plus there were group supervisions, staff meetings, de-briefing sessions and spiritual support from the chaplain. One nurse told us that at the end of a difficult shift, the team would get together for a 10 minute meeting. The team would get together for a 10 minute meeting to reflect and share their thoughts and feelings after a difficult shift to ensure staff were supported and emotional resilience was attended to. This enabled staff to fully support people and their families because their needs were met. This support was in addition to clinical supervision, which all staff had access to. In addition to this monthly case discussions were held by the practice educator, open to all hospice staff. These offered an opportunity for discussion and reflection regarding specific cases that had challenged and stretched the whole team. Nurses worked alongside the health care assistants and were always on-hand to offer advice and support. Senior nurses received clinical supervision support from an external source and this was being considered for other

qualified nurses.

The hospice director used a weekly email chat to communicate with all staff. This was used to inform them of events, achievements, staff changes and any other newsworthy information. Several of the staff who provided feedback told us the hospice director was a regular visitor to the in-patient and day therapy units and to the hospice at home team. One member of staff described the director as "contactable and approachable" and this was a sentiment expressed about all the senior managers.

Each person's ability to make decisions for themselves was assessed as part of the admission to the in-patient unit or the setting up a day therapy service or hospice at home service. Staff had received face to face training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They understood the principles of the MCA and DoLS and the implications for their day to day practice. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty of people who lacked the capacity to consent to the treatment or care they needed.

Staff were aware of the principles of the MCA and knew the importance of gaining consent before they provided any care, support and treatment. They referred to best interest decisions when supporting people who were unconscious and at the very end of their life. All decisions made were clearly documented. Those people looked after in their own homes by the hospice at home service provided consent to being supported prior to entering the end stages of their life.

People and their relatives in the in-patient and the day therapy unit were positive about the food provided. Comments included, "She has eaten more since she has been here than when she was at home. Only small amounts, but more", "The food is outstanding, it really is. It depends on my appetite how much I eat", "I am sure the food is good" and "As a visitor we are offered refreshments which is really appreciated and one less thing for us to worry about".

In response to feedback from people and their families, the service had introduced an out-of-hour's menu. This meant there was a range of hot foods and savoury snacks available for peoples who requested something to eat outside of the traditional meal times.

People were assisted to eat and drink where required. Nutritional needs were identified as part of the assessment process for each person and recorded in their care notes and included their preferences and choices. Where people were unable to eat and drink, mouth care and oral hygiene were provided in order to keep them as comfortable as possible. On admission to the in-patient unit, a member of the catering staff visited people to talk about their individual dietary requirements. The hospice at home staff would support people with eating and drinking where needed but were not involved in the preparation of meals.

The medical care of each person was reviewed each day either by the consultant in palliative medicine or a hospice doctor. There is consultant on-call availability for out-of-hours. This enabled pain management and symptom control to be regularly adjusted. For those people in their own homes, the nurses and health care assistants worked collaboratively with the GP, district nurses and other relevant health and social care professionals. The district nurses were the lead health care professional and there were good systems of communication in place. One district nurse (DN) told us, "We have excellent support from the team. The hospice at home staff provide a fabulous service to our patients. Whenever we want complex patients admitted to the in-patient unit they go out of their way to accommodate them. If a bed is not available we will do joint home visits with staff to support care in the person's home".

Is the service caring?

Our findings

People and relatives were overwhelmingly positive about the care and support provided in the in-patient unit, day therapy unit and by the hospice at home team. Comments we received included, "They have been fantastic here (in-patient unit), they are caring kind and nothing is too much trouble", "The staff are so caring and understanding. They are fantastic", "The staff are all very nice and the volunteers are fantastic. We are all in the same boat and I have made new friends (day therapy unit)", "You cannot fault it here – the staff are brilliant, caring, respectful and kind" and "The staff just knew when the end was near and they respectfully withdrew in to the background and left us to be with mum. That was so special".

The registered manager told us about occasions when staff had responded to people's specific 'dying wishes'. They gave us examples of big things they had helped people to achieve but also the little things that had meant so much to the person. One person had wanted to visit a treasured place one last time and the staff had worked with the family and other parties to make that happen. Other examples included assisting a person to get ready for their marriage ceremony, visits to the in-patient unit by a person's cat or dog, being taken out into the gardens, or to a show in Cheltenham.

The service displayed every single thank-you letter and card received in albums, near the main reception area. All the comments in these letters and cards were again very complimentary and full of praise for the service. In this same area there was a book of remembrance. The page was turned over each day and showed a record of who had died the previous years. Families were able to visit the hospice on the anniversary of the person's death and were comforted that their loved one was "still remembered".

The hospice at home team had also been highly complimented on the caring nature of the service they provided. Comments in letters of thanks included, "We appreciated the unrivalled level of care you provided", "Without your support our family would have struggled with the challenges we faced. Sue Ryder's calming support was a beacon in those very dark hours", "You are truly brilliant. It was so important to her to be able to stay at home surrounded by her family. With your compassion and skill this was possible" and "You were so kind and gentle with him and so helped maintain his dignity right up to the end".

Healthcare professionals told us the service was extremely compassionate. Comments included told us, "The care provided is very person-centred", "The staff who work for the hospice at home team are very caring and provide care of a very high standard", "The staff are professional, compassionate, caring and provide expert support" and "The staff very much have a 'can-do' attitude and would always do the best for people". It was evident the service was well thought of in Gloucestershire and provided an excellent, caring service to those people who needed this specialist care and support.

All staff we spoke with were passionate about getting things right. They all had chosen to work within a palliative care environment and were highly motivated to provide the best possible service. They talked about the high standard of care every single people received. One nurse said if there had been a difficult shift, the staff team would have a 10 minute de-brief at the end of the shift to see if things could have been done differently. Another comment made was that the hospice at home staff had great working

relationships and supported each other through the sensitive and emotional parts of the job. It was evident all staff received loving and caring support from their colleagues and the managers to enable them to do, what was at times a very difficult and emotional job. All staff spoke about the people they supported and had supported, in a kind and respectful manner. All said they would recommend the service to others.

The service had a hospice chaplain who worked with a team of spiritual care volunteers with the aim of bringing peace of mind to people, families and carers. The team offered opportunities for remembrance following bereavement. This was an important part of the hospice's care philosophy and feedback showed this offered huge comfort. The service, in recognition that special occasions such as Christmas were particularly difficult for those who had lost someone, organised a special remembrance service called Lights of Love.

During our inspection visit, we observed the chaplain in the day therapy unit. He spoke with each person who was attending the day unit and those there for an appointment with one of the therapy team. He knew each person by name and had a very calming influence, listening intently to what they had to say. The chaplain told us their remit was to get alongside people, ignoring the medical situation and being interested in the person. They told us they had helped people who were dying to re-affirm their marriage vows and had on occasions led a funeral service at the family's request. The chaplain helped people and their families to express their views and to not "leave things unsaid".

As part of their caring responsibilities the chaplain also had the role of engagement champion within the staff team. They acted as a channel of communication between staff and senior managers interpreting instructions from head office and advising on how these may be implemented in practice at hospice level. The chaplain was part of the rota of senior staff who facilitated reflective practice sessions held weekly and open to all clinical staff. These offered an opportunity for staff to reflect, share, challenge and support each other through the challenges of palliative care. One member of the hospice at home team described the chaplain as having "an incredibly soothing personality".

The families of people who had died in the in-patient unit or in their own home were offered bereavement support after death. They were contacted by telephone and sent a card informing them of the support the family support team can offer. Where a parent had died, the hospice would signpost the surviving parent to specialist children counselling services when this was needed. In addition families were told about the on-line national Sue Ryder initiative. This provided peer to peer support for bereavement and end of life issues and was open to all. Leaflets and signposting regarding this initiative was given to all family members and was displayed at the hospice and on the television screen in the reception area.

The hospice had a family support team and a new head of family support had just taken up post. The team mainly provided bereavement support and planned to introduce pre-bereavement support for both people and families. A carers support group met on a monthly basis and was primarily for the carers of people who attended the day therapy unit. This group enabled carers to be supported, to discuss any worries they had, provide practical help and explore solutions which would help them continue in their caring role.

We saw many incidences of loving care and positive interactions between the staff and volunteers in the in-patient and day therapy units. One nurse and health care assistant spent time getting a person comfortable. When they said they still weren't comfortable, the staff tried other alternatives until the person was satisfied. Volunteers served people's hot drinks and chatting with them. We sat in on a handover reporting sessions at the start of a new shift for nurses where the ward sister was talking about the in-patients. We noted that when the telephone was answered the nurse giving the handover stopped her report. This ensured details about people's personal information was not overheard by the caller. This showed great respect for the

people they were looking after.

Is the service responsive?

Our findings

People and their families said the service was extremely responsive. Comments included, "I get the exact help I need. I would not be able to manage to stay in my own home if it wasn't for the nurse and care staff who come and help", "As my wife's condition deteriorated, the help provided was increased. I didn't have to ask, it just happened", "It was the extra little bits the staff did for my wife that made all the difference. They helped her with her make up even when she was near the end. They brought round the Easter bonnets made in the day centre that the friends she had met had made. This made her still feel involved in the outside world" and "The nurse was brilliant. She talked us (the family) through what was going to happen and helped prepare us. As a family we feel we were lucky to have been able to have the support provided by the hospice at home team". One member of staff whose family member had used the service said, "The standard of care was excellent. (named person) did not get preferential treatment just because I work here, Everybody gets exceptional care".

People who used the services were provided with information about Leckhampton Court Hospice. The booklet had been revised in August 2016 and detailed the services and facilities available. It detailed what to do if they were unhappy about any aspect of their care. The hospice at home service had an information leaflet which they gave to families and this included contact details for the hospice at home manager. This meant that people and their families knew what they could expect from the service.

People and their families told us they knew what to do if they needed to raise a concern but each of them made it clear they had no reason to complain about anything. Everyone we spoke with was confident that the staff would listen to them if they were unhappy about anything and would do their best to resolve any issues. A copy of the complaints procedure was given to all in-patients and their families, those who attended the day therapy unit or used the hospice at home service. The service welcomed feedback and appreciated suggestions and comments that could be used to shape the service in the future. It was evident that any learning from complaints was seen as a tool for driving improvements with the staff teams using reflective practice to identify where things could have been done differently. There had been two recent complaints and both had been handled according to the complaint procedure.

People's care and support needs were fully assessed by the doctors and the nurses on admission to the in-patient unit. As much information as possible was gathered prior to the admission from relevant health and social care professionals. We saw this happening with a newly admitted person. As from the 4 October an electronic care planning system had been used. This recorded the treatment option being followed and critical information about the person, which guided the nurses on what actions to take. The core care plans were personalised with additional text, added by the nursing staff following discussion with the person and their family. It was evident that people were treated as individuals and received individualised care.

Each person had a 'do not resuscitate' (DNAR) discussion with a doctor on admission to the in-patient unit and this was clearly documented in their care notes and communicated to all staff who need to know. The recording of people preferences for preferred place of care, preferred place of death, and any advance decisions were documented within the person's medical records and reviewed at weekly multi-disciplinary

meetings. As part of the hospices continuous improvement cycle an internal quality inspection in August 2016 shortfalls had been identified. The registered manager had introduced a new template which focused on a review of these discussions. A follow up by the quality team in October 2016 had found the required improvements.

At the beginning of each new shift the nurses and health care assistants received a handover report at the bedside with the person and family present. People and family members were given the opportunity to have a say if they wanted things done differently or if they needed additional help in any way.

Referrals for the hospice at home service were received from the district nurses or the person's GP. The first visit was undertaken by the hospice at home manager or one of the team leaders, all qualified nurses. An assessment of their care and support needs was completed and an agreement made with the person and their family regarding how the service could support them. The service provided was based upon the person's specific needs and the support required by the family. Visits were provided overnight and during the day and supported people's wishes to die in their preferred place of death.

Care plans were reviewed as required by the needs of the person in all areas of the hospice but at least on a weekly basis. People were asked to contribute to the development of their care plans and these were personalised to their individual needs. At all times the person had the final consent to the care they wanted. Electronic care records were in the process of being introduced and could be accessed by the day therapy unit and in-patient unit. On a daily basis a record of each visit by the hospice at home staff was made as a paper record but this was then transferred on to the electronic records. Electronic mobile working was in the process of being further developed with the clinical team continuously reviewing to ensure best practice.

Each person in the in-patient unit had a white board by their bed informing them of the nursing team caring for them that day and who was the nurse in charge was for the shift.

Each person who received support from the hospice at home team had a named nurse who co-ordinated on-going care and communication with the district nurses. The team used a confidential NHS email service in order to exchange information. Information would be relayed back to the district nurses after each visit. These measures ensured all services were able to respond to changes in a person's condition and to instigate changes in service provision promptly.

Multi-disciplinary team (MDT) meetings were held each week, chaired by a senior clinician and attended by the consultant in palliative care. These meetings ensured a complete multi-disciplinary assessment was made of each person and referrals within teams were made as needed. Attending health professionals included the physiotherapist, occupational therapist, social worker and family support team. The team also discussed those people who had died or been discharged within the previous seven days and discussed any pertinent issues. The MDT plan and outcomes were documented, reviewed and shared with the patient.

People, and their families, were asked to share their views or make comments during their stay, whilst attending the day therapy unit or receiving hospice at home. The service actively sought views, opinions and feedback from people and families. Examples of things they had done were detailed in the In-patient handbook where a section on "you said, we did" detailed responses to comments and suggestions that had already been made. Volunteers who supported the service had a key role in gathering feedback from people and their families. Their support and gentle exploration gave people a voice at end of life. The registered manager said about 50% of in-patient people gave feedback - this compared favourably with similar units whose percentages for individuals giving feedback was less. Feedback was seen as important and enabled the service to be responsive and make changes based upon how people felt and the service they said they

wanted. They listened to any recommendations being made and told us they planned to also introduce "You said...We did" notice boards in order to demonstrate they were a listening service. Examples of changes made as a result of feedback have been included in the well led section of this report.

Is the service well-led?

Our findings

We did not receive any direct feedback from people and their families about whether they thought the hospice services were well led. The comments they made however supported the fact that the service was well organised, focused wholeheartedly on meeting peoples' needs well and provided good end of life care services.

The registered manager (head of clinical services) was supported by the hospice director and a senior management team in delivering a well led service. Support external to the hospice, was given by the Sue Ryder chief nurse and the deputy chief nurse who provided strategic and operational support to the hospice.

A feedback system was used to gather the views and experiences from people in the in-patient unit. Volunteers would meet with people and ask them to talk about their stay. The feedback was recorded on a tablet and could be used either by the person or the volunteer. People were able to complete the survey anonymously if they wished. People were asked to comment about their experience of care, meal times and the environment. There was an expectation the majority of in-patients would be asked to provide feedback. All feedback was forwarded to the registered manager for analysis.

Written survey forms were sent to people and their families who had used the hospice at home service. They were asked to feedback about their experience, whether their expectations were met, what the service did well and what did not go well. Feedback was collated and action plans devised where trends were identified, in order to change practice where possible.

One of the ward sisters on the in-patient unit had set up a service user group as part of their clinical leadership training programme. The group had been running for 18 months and a number of initiatives had already been implemented. The chair of the group was one of the service users which meant the remit was driven by first-hand experience.

Examples of improvements that had been made as a result of the various means of gathering feedback included 'service user questions' at staff interviews, mugs instead of cups and saucers, personalised bed spaces in the in-patient unit and the introduction of additional information leaflets (what to bring with you when you come in to the in-patient unit). These were examples to show the provider listened to the people who used the service and then took action to make the required improvements to the quality of the service.

The hospice at home manager was a Queen's Nurse. The Queen's Nurse award was given to those nurses who had demonstrated a high level of commitment to people's care and people-centred care. Nurses would have to demonstrate a high level of commitment to people's care and nursing practice. The two team leaders were currently working towards this award. All three had also completed an internal 'Be Incredible' management development programme. According to one staff member we spoke with this enabled them to provide good leadership and management of their staff team.

Nurses were allocated lead roles in a number of different areas. These included safeguarding adults and safeguarding children, management of medicines, infection control, falls management, dementia and specific medical and nursing procedures (stoma care, diabetes and pressure ulcer management for example). These nurses received additional training and were a source of guidance for the staff.

The registered manager produced monthly performance reports. These reported on issues such as, mandatory training, safeguarding, any infectious events, pressure ulcers acquired during a hospice stay, falls, medicine incidents and service user feedback. The report also included the bed occupancy levels for the in-patient unit, the number of hospice at home hours delivered and staffing issues.

Quality improvement group meetings were held on a monthly basis. The heads of departments, the director, registered manager and the senior nurse managers attended these. The matters discussed in these meetings were aligned to CQC's five key questions (Is the service safe, effective, caring, responsive and well-led). These measures ensured the quality of care and support and the service provided by the hospice was maintained at the standard they expected. Where any improvements were identified, the appropriate manager was provided with an action plan and this was followed up at the next meeting.

The provider had a team of clinical quality assessors and health & safety assessors and they had visited the hospice on 16 and 17 August 2016. They produced a quality and safety visit report and this was also in line with CQC's questions. Those areas where improvement was needed were rated and either had to be completed within one month (immediately if stated), within two or three months. The action plan had been revisited in September and October and was next to be reviewed on 8 November 2016. This evidences the provider has robust measures in place to assess the quality and safety of the hospice service and they were effective.

Other audits were completed and included an annual infection prevention and control clinical audit, pressure area care and equipment, an annual audit of medicines management and quarterly audits of controlled drugs. Regular audits were completed in respect of information governance and this included care documentation. Closures of all audit cycles were discussed at QIG meetings as part of quality improvement plan.

The service kept records of any accidents, incidents and near misses and the follow up action taken. The registered manager produced a 'Leckhampton' specific incident report and shared this at the QIG meeting detailing all incidents that had occurred in the previous month. The report contained information about the learning taken from the incident and steps taken to reduce the risk of them occurring again. The service had a culture of reporting all incidents and near misses to ensure learning and to promote a strong safety culture. The registered manager contributed data to monthly performance reports produced by the quality team, this was then used, discussed, analysed and an action plan prepared where necessary. In the quarterly review meetings with the chief nurse, director of palliative care, director of finance and the hospice director, the action plan was reviewed to ensure actions had been taken.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the service and which the service is required by law to tell us about. This meant we were able to monitor how the service managed these events and would be able to take any action where necessary. The registered manager and hospice at home manager were aware that notifications to CQC were only required if a person died whilst the health care assistant or qualified nurse were providing a service at the time of death.

The service worked together with other local hospice services with the aim of promoting, supporting and

facilitating good communication. They also shared good practice, provided peer support, offered a single point of access for commissioners and presented a unified and cohesive perspective of hospice care. This collaborative approach benefited the people of Gloucestershire and meant that on occasions people could be supported by more than one hospice service if necessary.

The service was members of the national Hospice UK association and staff attend conferences and regular meetings with the South West branch. This enabled the hospice to share good practice and learn about the way things were done in other hospices. The service kept a well-stocked library of resources to enable the doctors, nurses and health care assistants to keep abreast of all the up to date guidance.