St Michael's Hospice (Incorporating The Freda Pearce Foundation)

St Michael's Hospice

Inspection report

St Michael's Hospice
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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?	Outstanding ☆
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 30 and 31 March 2016 and was unannounced.

St Michael's Hospice provides care and treatment to people using the 20 bedded inpatient unit, day service, community nurses and hospice at home service and outpatient clinics. People may also receive support from the hospice's transport and a telephone triage service. All these services provide specialist palliative and end of life care to people over the age of 18 with life limiting illnesses. At the time of our inspection eleven people were using the hospice inpatient service.

There was a registered manager in post who was also known as the director of care. 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.

People were protected from harm and abuse due to the arrangements in place to make sure risks to people were reduced. Where people were at risk due to their health and physical needs these had been identified with measures put in place to help people to manage and reduce any known risks. Staff and volunteers had been suitably recruited and there were sufficient staff with a variety of skills to meet people's individual needs and to respond flexibly to changes.

Staff received the training and support they needed and were highly motivated to do their roles and deliver sustained high quality care. This included staff having the skills to effectively manage people's medicines so these were available and administered safely to people. People were extremely confident and positive about the abilities of staff to meet their individual needs.

Staff worked closely and in partnership with external health and social care professionals and providers and health commissioners. They also worked with educators and national organisations concerned with palliative and end of life care. This helped to ensure people received the right care at the right time and that knowledge was appropriately shared and used to influence best practice for people's care.

People told us they were supported with their nutritional needs with the assistance of the chef. They checked people's choices with them as they served meals which were both nutritious and presented in a way which met people's needs so that they could enjoy their meals comfortably.

Staff treated people with care and compassion and were highly motivated and committed to providing people with the best possible palliative and end of life care. Staff were kind and thoughtful to people. People told us staff spent time listening to them, did not rush them, and did all they could to meet people's individual wishes and requests. People's individual needs were assessed and staff always encouraged people to make their own choices about their care and treatment. Where this was not possible issues of

consent and decisions were made in people's best interests by people who had the authority to do this.

People received care that was tailored to their individual needs. Both people who used the service and family members were highly complementary and satisfied with the care provided, which they often described as excellent. People and family members felt they mattered and their views were taken seriously and acted on. Staff worked alongside people to enable them to live as full a life as possible and supported people in achieving their wishes with key comments from staff who believed they went the extra mile. People were supported to receive end of life care which met with their needs and wishes to achieve a private, dignified and pain free death. People, their families and staff were provided with the emotional and bereavement support they needed.

People were placed at the heart of the services they received by the strong values held by the management and staff team around supporting people to have quality of end of life care which was responsive to enable people to live their lives as they wished until their died. There was a strong sense of commitment within the management and staff team to source new initiatives and find creative ways of responding to the varied needs of the local population. Education, research and working in partnership was actively encouraged and supported to provide not only care and treatment but therapeutic benefits to people.

People and their family members, staff, board of trustees were actively informed and involved in developing the service. Their views were used to continuously inform service improvements and development and to influence the services people received so that these remained innovative, effective and raised quality where needed. The management team were continuing to make improvements and develop the hospice services further to ensure people received safe and effective palliative and end of life care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were kept safe because there were sufficient staff to meet their assessed needs. Individual risk assessments were prepared with people and measures put in place to reduce the risks of harm. People medicines were stored, available and administered safely.

Is the service effective?

Good

The service was effective. People's choices were respected and they were involved in decisions about their care and treatment. People received effective care, treatment and support from a diverse staff team, who received the training and support they needed to be able to undertake their roles. Staff worked closely with external organisations, commissioners and health and social care professionals in a way which made sure people received the right care at the right time. People were appropriately supported and encouraged to eat and drink.

Is the service caring?

Good

The service was caring. People were supported in a caring way with dignity, respect and kindness. People were supported to have choice and to be involved in all aspects of their care. People were treated with the utmost care and compassion and received a dignified and pain free end of life care and support.

Is the service responsive?

Outstanding

The service was very responsive. People were treated as individuals and were enabled to live as full a life as possible. People, their families and staff really mattered and their views about the care and treatment provided were sought, respected and acted on. People received exceptional end of life care and support, which met with their needs and wishes from highly motivated and committed staff. People and their families were provided with the emotional and bereavement support they needed, both during and after end of life care. Effective

information, communication systems and shared working, meant people's care and treatment was consistent, flexible and properly informed to meet their needs.

Is the service well-led?

Good

The service was well led. People believed the service was well managed and they received high quality care which effectively met their needs. The leadership team and staff shared strong values and beliefs centred on offering a personalised service to each person to fulfil their wishes. There was a focus on continual improvement to ensure the services people received were creative, effective, safe and of a high quality.

St Michael's Hospice

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.

This inspection took place on 30 and 31 March 2016 and was unannounced.

On the first day of this inspection the team consisted of one inspector, one member of the CQC medicines team and a specialist advisor who is a nurse and a practitioner health lecturer in palliative and end of life care. (Palliative care is specialised medical care focusing on providing people with relief from symptoms and stress of a serious illness). On the second day one inspector concluded the inspection.

We checked the information we held about the service and the provider including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We sought information about the quality of service from the local authority and the clinical commissioning team. In addition to this we requested information from Healthwatch who are an independent consumer champion who promote the views and experiences of people who use health and social care. We used this information to help us plan this inspection.

We spoke with four people, six family members and two friends in the inpatient service and one person who attended the day hospice. We saw the care people received which included spending time in the day hospice. We also attended two meetings with groups of staff and volunteers to discuss the needs of people who were using the inpatient and day hospice services.

After our inspection we spoke with three family members of people who used the hospice at home service by telephone. We also sought the views about the quality of the services people were offered at the hospice from a range of professionals. These included a consultant in palliative medicine and a general practitioner (GP).

We spoke the registered manager, medical director and chief executive. We also spoke with a range of staff which included the head of inpatient care, advanced nurse practitioner, social worker, chaplain, two nurses, day service nursing sister, two healthcare assistants, two volunteers and the chef.

We looked at four people's care documentation which included four medicine prescription charts. We also looked at the reports relating to the management of the service. They included checks of the quality and safety of people's care, projects, compliments and complaints.

Good

Is the service safe?

Our findings

People told us they had no concerns about their own safety and how staff provided care and treatment. One person who was spending time on the inpatients facility told us they felt, "Absolutely safe and comfortable, they (staff) have shown nothing but kindness to me." One family member whose relative was provided with care at home said, "Exceptional care from exceptional people who jolly well-made [person's name] feel safe and cared for."

We saw a wide range of possible risks to each person's wellbeing had been considered and assessed, for example people's physical abilities and skin care needs. People's care records detailed the action to be taken to prevent any identified risks and staff spoken with knew how to manage the risks to people. One person was at high risk in regards to their skin needs as they had experienced pressure ulcers. We saw to reduce the risks to this person they had appropriate equipment in place, such as a special mattress and chair cushion to sit on to help to relieve the pressure on their skin. For another person, whose physical abilities could be unpredictable thought had gone into ensuring their individual needs had been assessed by the physiotherapist. We saw they had the equipment they required to not only promote their level of independence but to relieve their feelings of tiredness and breathlessness.

Staff spoken with were able to provide examples of how they assessed and balanced the risks associated with what people wanted to achieve in their lives. At the staff meeting where people's needs were discussed we heard staff shared their different thoughts about how people's goals could be achieved. For example, a discussion took place about how the practical aspects of a person's life could be assessed so any risks could be identified to make sure they were not placed at avoidable harm. One staff member told us, "All the team here will always make sure patients are safe. We discuss safety and risks with patients and gain their views." One person we spoke with confirmed this was the case. They told us, "They (staff) do talk with me about my safety and treatment so I can have an input."

Staff told us how they promoted the safety of people who used the different hospice services. They were clear about to whom they would report any concerns and were confident any allegations would be investigated fully by the management team. Staff said, where required, they would express their concerns to external organisations if these were not listened to by the management team. This included the local authority and the Care Quality Commission [CQC]. Staff said, and records showed, they had received training in how to keep people safe from abuse and there were up to date policies and procedures in place to guide staff in their practice within this area. In addition to this we saw at meetings at board level and with staff any procedures which had been implemented both nationally and locally were discussed to enable a shared awareness. For example, a recent national investigation had produced information around the protection of children and young people as guidance for staff to follow, which had been shared with staff to ensure best practice.

Staff we spoke were aware of the process for reporting accidents and incidents. They were able to confirm how as a result of an accident or an incident changes had been made to show the learning from these. For example, gaps in a person's medicine records had been found and this was currently being investigated. We

were advised the outcome from this investigation would be shared with the staff team to make sure the recording of this person's medicine was accurate. We also saw specific equipment had been introduced for people who were assessed as being at a high risk of falling so injuries could be reduced, as a result of learning from incidents.

We saw volunteers were used creatively to assist and support staff in reducing risks to people's wellbeing across all the services offered. These included volunteers making drinks and supporting people by sometimes just having a chat while people were staying at the hospice and or spending a day there. We heard from a volunteer how they supported people to come to the hospice when required by their driving role so people could safely access the hospice service.

We spoke with people who used the inpatient facility and hospice at home service about the availability of staff to meet their individual needs. People told us they were very happy with the availability of staff and had no concerns about the staffing arrangements. One person told us, "They just appear when I press the buzzer" whenever they needed the staff's support. Another person said, "I can press the button and they (staff) appear, they help me to move about as I want." A further person told us, "The healthcare assistants are always happy to have a chat if I want one." When we spoke with staff they told us they felt there were sufficient staff to meet people's individual needs and spend time with people. One staff member told us they had time to sit and comfort people when this was required.

The registered manager told us they reviewed the skill mix of the staff and staffing levels on a regular basis to ensure the complexity of people's individual needs could be safely met. This included consideration of the layout of the new inpatient facility when deciding the numbers of nurse's required to ensure people's welfare and safety were not placed at avoidable risk. A recruitment drive for additional nurses had been successful which was driven by making sure the staff with the right skills were in place.

We looked at the procedures which were used to check the suitability of staff and volunteers before they started work in any of the services offered to people. We saw appropriate employment checks had been completed. This included the Disclosure and Barring Service (DBS) check to make sure people employed were suitable to work with people who used the hospice services. We also spoke with a staff member who had recently been recruited. They told us how they had completed an application form, attended an interview and references had been obtained before they started work at the hospice.

We checked the medicines prescribed on four prescription charts. We noted that there was clear recording of the prescribed medicines which also included additional instructions for safe administration. One person told us their medicines were received on time and of the staff,"They are very, very good. I have no complaints at all". Another person told us that their, "Pain control has been much better" since being at the hospice and that, "Staff come quickly when you need assistance."

The service used the local trust for the supply of all medicines including out of hours. Nursing staff could also obtain medicine from local community pharmacies out of hours. A specialist pharmacist from the local trust came to check prescriptions each week. If advice from a pharmacist was needed at any other time, staff could contact the pharmacist.

A clear system for managing the ordering and supply of medicines including controlled drugs was in place. Medicines were checked when a person was admitted to the service by a doctor and a nurse to ensure medicines were accurate and current.

Medicines that people brought in to the hospice were used in addition to medicines prescribed by the

hospice doctors. These medicines were kept in people's rooms in a locked cabinet. Only nurses had access to these medicine cupboards. Arrangements were in place to enable people to look after and self-administer their own medicines following a risk assessment.

Medicines that were kept in stock were stored securely in locked cupboards in a locked treatment room. Only authorised staff had access to the treatment room. Processes were in place to check medicines were within their expiry date and suitable for use. Daily temperature records were available which recorded the temperatures for the medicine refrigerator and the medicine room temperature. This ensured that medicines were stored within safe temperature ranges

Prescription pads were securely locked away with a copy kept of what had been prescribed on each prescription for audit trail purposes.

Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored securely and monitored appropriately.

Medicine incidents were reported and arrangements were in place to ensure they were investigated and an action plan was completed. They were discussed at regular meetings and a monthly report of incidents was produced to share learning with all clinical staff.

We saw limited evidence that safety alerts were being looked at regularly. This increases the risk that medicines and appliances that are no longer safe to use would still be in use. In the event of an allergic reaction [anaphylactic reaction] there were emergency medicines available on site but the provider was looking in to quicker access to these medicines.

Good

Is the service effective?

Our findings

Without exception people spoken with believed staff had the knowledge and skills to meet their care and treatment needs. One person told us, "They (staff) are supportive staff but not in your face" and they really know what they are doing with patients here." One family member said, "I have peace of mind that she's getting extremely good care."

Staff and volunteers spoken with told us their induction and training had supported them to provide the care and support people required. One staff member told us they had completed a structured induction which included training and opportunities to shadow colleagues. Two volunteers we spoke with also confirmed the training opportunities they had received had been worthwhile and supported the knowledge they needed within their different roles. The registered manager reviewed the induction and training programmes provided to staff on an on-going basis to ensure these were supporting staff to feel confident and competent in their roles. As part of this review the registered manager used the interviews they had with staff before they left their employment to drive through improvements. We were provided with an example where the induction programme had been reviewed to make sure nurses gained the skills required to provide effective palliative care and treatment.

Staff told us about the training opportunities which were available to them. One staff member told us, "There is no short supply of on-going training opportunities. I have done many courses from moving and handling to communication skills. All have been very well presented so I have been able to develop my knowledge." Another staff member told us they had attended a master's programme in advanced nursing practice as well as clinical training around syringe drivers and blood transfusions. (Syringe drivers are used to provide people with a continuous supply of medicines to aid their comfort).The staff member said they really enjoyed palliative care and confirmed, "I can look after someone in the last days of life and care for that person right through to last offices, it is an honour to do that."

We saw and heard many examples where staff used different aspects of their skills and knowledge to good effect to ensure people received effective care and treatment to meet their needs. One person told us with the support from the physiotherapist they had built up strength in their legs by using the bike in the gym. They said this had helped them to improve their physical abilities as they were now more independent when they moved from bed to a wheelchair. We saw how this person was able to move from their bed to a wheelchair unaided. Another person had been referred to the inpatient facility by the community nurses who noticed the person needed some help to manage their pain. We spoke with their family member who told us, "They are doing a good job working on the pain management; they are working at (person's name) pace."

Staff we spoke with told us they were provided with regular supervision and support. One staff member said, "Since I started to work here I have found the support I have received to be exceptional both from colleagues and the managers." Another staff member told us they were well supported in their role, "[Name of person] is my line manager and she is very approachable." This person also said complementary therapy, counselling and psychology support were available when they needed any of these. Shift handover

meetings, a communications noticeboard, written notes and regular staff meetings were used to ensure staff kept up to date with changes in people's care needs and any important events.

We saw and heard how staff effectively provided care and treatment which was centred on each people. There were examples where staff had considered people's physical, mental, emotional and spiritual health needs. One family member told us, "I have even enjoyed a massage from the complimentary therapy team." Complementary therapies were readily available and people and their families could access psychological therapies if this was required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in hospices are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff spoken with knew about their responsibilities to make applications to the supervisory body for people who did not have the mental capacity to agree to any restrictions placed on them in order to promote their safety and wellbeing.

Staff we spoke with were able to tell us how their training had helped them to understand the importance of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) in their roles. Staff spoken with told us people's consent to their care and treatment was always sought and we saw this was the case. Where this was not possible this was done in people's best interests with people who knew them well and were authorised to do this. One person we spoke with told us staff had involved them in the decisions about their care and treatment. We saw staff gained people's consent during the day of this inspection about their everyday decisions, such as, asking about medicines for pain relief and what to eat and drink.

We saw people had been supported to make advanced decisions about their future care in the event of them not being able to make that decision at that time. Legal documentation was in place which provided information about people's wishes in events, such as; if their heart were to stop of they were to stop breathing. At a meeting with staff we saw these important decisions were discussed alongside people's changes in needs. It was decided that one person would not be able to make their own decision at this time and therefore this was made with their close family member.

People we spoke with told us they enjoyed the food at the hospice and they appreciated the varied and flexible menu. One person said, "The food is marvellous they know how I like it, plenty of gravy to make it soft. A pile of food on my plate puts me off so they give me small amounts so I can enjoy it." Another person said, "The food is absolutely awesome, absolutely brilliant." One family member we spoke with was equally positive about the food. They told us, "The food is amazing and we can all eat together in our room, he is eating really well."

Records showed people's nutritional needs were assessed and monitored to ensure staff could identify concerns with people's nutrition. This assessment also recorded people's required dietary needs, such as reduced sugar and or gluten free diets. One staff member told us when a person had a reduced appetite or difficulty eating and drinking they were encouraged and supported to eat 'little and often.' We saw staff had

the skills to request specialist support from a dietician or speech and language therapist if a person's eating and drinking deteriorated.

The chef we spoke with told us they and all the kitchen staff had on-going training to meet their specific roles and responsibilities. This included food hygiene and handling of food. The chef told us they received information from nursing staff about people's specific dietary needs. They also told us about the direct contact they had with people each morning. They confirmed to us the, "Chef in charge goes round to ask patients what they would like from the menu. If they don't want the main meal on offer we can do anything the patient wants. If they want sausage and chips or fish and chips, we will do it, if that's what they fancy." This practice was confirmed by one person who commented, "Chef comes round every morning to take the menu choices he is so considerate."

We saw staff from the different services within the hospice worked closely with each other and other professionals and services to make sure people were provided with continuous and consistent care. Staff who worked in the hospice at home team had recently integrated with the Marie Curie service to provide a home care service in people's homes. This helped people to benefit from a seamless service which was provided by staff team who brought their different skills and knowledge together as a team to ensure the local population had the resources they needed to provide people with effective care and treatment both during the day and at night.

Good

Is the service caring?

Our findings

People who used the services and family members we spoke with told us they were very happy with the care and treatment provided. One person said, "There is only one place (person's own home) better than this. I am exceptionally well looked after." Another person told us the staff were caring and friendly. They said, "It's such a lovely place, the staff are lovely and they are helpful, it's like a five star hotel."

All staff spoke positively about spending time with people and their family members having time to listen to people and respond to their wishes and not to be rushed. One staff member said, "We really spend time with patients and it is such a privilege to be able to share and be part of people's care journeys."

People told us they were supported by staff who were warm and caring towards them. One person said, "It doesn't matter what you want, they say don't worry we're here for you". A family member of a person who had used the hospice at home service said they, "Loved the dignity they gave him as they talked with him and explained everything along the way." During this inspection we saw staff spoke with people about their individual needs in a sensitive and caring manner.

We saw several examples of the registered manager and staff team's commitment to supporting people's friends and relatives. For instance, one person's two friends visited and they told us they were always made welcome. They told us, "It is so lovely to sit here and drink a cup of tea together. They even get out their best china for us; it is lovely to have such beautiful cups and saucers." We saw the person and their two friends chatted in a relaxed way as if they were at home. We saw there were rooms available if visitors wanted to stay so they could spend as much time as possible with their relatives especially when they were nearing the end of their lives. One family member told us, "They don't just care for (person's name) here they look after me and all the children. I am staying in the room with (family member's name)." We saw how staff had made sure the person had a bigger room to accommodate a second bed so the person's family member could get some much needed sleep.

People told us they were treated with dignity and respect. One person who attended the day hospice told us, "They are angels and they are always help me in a dignified way." Another person who was using the inpatient facility said staff helped them to do what they wanted to do. They said they liked to stay in their room for most of the time with the door closed and this was fully respected. At the meeting we attended on the day hospice we saw and heard staff and volunteers spoke about people in a respectful way. They were particularly caring in their approaches to ensuring people who used the service were individually valued. For example, when a person came for the first time staff made sure they took time to establish what would make the person feel important and what they enjoyed doing.

We saw evidence of the registered manager and staff team's commitment to giving people as much choice and control as possible. For example, one person had a plan to meet their sleepless needs which reflected the times they liked to be woken in the morning. We also saw a sign had been made for the door as they did not like to be checked overnight unless they called for help. Another person was consulted about how they would like their medicines given to them so they were able to express their own wishes.

From speaking with staff and attending the meetings on the inpatient and day hospice facilities we saw staff spoke about people's care and support preferences. This included people's individual wishes at the end of the lives so staff were fully aware of these in order to follow people's preferred choices. One family member told us about their experience of the end of life care provided and said, "He is so pleased and happy we are here he doesn't like hospitals but he loves it here. They (staff) listen and take note of what you want."

We heard from staff we spoke with how people received their end of life care in private whether this was at the hospice or in their own homes. People's families and friends could stay with them during this time and staff offered support. One staff member said, "Looking after families is very important as they need time to say their goodbyes in their own time." They told us if a family wanted their relative to remain in their room at the time of their death this was facilitated as rooms could be adapted.

We saw people and their family members could access a range of support services across the hospice and community setting to suit people's preferences and needs. For example, art and complementary therapist support and bereavement support. In addition to this people were able to access a chaplain so they could gain spiritual and bereavement care and support. One person told us they enjoyed going to church and whilst in the hospice they had taken part in the services and communion in the chapel.

Outstanding ☆

Is the service responsive?

Our findings

Without exception all the people we spoke with told us they were very happy with their care and how staff consistently responded to their care and support needs. One person told us, "They (staff) are all amazing and know exactly how to make me feel at ease and pain free. They are all angels as nothing is too much trouble; they go over and above the call of duty." Another person told us pain had been a problem for them when they first arrived at the hospice. They said how the staff had responded to their symptoms which had resulted in them being free from pain and feeling sick.

Before people received care and treatment at the hospice their individual care and treatment needs were assessed to help make sure these could be met. People's care plans were personalised to the individual and gave clear details about each person's specific needs expectations and wishes. One person shared with us staff were excellent in how they met their needs. They told us staff knew their likes and dislikes really well without them having to remind them. Another person told us how staff had responded to their needs to enable them to enjoy small portions of food. They said, "I am totally at peace here. I know the prognosis; I'm having quality of care."

Staff we spoke with were able to tell us the needs of all people who were using the service at the time of our inspection and how they responded to people's care, emotional needs and wishes. For example, one person had a painful sore mouth and swallowing difficulties. We saw staff and the person told us how staff responded to their individual needs in order keep their mouth moist so they were comfortable. This person told us, "They (staff) have been my saviour's here. The relief when I came through these doors, I can't explain." Another person came into the hospice as they had become unwell and were experiencing a lot of pain. We saw staff were supporting this person with their pain at the time of this inspection. A further person told us how they had found staff's response had enhanced their wellbeing and made them feel good. They said, "One healthcare assistant is a hairdresser and she has cut my hair for me."

There was a strong sense of the management and staff team being aware of the potential impact people's conditions posed to their mental health and wellbeing. Services were offered to people to help reduce the risk of depression, anxiety and social isolation. These included access to the day hospice, psychological support services, complementary therapies and community support groups. One person told us, "I've been an inpatient and a day patient. I don't know what I would do without this place". Another person told us they were supported by the staff to adopt a voluntary role at the hospice. They told us their voluntary work had become very important to them and, "Very few people have not been touched by the hospice, they (staff) care deeply." Another person told us, "I love every minute (of their volunteer role) and I meet some absolutely super people." We saw and heard how volunteers in the day hospice supported people with things they were interested in to reduce the risk of them feeling socially isolated. People were also supported to share their feelings with each other. One person told us, "I walk in here and I feel they all make me feel welcomed and important. I am lucky to have found some solace here."

At the meeting we attended we heard how staff valued each person and wanted to ensure how they responded to people supported them to feel worthwhile and they mattered. For example, one person really

enjoyed swimming which was a topic staff could talk with them about. Staff told us when people enjoyed a particular pastime, such as bridge but could no longer go out to play this with other people they brought bridge players into the hospice. On the day of our inspection we saw people enjoyed singing and the playing of musical instruments. Staff had included the student who was spending some time with them as they said if they wanted to bring in their musical instrument they could.

Staff we spoke with told us of many examples where they supported people to cherish and experience things which they may never have had the opportunity to do before. One staff member told us about a person who had never seen reindeer so staff arranged for this to happen at Christmas time. Another example showed the commitment and enthusiasm of staff to their individual roles. The chef told us about the special meals they prepared for families to celebrate different events or enable the person who used the service and their families just to be together. The chef had recently prepared two separate meals for couples in the hospice to celebrate Valentines. The chef said they were proud of, "Getting to know the patients and putting a smile on their faces, it's so rewarding."

Exceptional thought had gone into making sure families and friends were supported at the time of each person's death. One staff member told us about the great amount of consideration which had gone into creating a small private garden area with a path which led to a gate which opened out to where the funeral directors would leave with the person who had died. The staff member said how this supported families when saying their goodbyes and they could also leave the hospice through this exit if they wished. This garden area was also used as a space for people to have time for reflections after people had died.

The registered manager and staff held shared values of how as team they could contribute to providing the best possible quality end of life care and support for people. One staff member had been encouraged and supported to be innovative. The staff member told us they were supporting people to record films reflecting people's moments in time for their family members as keepsakes when they had died. We saw examples where creativity was embraced by each person being supported to record different aspects of what made them the person they were. For example, people were filmed doing things they enjoyed and were their hobbies. Other people wanted to be filmed whilst they talked about their lives and how important people close to them had been. The staff member told us how sometimes these recordings were played at people's funerals. They said they were working with a local university focusing upon the therapeutic benefits of the recordings to people as they gave them opportunities to talk about their lives and leave recordings for those people close to them to keep.

The management team were committed to engage with the local community to improve the quality of care and to meet the unmet needs of the local people. There was a strong motivation to want to continue to be responsive to people and their families by always striving to improve the range of services offered. For example, one of the chaplain's was enthusiastic about their vision of creating a labyrinth for therapeutic purposes (a circle or spiral for people to purposefully walk through) for all people and their families to access this. We also saw how the visions of the management and staff team had been brought to life by listening to the experiences of people with palliative and end of life care needs when there was a strong feeling to have support closer to where people lived. This ethos had been successful in developing the hospice at home service which was a jointly provided with Marie Curie Nurses who provide care to people with a life limiting illnesses in their own homes both in the day and during the night. This service was set up to provide people with support and care in their own homes so people's wishes to die at home could be fulfilled. One family member whose relative had received this service told us, "Everything about the service is excellent and I rate the staff very high due to how they cared for [person's name]." One healthcare professional's comment read, 'There is no doubt that high quality, individualised and safe care for patients and their families remain at the heart and the overall priority for what the hospice is providing to the people

of Herefordshire.'

Care and support was inclusive and responsive to the diverse needs of the people who used the service which included their family members. We spoke with one of the social workers who told us about how the project they were participating in enabled children and young people to be able to talk and share their experiences. For example, children and young people were writing songs and creating compact discs with these on. The social worker told us, "It's miraculous how they support each other." The film children and young people had made about their journeys when they were faced with a family member dying looked at before the death of the person and following this. This film was going to be used an as education tool across schools and colleges to help other children and young people. Another example of how staff were thoughtful when considering how to help children to cope and express their feelings were the teddy bears which were given to each child by hospice staff to provide another support mechanism and may be of comfort to them.

We saw people had opportunities of making comments about their experiences of the services they received. These were used to provide the leadership, staff and the board with an insight into how effective and responsive services were in meeting people's needs. One person commented, 'it was very helpful for me to stay [person's name] as his wife and carer, to keep our lives as normal as possible, also a bed to sleep next to him, to have cuddles and closeness.' Another person commented, 'To me they (staff and volunteers) were guardian angels they looked after him as though he was their own, they went beyond the call of duty and that love and care he received will stay with me forever. When they prepared him as the end they talked to him as if he was still with us and you can't buy that sort of care becomes it comes from the heart.'

A range of information was provided for people, their family members and friends, which helped them to understand the hospice and relevant external support services and agencies. Accessible information was provided for people about how to make suggestions or complaints about their care. We saw there was a process where people's views including any complaints were captured and taken seriously by the management team as they used these to change any practices and as a source of learning. People we spoke with were positive about staff and the care they received and did not share any complaints with us.

Good

Is the service well-led?

Our findings

Throughout this inspection we saw there was an open and welcoming atmosphere in the hospice. People told us how highly they thought of the staff team which included the management. One person said, "It's like your own family, they get to know you and they look after you. You feel like you are their number one priority." One family member of a person who had used the hospice at home service gave us their views about the service provided. They said, "They (staff team) were amazing. Nothing was too much trouble and they gave me time back to be a daughter."

There was a defined structure to the organisation with a board of trustees and layers of senior managers, managers, staff and support services. The registered manager was aware of their role and responsibilities and was able to tell us about all the changes which had taken place since they came into post. One of the big changes for the management and staff team had been the building of the new hospice which in parts was still on-going. This included the registered manager making sure they had the right skill mix of staff and numbers to make sure people received safe and effective care and treatment. This was specifically around the staff needed for the inpatient facilities partly due to the layout of this in the new hospice building. The registered manager shared with us that although the management and staff team had come a long way improvements continued to be on-going.

The registered manager showed they were knowledgeable about the areas where work needed to be progressed. For example, to set up structured patient forums to provide people with a formal way of expressing their views about the care and treatment offered. This was because although people's feedback was sought and shared with them in a variety of ways, such as patient care reviews, questionnaires and through social media it had been identified a more structured approach was needed. We saw the recent feedback from people who had used the inpatient facility was positive. This was shared with the management and staff team to extend best practice across the services people received. One staff member told us this helped to promote good staff morale as they were able to see how well they were doing in their caring roles.

Staff we spoke with were aware of the roles of the management team at the hospice which included the chief executive. Staff told us the chief executive was visible around the hospice which included having their lunch in the staff room which we saw happened on the day of this inspection. The staff member told us they liked working at the hospice and were motivated to provide a good standard of care and treatment to people. One staff member said, "Real team spirit here. Never felt pressurised or rushed, just a lovely experience working here. The little things matter and people are at the heart of everything we do." We saw many examples where staff worked as a team and communicated with each other and understood their roles and responsibilities. One staff member told us there were many opportunities for staff to lead on different projects and share their ideas for the benefit of people who used the hospice services. For example, they showed us how training was made inclusive for all staff to access which included a video which had been made of a new piece of equipment to help and support staff to respond to people's individual care and treatment needs. Another example was how a weekly living well day had been developed to provide people with various opportunities of support which included workshops to share information. These workshops

were varied, such as providing people with information about fatigue and breathlessness.

We saw the management team discussed their expectations of staff during meetings and how improvements could be made to the quality of the care and treatment people received. There was a culture amongst the management and staff team where suggestions and concerns raised by staff were taken seriously and acted upon. Staff were also aware of the organisations whistle blowing procedures which they told us they would not hesitate to use if they felt their concerns were not addressed by the management team.

Information following investigations were used to aid learning and drive quality across the services people received. Staff spoken with told us about the daily team briefings they had and how meetings were also used as time to reflect on their own standards of practice and make suggestions. The registered manager confirmed meetings were also used for reflecting on the emotional parts of the work staff did at the hospice. For example, if a person's death particularly touched a staff member in some way. One staff member told us they felt there were a variety of support networks for them to access, such as the chaplain and social workers.

Effective quality checks were undertaken to drive continuous improvement for the benefit of people who used the service and staff. Checks were used to review and measure the performance of the hospice services people received and included care and clinical treatment. The audit checks were seen by all the management team, staff and reported to the board of trustees. We saw the management team benchmarked themselves against other hospices and used this as one measure of how they were doing and where improvements needed to be made and or strengthened. We saw any actions for improvement included looking at how the care and treatment directly impacted upon people who used these. For example, the equipment which had been purchased to reduce the risks of people falling. The equipment was used when people were assessed as being at a high risk of falling and had been successful as there had been no significant falls reported. Another example were the discussions around the intellectual isolation for some people when they were on the inpatient facility and one solution was for newspapers to be delivered to the inpatient facility for people to read.

The management team and staff told us about how they reached out to the local community to raise the profile of the hospice which included children and young people from the local schools. The registered manager told us about the initiatives they had with the local high school to encourage young people to come and support the work at the hospice. For example, a project to create ceramic mosaics with people who used the day hospice service had been very successful and feedback showed this joint activity had been enjoyed by both people who used the service and young people.

The registered manager showed they were passionate about people experiencing high quality palliative and end of life care and told us people were at the heart of what they were striving to achieve. The registered manager talked about their commitment to promote palliative and end of life care within a hospice setting as a career choice. They told us, "Making career progression possible so junior nurses are not coming into a dead end job." We saw and heard how the registered manager was developing a culture for all staff to have a desire to continually improve their practices. One staff member told us how they had received an award from their colleagues in recognition of being creative in their work with people. They told us they were proud of this achievement and their role in trying to make a difference to the care and support for people who used the hospice services.