St. Luke's Hospice

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Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Outstanding ☆
Is the service caring?	Good ●
Is the service responsive?	Outstanding ☆
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

This inspection took place on 17 and 18 October 2016 and was unannounced. This meant staff at St Luke's did not know we were coming. Our last inspection at St Luke's took place in August 2014. The hospice was found to be meeting the requirements of the regulations we inspected at that time and overall we rated the service Good.

St Luke's Hospice provides a range of specialist palliative care services for adults within a dedicated building offering 20 inpatient beds along with outpatient services. The hospice also has a community team who provide care and support for people and families in the home environment.

At the hospice there is a therapies and rehabilitation centre providing day care support, physiotherapy, occupational therapy (including art therapy), wellbeing services (including complementary therapies), psychology, spiritual care, social work and bereavement services.

St Luke's had a registered manager. 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. The registered manager also has the role of deputy chief executive and director of patient care.

Day-to-day operation of the hospice is delegated by the Board of Trustees to the Chief Executive Officer (CEO). The CEO discharges responsibilities through the Hospice Executive Team.

At the time of our inspection there were 18 people being cared for on the Inpatient Centre, 10 people were being supported in the therapies and rehabilitation centre and approximately 250 people were being cared for in the community around the city of Sheffield.

People, relatives and healthcare professionals consistently praised the exceptional standards of care, treatment and support provided by hospice staff.

People received exceptional care which was founded on best practice ensuring people were involved and central in the planning and review of their care.

We observed staff supporting people who used the service with consideration, dignity and utmost respect.

People received excellent care and treatment which enabled them to have a dignified and pain free death. Families and those that mattered to the person were supported to spend quality time with them. Relatives were also able to access bereavement support following their family member's death.

People gave exceptional feedback about the meals and innovation provided by the hospice surrounding

their nutritional needs.

St Luke's Hospice was continually striving for excellence through consultation, research, and reflective practice. The hospice was extremely forward thinking and had a number of new developments underway based on best or evidence based practice to improve care or develop new initiatives.

We saw a number of quality assurance systems and audits to monitor performance and to drive continuous improvement.

The hospice had undertaken innovative work to support people and communicate with different groups of people within the city of Sheffield.

We found suitable arrangements were in place to help safeguard people from abuse. Staff knew what to do if an allegation of abuse was made to them or if they suspected that abuse had occurred.

We found people were cared for by sufficient numbers of suitably skilled, competent and experienced staff who were safely recruited.

We were informed there were over 800 volunteers providing support to the hospice. Volunteers had a wide range of skills and experience. Some worked in the charity shops, others helped with fundraising, running events, collecting donations, driving, bereavement support and many other roles. All the St Luke's staff, people and relatives we spoke with said volunteers formed a vital part of the St Luke's team.
The service had appropriate arrangements in place to manage medicines so people were protected from the risks associated with medicines. Staff had received training and support to manage people's medicines.

Systems were in place to maintain the safety of the hospice. The environment was well designed, welcoming, well maintained, clean and suited people's needs.

The hospice provided a wide range of learning opportunities to staff employed in the service and other professionals.

People said that they took part in, and enjoyed, a wide range of activities and therapies which were extremely beneficial to their care and support.

The service was actively involved in building local community links, took part in project work and close working wither other hospices and organisations at regional and national level. This was to promote excellent standards for 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.

We found suitable arrangements were in place to help safeguard people from abuse.

We found people were cared for by sufficient numbers of suitably skilled, competent and experienced staff who were safely recruited.

The service had appropriate arrangements in place to manage medicines so people were protected from the risks associated with medicines.

Is the service effective?

Outstanding

The service was very effective.

People, relatives and healthcare professionals consistently praised the exceptional standards of care, treatment and support provided by hospice staff.

People received excellent care which was founded on best practice ensuring people were involved and central in the planning and review of their care.

People gave exceptional feedback about the meals and innovation provided by the hospice surrounding their nutritional needs and told us staff always went out of their way to meet their preferences.

Is the service caring?

Good

The service was caring.

We observed staff supporting people who used the service with consideration, dignity and upmost respect.

People received care and treatment which enabled them to have a dignified and pain free death. Families and those that mattered to the person were supported to spend quality time with them.

Relatives were also able to access bereavement support following their family member's death.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People we spoke with told us they received care that was exceptionally responsive to their individual needs.

People said that they took part in, and enjoyed, a wide range of activities and therapies which were extremely beneficial to their care and support.

People were encouraged to provide feedback about the care they received from the hospice. Robust systems were in place to share lessons learned from complaints with staff and ensure any required changes in practice took place.

Is the service well-led?

Outstanding ☆

The service was very well-led.

People, relatives and other care professionals consistently offered exceptionally positive feedback about the excellent quality of care and the innovation and management of the hospice.

St Luke's Hospice was continually striving for excellence through consultation, research, and reflective practice. The hospice was extremely forward thinking and had a number of new developments underway based on best or evidence based practice to improve care or develop new initiatives.

The service was actively involved in building local community links, took part in project work and close working wither other hospices and organisations at regional and national level. This was to promote excellent standards for palliative and end of life care.

St Luke'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 carried out 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 was carried out on 17 and 18 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor in palliative care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection, we spoke with stakeholders, including local NHS Clinical Commissioning Groups. This information was reviewed and used to assist with our inspection and the findings are included throughout the report. Stakeholders we spoke with told us they had no concerns about St Luke's Hospice and provided very positive feedback about the service.

Before our inspection, we reviewed the information we held about the hospice. This included correspondence we had received about the service and notifications submitted by the service.

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

During the inspection we spent time observing the care and support being offered to people and families on the inpatient centre, and therapies and rehabilitation centres. We spoke with seven people and ten family members or visitors who used the services of the hospice.

We also, with prior agreement from the family, accompanied the community team to visit two people who were receiving care and support in their own home. During these visits we spoke with two people and two family members.

Over the two days of inspection we spoke with 35 hospice staff and volunteers. Staff we spoke with included the registered manager/director of care, heads of inpatient and community care, head of wellbeing, medical director, social workers, allied health professionals, nursing and medical staff. We also spoke with the chief executive officer, risk management coordinator, head of human resources, learning and development coordinator, bereavement services coordinator, maintenance and portering service manager, administration staff, maintenance, catering and housekeeping staff and people who worked as volunteers at the hospice.

We spent time looking at records, which included six people's care records, six staff records and other records relating to the management of the hospice such as training records and quality assurance audits and reports.

Good

Is the service safe?

Our findings

All the people we spoke with during the inspection told us they felt safe when they received care and treatment from hospice staff. Comments people who used the service made to us included, "I cannot think of anywhere safer, it's the staff that make you feel so safe," and "I believe my room to be a place of safety and privacy."

Families were positive in their comments about the safety of their relative. Comments included, "My dad being here makes a world of difference to our family," and "St Luke's makes dad feel really secure, you can see it in his face every time he comes in."

The provider had systems to protect people from abuse. A safeguarding policy was in place along with local area safeguarding procedures for staff to follow. We spoke with staff about safeguarding people from abuse and they knew what to look for and how to report abuse if they had concerns. The staff training plan evidenced training in safeguarding was given to all staff. A safeguarding lead was appointed to oversee safeguarding practices at the service. Staff and volunteers said, "I am involved in all safeguarding training. I am clear about this."

St Luke's had a safeguarding register to monitor safeguarding alerts, referrals and outcomes. The hospice staff held regular monitoring meetings with the safeguarding lead at the local NHS Clinical Commissioning Group. Stakeholders said, "St Luke's performs very well. Training levels of staff are high. They have had no involvement in any formal safeguarding review /serious case review."

People were protected and their freedom supported and respected because the risk of possible harm was identified and managed. Risk assessments had been carried out to identify and manage people's individual risks. There were a number of clinical risk assessments observed in people's notes. These included risks to monitor people's skin condition, nutritional needs, fall risks and overall safety.

We looked at the staffing arrangements for the service. The hospice employed a range of health and social care staff to meet people's physical, psychological and social needs. In-patient, therapies and rehabilitation centre and community care was provided by a specialist team of doctors, nurses, healthcare assistants, therapists and social workers. They were supported by housekeeping and maintenance teams, administration staff and volunteers.

The medical director said there was a team of palliative care doctors supporting the hospice. There were two consultants (one leading on community and one on inpatient care) who along with the medical director formed part of the palliative care on-call telephone advisory service, ensuring 24 hour, seven day a week medical support to services across the local area, covering the hospice, hospital and community.

There were also two hospice practitioner posts, a speciality registrar and three GP trainees and two NHS Trust trainee posts supporting hospice and community services. Some of these posts were full time and some part time.

Staff we spoke with told us there were always enough staff on duty and they felt they worked well together as a supportive team.

The hospice were very proactive in ensuring there were enough staff to safely meet people's needs. St Luke's had developed an acuity (acute needs) and dependency tool which on a daily basis assessed and advised the staffing requirements to meet the acuity of the person, this then informed a daily bed status which determined the number of admissions against current activity of nursing and medical staffing levels. We saw that this tool was currently being validated by academics at Sheffield Hallam University.

Within the community the hospice had a working policy to ensure the safety of lone working staff. We saw the rapid response nurse used an electronic system to sign in on arriving at each home visit. They also used a lone worker device in which they recorded the address and arrival time and who was on the visit. They told us this met the required practice stated in the hospice's lone worker policy.

The registered manager said there were over 800 volunteers providing support to the hospice. Volunteers had a wide range of skills and experience. Some worked in the charity shops, others helped with fundraising, running events, collecting donations, driving, bereavement support and many other roles. All the St Luke's staff, people and relatives we spoke with said volunteers formed a vital part of the St Luke's team.

We reviewed staff recruitment records for six staff members. The records contained a range of information including application form, references including one from the applicant's most recent employer, employment contract and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. All staff and volunteers we spoke with that they had undertaken regular checks with the Disclosure and Barring Service (DBS).We also saw evidence where applicable, that the nurse's Nursing and Midwifery Council (NMC) registration had been checked. This told us that people were cared for by suitably qualified staff that were of good character.

We looked at the systems in place for medicines management. We reviewed ten medicine administration records (MAR) and spoke with five members of medical, pharmacy and nursing staff involved with medicines management and the prescribing and giving people their medicines.

People we spoke with told us they received their medicines in a timely manner, including pain relief, and that doctors and nurses discussed medication changes with them so they remained informed about their treatment. People said, "I have so many medicines but they seem to be helping the pain," and "As soon as I was admitted the staff focused on my pain control, what a relief."

We observed the administration of medicines by a nurse on the lunchtime medication round. All medicines were labelled with the person's name and dosage corresponding to the MAR. We saw the nurse followed safe practices and sought consent. The nurse spoke with the person letting them know what the tablets were and made good eye contact with the person. Nurses wore tabards to advise people they were administering medicines to reduce the risk of being disturbed when undertaking this clinical practice.

We found there was a medicines policy in place at the hospice. This policy was available to all staff and covered all aspects of medicines management.

Medicines and intravenous fluids were stored securely with access restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and we saw evidence of

routine balance checks. A random selection of controlled drugs was checked and the stock levels recorded were all correct.

Ten MAR sheets were reviewed. The charts were legible, written in black ink and filled in consistently with no gaps observed on any of the charts. There was a wide range of anticipatory medicines (medicines a person may require as their condition changes) written upon every chart. Allergies were clearly stated on the front of the charts and corresponded to the allergy alerts in the person's' records.

Medicines requiring refrigeration were stored appropriately in the treatment room and records were maintained in accordance with national guidance.

There were locked medication trolleys, secured to the walls in the corridors, with individual locked drawers for each patient. Only the nurses and pharmacists had the keys to access medication trolleys and cupboards/ rooms. Disposable medication pots or syringes were used, all for single use only.

The pharmacist said they constantly checked stock levels of medications in all locations, ensuring that stock levels were adequate and that medications were in date. The pharmacists provided a 'strategic overview' and carried out medication audits and offered guidance and advice to the hospice team as needed.

The pharmacist and nursing staff said that syringe drivers were used and often delivered a combination of medicines. (A syringe driver is a small, battery-operated pump used to give medication continuously under the skin for a period of time, such as 24 hours). Syringe driver medicines were recorded on a separate chart/ document. Staff told us they were trained to use syringe drivers on their induction programme. We checked training records which showed this training had taken place.

All nursing staff completed medicines training/competency assessment on starting at the hospice during induction. The registered manager and in patient centre manager said this training was repeated again in the case of a staff member making any medicine errors or if it was considered that a member of staff's practice required updating.

There were adequate supplies of emergency medicines and equipment, and a procedure was in place to ensure they were fit for use.

Records we checked showed fire safety equipment had been serviced and was regularly checked. Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. Maintenance issues were dealt with in a timely manner.

The clinical areas and premises were very clean, organised and uncluttered. Staff wore appropriate personal protective equipment (PPE) which was in ample supply. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe.

Outstanding ☆

Is the service effective?

Our findings

People who used the service, relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff. Comments people made to us included, "The staff are so well trained. They have a great understanding of what I am going through," "The treatment in here is second to none," "I never thought I would benefit from complimentary therapies ,now I cannot get enough. The massage therapy has greatly improved my digestive system," and "Staff have been wonderful, every single one of them, all of the time."

We saw innovation in how people were involved in the assessment of their needs. People completed an Integrated Palliative Care Outcome Scale (IPOS) on a regular basis during their period of care, which ensured the process of individualised person centred care was paramount. The IPOS is a scale used to measure a number of physical, psychological, social and spiritual domains and allows a person or family to rate them on a score of 0-4. (A 0 score being low or not at all to 4 being severe). This tool introduced by the hospice was observed in use in people's records and was recorded every three days and staff said that the information gathered was fed into Multi - Disciplinary Team (MDT) meetings. People also had the opportunity to express their views on their care each time the IPOS was completed. This meant people were involved and central in the planning and review of their care. People and relatives said ,"I am totally in control of my treatment options," "We fill in a form every time we come in .That is the basis for our care planning they involve you in every decision," "They (staff) ask you just how you want to have your care delivered, it puts you in charge," and "I see the doctors every day and they are in touch with my daughter all the time."

We attended the MDT meeting between staff working in the hospice, which was held each week. We heard the care and treatment needs of individuals being discussed in a sensitive manner and arrangements were made to offer people services to meet their needs. We observed the person's views and IPOS score were central to any discussions surrounding the persons care and support. This helped to ensure people received care, treatment and support in a timely and effective manner. For example one person felt a particular therapy was not working for them. The person's views were respected and an alternative therapy had been suggested. One person had said that although they were pain free their medicines were making them drowsy. The medical staff said how they were discussing other options with the person to manage their pain.

Discussions and interactions between the nurse, people and families were observed during our home visits. The nurse provided plenty of clear information and repeated things that were important or not understood. They put everyone at ease and gave people and families plenty of time to ask questions or raise any concerns.

Stakeholders we spoke with said, "St. Luke's provide a high quality innovative service. They are a forward thinking, pro-active organisation, constantly seeking ways to improve their service and work with educational organisations to provide an evidence base to their work."

We found evidence of this innovation during the course of this inspection. The hospice was forward thinking and had a number of new developments underway based on best or evidence based practice to improve care or develop new initiatives. Some of these ventures were being worked on in partnership with other local or national organisations.

Initiatives included Extension for Community Healthcare Outcomes (ECHO). St Luke's was piloting project ECHO in collaboration with ten nursing homes in the city. ECHO works by providing primary care providers with training in palliative and end of life care that would otherwise be treatable only by specialists. This is done through a model of 'guided practice' and mentoring using video-conferencing technology. There was a nurse at the hospice leading this work and they were being joined by an advanced care practitioner and administration staff to support the pilot work. This work will help ensure the specialist knowledge, skills and experience of staff at St Luke's can be shared with nursing and care staff within the city to further promote high standards of end of life care for people in care homes in Sheffield.

St Luke's had also piloted the Enhanced Community Palliative Care Support Services (EnComPaSS) project. The hospice was the first healthcare provider to trial this new model of care in the UK. It is a model that has been proven to deliver effective and cost efficient care and support to people and families in their own homes. With advanced technology medical and nursing staff can monitor several people from a remote setting. The nurses use tools such as IPOS to capture the person's most important needs and identify any changes in the person's condition. Using secure computers this real time assessment is then shared with senior staff back at St Luke's who can advise on any treatment required. The aim is to provide greater levels of end of life care for people at home and reduce unnecessary hospital visits and admissions so people can stay at home longer and die with dignity in their place of choice. Through the use of the EnComPASS project clarity tool, St Luke's plans to monitor and enhance the use of multi-disciplinary team working in the community. The initial findings of the project were currently being validated by a local university. This project has helped to improve care quality and provide greater levels of end of life care for people in their own home. It has also helped to reduce unnecessary hospital visits and admissions and helped people to stay at home longer and to die in a place of their own choosing.

We looked at how staff were supported to develop their knowledge and skills. We looked at the induction programme that newly appointed staff had to undertake on commencement of their employment. Induction programmes help staff understand what is expected of them and what needs to be done to ensure the safety of the people who use the service, staff and visitors.

The head of community services said the induction programme had just been reviewed for community staff and a new process was being piloted. This would involve all new staff spending the first month on the inpatient centre to gain understanding about how the hospice works, and to have time to do a medicines assessment and complete/ sign off competencies such as case management, diary management and home assessment. This allowed those joining the community team to get a solid foundation of knowledge, before they took supported people in the community.

The registered manager confirmed staff started work at the hospice on a three month probationary period, and induction took place during this time.

There was a clear planned programme of training events for all staff which ran over the year. We looked at the training 2016/17 programme which clearly indicated which sessions the staff groups were required to attend. The sessions ran three times over the year to enable all staff to access this training. Sessions covered a broad range of palliative/ end of life care topics, including symptom management, pain management and assessment, palliative care emergencies, nausea and vomiting, advanced care planning, community care,

spiritual care, safeguarding, dementia care, bereavement and comfort and well-being. We sampled a selection of six personnel /training files. These files identified regular training was available and took place for staff.

Staff we spoke with said they had access to a range of mandatory and professional/ clinical based training run by the hospice. Staff said there were opportunities for them to attend training and development opportunities outside the hospice. One member of staff said they were undertaking the assistant practitioner training and development to give them extended roles and become a more effective resource for the hospice.

Staff said there was a link nurse system in place and nurses led on areas of clinical interest and kept the rest of the team updated.

There was evidence of opportunities for staff to be supported with training/ learning and career development. For example, some of the staff had been volunteers at the hospice and had gone on to apply for substantive posts. One member of the nursing team had originally started at the hospice as a volunteer. They had then completed nurse training and had returned to the hospice and had eventually become a head of department. Staff were offered development opportunities by getting involved in some of the new initiatives such ECHO and EnComPaSS.

There was a clinical facilitator in post at the hospice. Staff spoke highly of them and said, "She is really great and very approachable, I can go to her with anything" and "There are lots of learning days put on at the hospice, which develop my practice and keep me up to date" and "The skill set and knowledge base of the nurses has increased to support the care we are delivering" and "I have just finished my Masters degree. I was really supported to do that here."

The hospice supported placements for a number of students including student nurses and for trainee medical practitioners.

The hospice's system of appraisal and clinical governance supported all doctors working at the hospice to achieve their revalidation. The medical director described the MDT education programme running at the hospice, which supported the medical team to achieve their required continuing professional development and education.

We found the provider had policies on supervision and appraisal. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually.

Staff we interviewed had received annual appraisals and said their managers were accessible and approachable. They told us training and development opportunities were agreed, based on training needs and identified in appraisal meetings.

Staff we spoke with said they had access to supervision along with debriefs and regular hospice wide reflection sessions open to all members of the team. We saw records of this supervision.

The registered manager said a volunteer coordinator recruited and supported volunteers working for the hospice. Volunteers received supervision and time for reflective practice within the teams in which they were based.

Staff said, "I always have someone to talk to," "My manager is brilliant, really supportive," "Fantastic support," "I have regular clinical supervision," "We can access chaplaincy or counselling support any time," "I can see managers any time and have regular supervision," "We have clinical meetings. I have an appraisal each year" and "We have reflective meetings which are really good."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards. One staff member was designated to oversee this area and they had a good knowledge in relation to their responsibilities. We spoke with another staff member about how they would judge whether a person had capacity. They could describe in depth the tools available to them, and what steps they could take if they were unsure whether a person had the capacity to give consent to their care and treatment.

From our discussions with people, our observations and reviews of people's care records we saw that people were consulted with and, if able, consented to their care and support. We saw how staff requested people's consent before attending to their needs.

We saw examples of DNACPR (do not attempt cardio pulmonary resuscitation) decisions which had been made and we could see the person involved had been consulted and agreed the decision.

Staff told us that if people were not able to consent then a 'best interest' meeting would be held on their behalf. A 'best interest' meeting is where other professionals, and family where relevant, decide on the course of action to take to ensure the best outcome for the person using the service. We attended an MDT meeting and heard staff discussing best interest decisions. This demonstrated staff understood the legal framework in which they were working.

We checked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met. All the people we spoke with gave exceptional feedback about the meals and innovation provided by the hospice surrounding their nutritional needs and told us staff always went out of their way to meet their preferences.

People said, "I can have a glass of wine with my dinner and I can have a small whiskey, I like a malt," "The food is lovely and you always have three or four choices on the menu," "It is like eating in a first class restaurant," "The chef went out and bought me some liver because I said I fancied some. There are many examples of this happening to other folks" and "They send me home with freshly baked bread and scones, every time I come." Relatives told us, "Dad has put weight on, he is a different man, it has meant that he can go home and be with mum and cared for in his own home," "Our mum loved the hospitality staff, they really cheered her up" and "The food is prepared with love and delivered with care, it means so much."

The care records we looked at showed that people had an eating and drinking care plan and they were continually assessed in relation to the risk of inadequate nutrition and hydration. People who were at risk of

malnutrition and poor hydration had their food and fluid intake monitored to help ensure their well- being.

The hospice catering team were actively involved in ensuring patient needs were met. The ethos of the catering and hospitality team being the person can have whatever they want whenever they want it. We saw St Luke's had a hospitality service with staff who ensured freshly prepared food was delivered to people, individually on nicely set out trays, when they were ready to eat. Sauces, gravy and custards were placed in individual jugs. Chef said, "People don't want me to pour sauces or custard all over their meal, they can add as they wish. It's about respect." Catering staff said, "People eat when they want, what they want and where they want."

The catering team provided us with examples of how they went that 'extra mile' to accommodate people's choices and focus on individual care and support .We were told the chef made pizza and put it in a box so the children of a person could sit on their parent's bed on the inpatient centre and watch a film together like they always did at a weekend, when the parent was at home.

The chef told us how one person liked to taste food but could not safely swallow it. The hospice has a machine that can turn food into a powder solution so the person could still safely taste the food when it was placed on their tongue.

St Luke's had undertaken two innovative projects to support people at home through the provision of tailored nutritional services. Staff of the community team assessed people and if they were struggling with their appetite, freshly prepared food parcels containing a selection of home-made soups, bread, smoothies, fruit juices and cakes were delivered to the person without cost. This meant the hospice were providing a balanced nutritious diet to people in the community. People said, "I've been eating more regularly, because at lunchtimes I know I have something to eat that is going to be enjoyable."

The hospice had identified that family dynamics may change when someone was being cared for at home or in the hospice in patient centre. People may be caring and cooking for someone with a terminal illness or cooking for themselves for the first time in a long time. To help people gain and develop new cooking skills, St Luke's started a six week cooking course that was held in the kitchen and café and called 'Ask the Chef.' At the end of each session the participants sat down together in the cafe and enjoy eating the food they had prepared, as well as adding a social occasion to the experience. The chef told us the course was proving extremely popular.

We looked all around the premises which were spacious, comfortable, well lit and airy. The in-patient centre was spacious and provided comfortable rooms overlooking beautifully managed gardens. Within the gardens there was a garden room which was used for a range of activities with people, visitors and staff

A range of hospice facilities were observed appropriately decorated, equipped and furnished for delivery of palliative, end of life care and family support. People said, "It is a very pleasant room," "The en-suite is extra good" and "It is very calm here."

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff supporting people who used the service with consideration, dignity and upmost respect. We observed interactions between the nurse, people and their families during two home visits we made. The nurse knelt to speak to both people to be at eye level and made eye contact when talking. They were considerate about privacy and shut the curtains when doing clinical examinations. Their approach was gentle, respectful and caring to both the person and their family members present.

All people and relatives made extremely positive comments about the staff. Comments included, "The care is beautiful," "The night staff are so kind to me," and "Every member of staff is so caring and kind."

Part of the vision, mission and strategy statement of St Luke's Hospice is, 'Above all, we are about life, and enabling our patients and their loved ones to live theirs and die with dignity and respect.' St Luke's has set of core values for all employees and volunteers. These are around compassionate care being at the heart of St Luke's.' Our discussions with people and relatives confirmed this view.

Staff we spoke with said, "You have time to spend with people and their families and provide good, quality care. You get to know people and their preferences," "Sometimes it can be a very dark time for people and their family .Here we try to make a difference to make it more bearable" and "We all work here for the same reason, to improve lives."

We saw all staff were very mindful about people's privacy and dignity. For example staff were observed asking people if they would be happy to speak to the inspection team. Curtains were seen pulled around some people who were in the three bedded bays to maintain their privacy. We saw staff knock on doors and calling out before they entered any person's room. People said, "Staff always knock my door before entering the room."

The staff and people looked comfortable together. For example, there was laughter and friendly chat between people. People said that staff were good at listening to them and meeting their needs. Relatives and visitors were also welcomed in a caring and friendly manner.

People being admitted to St Luke's were given a handbook which set out expectations they would receive and services available. People also received information leaflets with a supporting letter detailing the hospice's processes and practices around information governance and confidentiality.

Meeting people's spiritual, religious and cultural needs was a key focus of the hospice team. The staff supported people with whatever spirituality meant to the individual. A chaplaincy team visited people and families at the hospice regularly and also responded to specific requests. They were available to all, with any belief or none and provide spiritual guidance. A non-denominational room known as 'The Chapel' was available for anyone to spend quiet time.

We heard during the MDT meeting we attended, people's spirituality played a key role in discussions about

individuals care and support.

There were counselling and bereavement services for people and their families which were based at the hospice.

Staff told us how they supported families at the time of death and after; this included families or being able to stay with their loved one as they as wished. The staff had access to bereavement information and documents which were given to the family explaining what they needed to do next such as registering the death and arranging the funeral. Another leaflet produced by the hospice and available to families was called, "Supporting care in the last few hours or days of life."

After a period of time the hospice contacted family's to offer 'follow up' support such as attendance at a bereavement group or individual counselling. Staff told us they supported people to attend 'follow up' sessions though this was left up to the individual to make that choice either then or at a later time.

There was a viewing chapel with the bed pointing South East which was important for some people with particular religious beliefs.

Staff told us how they responded to people's individual needs to help people and family face end of life. Staff told us how they arranged a film, takeaway and sleepover night for a family and their children so they could spend precious time with their parent. This meant family close to the person were able to spend time together doing things they enjoyed. It was very positive to see such thought and care from staff for the whole family. Staff also told us how a person who was close to death became frightened because of the poor lighting in the room. Staff moved the person to a room with a larger window so the person had a peaceful death.

St Luke's had identified previously that it did not offer specialist bereavement support for children aged 12-16 years. The hospice therefore embarked on a pilot with a youth charity trust to support young people on a 12 week pre and post bereavement programme. St Luke's had also recently started a Saturday club for children who have had family member diagnosed with a terminal illness or if they had recently been bereaved.

We spoke, at their request, to a family whose relative had recently died at the hospice. They had come to the viewing chapel to see their family member's body. The family said they wanted to speak with us to tell us, "(Named staff) are particular staff of note but all the staff did everything to help [Name] stay happy and comfortable."

The hospice held annual remembrance services for the families and friends of people who had died. The registered manager told us these services were very well attended by families and were supported by staff and volunteers from the hospice. The festival of light remembrance event was held in the hospice gardens and was particularly well attended and was always held just before Christmas.

One relative told us they had attended the 'festival of light' previously and it was so popular the hospice had started a park and ride service from a local supermarket as the roads around the hospice became so busy. The relative said all their family gathered for this event and had a, "Party with food and drink and talked of special memories of the person who they had lost."

Outstanding ☆

Is the service responsive?

Our findings

All the people we spoke with told us the hospice had been extremely responsive to their needs. People said, "Staff are there when you need them, wonderful," and "If I ring my bell staff always come immediately. I am getting ready to go home. Everything is so organised. The therapists are seeing me and helping to make changes to my house. They are really good."

One staff member we spoke with said, "It's all about what people want here, its holistic care, little things make a difference. We all want the best for people and we go the extra mile to make sure they get it."

People on the inpatient centre we spoke with were clear about why they had been admitted and of their discharge plans. They said they were receiving good information from the hospice team and were very happy with the care they received.

The hospice had undertaken some innovative work to support people and communicate with different groups of people within the city of Sheffield. The registered manager discussed with us how the hospice wanted to reach out to all of the city of Sheffield.

For example, some research was undertaken and it was found that some communities were not accessing the inpatient and community services of the hospice. It was found that some cultures preferred to care for terminally ill family members at home.

St Luke's had undertaken an assessment of needs of the local black and ethnic minority population and had identified particular areas for focus of the south asian population such as supporting people to die at home. The hospice had appointed a community liaison worker to work with St Luke's and start a pilot to understand and enable greater community engagement in the first instance with south asian network. The registered manager told us if successful, this model would be expanded to reach out to other minority populations and special need groups.

Stakeholders told us, "St Luke's has, over several years looked at improving the quality of care. This year St Luke's aim is at improving support within the black and ethnic minority community."

St Luke's had launched a pilot (Dancing for Health) project to try to maintain people's health and benefit people and family members managing long term conditions and terminal illness emotionally and socially through dance. Dancing for Health is a national organisation that creates partner dancing programmes to enhance the health and well-being of people with health issues. The Dancing for Health organisation have said that never before had anyone used partner dancing as a physical and social activity for terminally ill people and their partners within the hospice environment. St Luke's are the first hospice in the UK to pilot the new programme. This project has helped people to address social isolation and enhance physical wellbeing.

St Luke's had undertaken work to support people at home through the provision of tailored laundry

services. Laundry packs and towels were delivered and dirty laundry collected and laundered for people who require intensive laundry services. This helped people remain at home and spend time together rather than continually having to launder their own bed sheets. People told us, "I hated getting up in the night to wash bedding. I wanted time with my family. This service is wonderful" and "The laundry system is amazing, they deliver clean bedding .It has transformed our daily routine."

The registered manager told us the hospice's community care rapid response has recently been extended to cover seven days so people now received this support at weekends.

People said they were happy for us to look at their care notes. People readily shared their diagnosis and care needs with us.

We checked six peoples care records. Care records contained care plans, which were appropriate for people's care needs and were in line with their medical records. They also managed any risks identified. All care plans were reviewed weekly and signed and dated. There were individual care plans for pain management which included a numerical pain assessment tool so staff could respond with medicines to control people's pain.

People had completed an IPOS form every three days, which was shared at MDT meetings. This allowed people's care and support to be planned proactively with them and enable them to be at the centre of all decisions about their care and treatment. This enabled staff to provide exceptional care and be responsive to the person's preferences and care and support needs.

There were records of interventions by a number of different members of the MDT. These included the social work team, wellbeing services (massage/ reflexology/ and reiki), occupational therapy and physiotherapy. The chaplaincy team had also seen people and volunteer spiritual support had been suggested in one person's file we checked. This request was discussed at the MDT meeting we attended and a visit had been arranged for the person the following day in response to their spiritual needs.

Records of community support were observed for the period of time one person had been cared for at home between their two admissions to the hospice. This evidence of detailed MDT information which involved people and their family promoted joined up responsive care for people.

We found the staff responded to people's choices regarding there preferred place of care. Our discussions with staff showed there was a commitment to ensure people were able to make these choices. The preferred place of care was discussed at MDT with the person's choice being central to the decision. We saw that one person who wanted to be at home to die had specialist equipment, support and medicines organised so they received personalised high quality care to die at home.

We saw there were advance care plans available for some people who were at end of life. These plans were so people's care could be managed in a place of their choice and their wishes around end of life care were documented. A relevant range of anticipatory medicines were written up on the medicine charts observed, and stock medications were available to respond quickly to patient needs in the case of sudden changes in condition.

The hospice understood the need for social contact, and provided activities and complementary therapies which were based on the people's needs and preferences. There were a significant number and range of high quality therapies and activities. For example reflexology, aromatherapy, massage, relaxation, reiki and beauty therapy. The therapy team helped people tackle physical or emotional issues associated with their

illness.

One person said, "I like to watch a bit of TV at night. I listen to classical music and read" Classical music was playing in the person's room during our discussion and they had been reading the paper. The person added, "The cleaners have just been in, they asked if I had my newspaper and I didn't, so they went and got one for me."

Other people's comments included, "I get involved with anything I can," "Who would have thought I would have aromatherapy and reflexology, I love it."

Relatives said, "Dad has got fully involved in the art therapy group, he is busy making scarves for everyone" and "I know mum benefited from the therapies group, they made a real difference."

We saw there was a clear and comprehensive system that enabled and encouraged people and their families to bring a complaint should they feel it was needed. The hospice had a positive approach to using complaints and concerns to improve the quality of the service.
The registered manager told us any complaints received were dealt with quickly and people received a written response.

People said, "This is a first rate service how could anyone complain about it."

Volunteers we spoke with, "I would not hesitate to tell (manager) if I was worried about anything. She even encourages this"

We saw that over 200 compliment letters, cards or emails had been received by the hospice over the previous 12 months. We noted that one person had commented, "Amazing place with fantastic staff."

Outstanding ☆

Is the service well-led?

Our findings

People, relatives and other care professionals consistently offered exceptionally positive feedback about the excellent quality of care and the innovation and management of the hospice. Comments included, "St Luke's is so well run .Everyone knows what they are doing," "I cannot speak highly enough of the managers," "You feel as though you are involved in the development of the service," "The manager is an inspiration to her staff," "All the team share the same vision to give people excellent care and a good death," "This hospice is run to an excellent standard" and "This city should be proud of the service that St Luke's offers."

All of the staff we spoke with across the organisation demonstrated a very caring approach and were highly motivated to provide a high quality service. All staff and volunteers we spoke with said they were proud to work at St Luke's. Comments included, "I love working here," "It was the best decision I ever made to work here," "I am proud of how the team have adapted and the changes we have made. We are keeping more people at home for end of life care," "I am very proud of the team working and how the team adapts to things" and "I am proud of saying where I work. People are cared for so well here. We do it how it should be done."

The service had a registered manager and other members of the executive team including a chief executive, deputy chief executive (also the registered manager),medical director and director of finance and operations. The team were responsible for the strategy, planning and management of St Luke's. The hospice was overseen by a board of trustees who, as well as attending board and management meetings, attended the hospice regularly.

The hospice's management systems were supported by a formal structure of committees and governance groups. We checked the minutes of recent meetings to assess their effectiveness. The senior management team meeting looked at areas for improvement and development; monitored referrals and looked at plans to address increasing need for the hospice's services within the community. This meant that senior managers within the service had oversight of developments and the needs of people who used the service.

Medical and nursing staff said they attended the hospice Clinical Governance Committee and trust board meetings. They also linked in with the quality and clinical effectiveness group and Patient Safety Group. These meetings had minutes distributed, so staff could get feedback if they were not able to attend.

There was also a monthly safety and risk management group, again attended by senior personnel within the hospice. This group monitored accidents and incidents, looking to analyse trends and patterns in order to improve safety. The group also had oversight of complaints, safeguarding, risks and the Deprivation of Liberty Safeguards. This allowed senior personnel to contribute to and improve safety within the service.

The hospice used a benchmarking system which was a collation of information relating to patient safety and quality in comparison with other hospices in the region. This further monitored how the service was doing and highlighted what other improvements could be made and helped to understand the specific needs of the local population. Audits and key quality indicators were assessed in drug and clinical incidents, acquired

infections, end of life care, ethnicity and using the patient safety thermometer and harm free care. These audits and their findings were used to help keep people safe and improve the quality of care.

Stakeholders told us they met regularly with St Luke's senior management to monitor quality and had, "A good working relationship with them."

The Sheffield Clinical Commissioning Group (CCG) held a quarterly quality meeting with St Luke's deputy chief executive and the risk management co-ordinator to seek assurance on quality issues. This covered specific issues on the NHS quality agenda as well as quality indicators set in the local quality schedule. A formal quarterly contract quality and performance meeting was also held with the chief executive and deputy chief executive. This meeting covered both clinical and non-clinical items that were reportable locally or nationally.

St Luke's recorded four quality improvement priorities for 2016-2017 including implementing the ECHO project and wider engagement with black and minority ethnic communities. It was positive to see the service had started or had already met these priorities which indicated an emphasis on the provider continually striving to improve.

There were a range of quality assurance methods used to gain people's views and ultimately to drive up the quality of the service. People said they were encouraged to speak out and fill in surveys. Relatives said that they had approached the managers about various matters and they felt as though they were listened to.

People were routinely asked to complete a 'Views on Care' questionnaire that asked them to rate whether their main problems and concerns have got better or worse, their quality of life, and the difference the service is making to them. This enabled the registered provider to evaluate the effectiveness of service on the person's quality of life and measure this over a period of time.

People could provide 'real time feedback' (via an electronic tablet).This was managed through the service user co-ordinator which enabled people and relatives to express their views and for staff to respond to their needs.

Quarterly 'service user' team meetings were held which included people and relative representation to review feedback from that quarter, actions taken and reflect on any other areas of improvement within the organisation.

We saw minutes which identified that trustees and board members actively participated in 'patient safety walk rounds' and observations. It was innovative to see a person who used the service and a relative or visitor were involved in these walk rounds. This was so people who used the service had an active voice and could influence how the service was run. We saw an action plan was produced following a recent walk round and as a result signage to the Inpatient Centre was changed to help people navigate around the hospice. This was an example of people being able to influence and improve the quality of the service for people.

The quality assurance tools used showed exceptionally positive feedback in relation to being treating with dignity and respect. All of the matters raised in the quality assurance documents that required improvement were acted upon. Examples included improved parking for visitors and improving facilities and refreshments for visitors who wanted to stay with their family member at end of life. This showed the service was committed to continuous improvement.

People and relatives said, " I have completed a survey but everything is so good, what more can I say."

Staff and volunteers had provided positive feedback about the excellent support they received from managers the service. Staff said, "The manager has a strong work ethic and lots of energy and she gives me the most amazing opportunities," "My support is really, really good," "I have a lot of opportunities in this role," "The managers doors are always open" and "There is no hierarchy, as such, we are all seen as part of the team."

Staff said they were supported and listened to. As part of the focus on St Luke's employee wellbeing, the hospice entered into an agreement with an NHS Trust to offer staff additional psychological support. The workplace wellbeing programme offered specialist counselling services by clinical psychologists for staff who may be struggling to cope in the work place due to the nature of what they are dealing with on a daily basis.

The hospice facilitated a monthly reflective forum with the director of patient care and a psychologist which enabled staff to meet in a safe, reflective environment enabling reflection time with no formal agenda, led by the teams that attend.

Staff said they regularly completed staff surveys, the findings of which were shared widely with the hospice team. Staff said they were listened to and could influence change.

Staff said they regularly saw all of the executive team and said the chief executive held a twice yearly staff forum to update the teams on the work of the hospice.

Staff said they attended regular team meetings to discuss every aspect of the service, including staff training and policy and guidelines reviews.

St Luke's Hospice has a high profile in Sheffield and was actively involved in building further links with people in the region and nationally. There were many organised events such as the upcoming 'Festival of Light' an event in the hospice gardens where people can remember loved ones with the illumination of thousands of lights, cycle rides, tractor rally, skydives, Santa's grotto at a large department store in the city, car boot, coffee mornings, golf days, links with local sports teams and schools and universities. Volunteers and staff contributed to the planning of events. There was a fundraising team who ensured the hospice maintained a high profile in the community and was regularly prominent in the area press.

The hospice produced a seasonal newsletter called "In touch" which contained articles from people who used the service, their relatives and staff and forthcoming fundraising events.

St Luke's Hospice were striving for excellence through consultation, research, and reflective practice. The hospice was very forward thinking and had a number of new developments underway based on best or evidence based practice to improve care or develop new initiatives. Some of these ventures were being worked on in partnership with other local or national organisations.

We have already identified some of the initiatives and innovations the hospice has or is undertaking throughout this report including the ECHO project and EnComPaSS and IPOS tools.

The hospice provided further evidence on work the team have been involved in to progress practice.

The hospice were proactive in how the MCA affected people receiving palliative and end of life care nationally. The medical director has been working with The Law Commission and National Mental Capacity Forum to consider/ make recommendations on the application of MCA and DoLs in palliative care. The

hospice was involved in hosting two events in Sheffield and in London with the Law Commission to consider this issue more widely with colleagues. We saw a briefing document from Hospice UK which contained an article/ report about this work.

For the past two years St Luke's have supported the 'Dying Matters' campaign and worked with Sheffield Hallam University to run a Death Cafe on their city campus. Death cafes are an established social tool with the purpose of encouraging people to open up and talk about death, dying and have some often difficult conversations.

The hospice was working towards achieving, "Introducing the Outcomes Assessment and Complexity Collaborative (OACC) Suite of Measures". This is work is being led by Kings College London and involved introducing a range of recommended outcome measures reflecting the key domains of palliative care which monitor changes in health status as a result of interventions. This outcome assessment toolkit includes measures of a patient's phase of illness, assessment of symptoms and other concerns such as impact of palliative care on the people's family's quality of life. The suite of measures can be implemented in its entirety or in stages. The hospice had implemented four phases of illness. (Stable/ Unstable/ Deteriorating/ Dying/ Deceased.) This was observed in use at the hospice and recorded in people's records.

The head of the inpatient centre discussed with us and showed us the pilot study the hospice were involved with relating to single nurse administration of controlled drugs to ensure people get medication in a timely manner and to release nursing time to care.

The hospice work closely with Hospice UK to help establish and drive the agenda for quality with representation on the executive clinical leaders in hospice practice quality improvement / assurance groups. The registered manager has been chair of this group for several years.

The registered manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

All records relevant to the running of the service that we saw were well organised and reviewed regularly.