

Barnsley Hospice Appeal

Barnsley Hospice

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

Barnsley Hospice is an independent registered charity. It provides a 10 bedded in patient unit, day care and out patient services for people with a life-limiting illness. Referral to use the service is generally made by a doctor or specialist nurse. No direct charge is made to people using these services. Care is provided to people over 18 years of age who are resident in the borough of Barnsley.

Barnsley Hospice also offers treatment for patients suffering from cancer and non-cancer related oedema. The service is also available to those who have had cancer in the past. There are three Lymphoedema Practitioners who can see patients in their home, hospital or the clinic based at the hospice. (Lymphoedema is a chronic (long-term) condition that causes swelling in the body's tissues). Individual plans are created to include some of the following: skin care, exercise, massage and compression. The key element of this service is to enable patients to successfully manage Lymphoedema on a day-to-day basis.

Barnsley Hospice also provides a day service at The Limes support and therapy centre. The Limes is open Tuesday to Friday. The day service is designed to help patients adapt to the limitations caused by serious illness. Each patient is assessed individually and support is also available to their families and those close to them. The day service offers support and advice with symptom management and treatment. People benefit from socialising with people who are going through similar experiences. Refreshments and a meal are provided free of charge. Transport can be arranged if necessary. The care team providing support at the centre include registered nurses, an activity coordinator, doctors, complementary therapists and volunteers. If required there is access to a social worker, counselling service and spiritual support.

Barnsley Hospice has 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.

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, comprising of the Patient Services Director, Consultant Clinical Lead, Support Services Director and Finance Director. The registered manager is also the CEO.

Hospice Practitioners provide medical cover together with four part time consultants in Palliative medicine.

24 hour cover by the medical team is provided. There is a system called 'Pall Call' in place at the hospice. 'Pall Call' is a specialist palliative care telephone advice line for health care professionals and is open 24 hours seven days a week. It is also available for patients and carers to call.

Our last inspection at Barnsley Hospice took place in November 2013. Barnsley Hospice was found to be meeting the requirements of the regulations we inspected at that time.

This inspection took place on 1 August 2016 and was unannounced. This meant staff at the hospice did not know we were coming. On the day of our inspection all 10 beds on the in-patient unit were occupied.

Staff were trained in how to protect people from the risk of abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

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

There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs.

Robust and safe recruitment procedures were followed which meant suitable staff were employed to help keep people safe.

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.

People were supported to maintain a nutritious diet at the service and people told us about the high quality of the food. There was a choice of menu, drinks and snacks provided.

Staff told us they were supported through induction, regular on-going training, group supervision and appraisal. The registered manager said they had identified improvements in staff supervision were required and said they planned to increase the consistency and frequency of individual staff supervision within the next three months.

Staff worked within the principles of the Mental Capacity Act (MCA) where appropriate. People had choices about their care and their consent was sought by staff. They told us they were involved in all decisions about their care.

People, who used the service, and their families, told us that they were treated with kindness and respect.

People were encouraged to be involved in making choices regarding their care and treatment.

People's care plans we looked at reflected people's needs and gave information about their treatment regimes.

There was a complaint's process in place. We found the service had a robust process in place to enable them to respond to people and/or their representative's concerns, investigate them and take action to address their concerns.

We received very positive comments regarding the overall management of Barnsley Hospice from staff, other care professionals, relatives and people who used the service.

Quality assurance and clinical governance systems were in place and were used to improve the service.

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.

There were sufficient staff on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

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

The environment was secure and well maintained and fit for purpose.

Is the service effective?

Good ●

The service was effective.

People were supported to maintain a nutritious diet and people told us about the high quality of the food. There were varied choices of menu, drinks and snacks provided.

Staff were trained in the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards and were knowledgeable about the requirements of the legislation.

Staff told us they were supported through induction, regular on-going training, group supervision and appraisal. Individual staff supervision was less frequent and meetings were not always recorded. The registered manager said they had identified improvements in staff supervision were required and said they planned to increase the consistency and frequency of individual staff supervision within the next three months.

Is the service caring?

Good ●

The service was caring.

People and relatives made positive comments about the staff and told us they were treated with dignity and respect. The staff were described as being kind and caring.

Staff were attentive to people's needs and choices and treated them with respect.

Staff protected people's dignity and privacy when providing care for them.

Is the service responsive?

Good ●

The service was responsive.

People were encouraged to be involved in making choices regarding their care and treatment.

The care plans we looked at reflected people's needs and gave information about their treatment regimes.

The hospice staff worked closely with community-based professionals to provide an integrated end of life care service.

A copy of the complaints procedure was available and complaints records were maintained.

Is the service well-led?

Good ●

The service was well led.

We received very positive comments regarding the overall management of the hospice from staff, other care professionals, relatives and people who used the service.

Quality assurance and clinical governance systems were in place and were used to improve the service.

The service was actively involved in building local community links and took part in close working with other hospices and organisations at regional level.

Barnsley 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 1 August 2016 and was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector and a specialist advisor in palliative care.

Prior to our inspection, we spoke with stakeholders, including the local NHS Clinical Commissioning Group, local authority joint commissioning unit and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was reviewed and used to assist with our inspection. Stakeholders we spoke with told us they had no concerns about Barnsley Hospice and provided 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. The service was not asked to complete a provider information return (PIR) for this inspection because we had changed the inspection date. A PIR 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 and spoke with five people on the in-patient unit and four visitors to the hospice. We spoke with sixteen staff including the registered manager, nursing and medical staff, student nurses on placement at the hospice, health care assistants, an assistant social worker and nursing auxiliaries. We also spoke with administration staff, catering and housekeeping staff and people who worked as volunteers at the hospice.

During our inspection we looked at the systems in place for managing medicines; spoke with four members of staff involved with prescribing and giving people their medicines, looked at five people's medicines charts and spoke to two people using the service and one person's relative in relation to medicines management.

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

Is the service safe?

Our findings

People told us they felt safe in the service. Comments included, "I get a little worried about being on my own sometimes, but staff are great they sit with me and my family can stay when they want" and "I wake up in the night, staff make sure you are safe and alright, they come and have a chat, which makes me feel better." Relatives comments included, "I have no worries about [name of person] staying here, I know they are safe and well looked after."

Staff we spoke with were fully informed of types of abuse, when to raise a safeguarding concern and who they needed to escalate it to. Staff we spoke with also said they felt confident to speak with managers if they witnessed poor practice, and to escalate their concerns if they felt the matter had not been dealt with appropriately. Records showed staff received training about safeguarding vulnerable adults and children. This ensured that people were kept safe and staff were updated on actions which could be taken to reduce the risk of harm to people.

People were protected and their freedom supported and respected because the risk of possible harm was well managed. Risk assessments had been carried out to identify and manage people's individual risks and also with regard to their needs and wishes at the end of their life. The computer care planning system included risk assessments including falls, nutrition, mobility and tissue viability. For example, care plans showed how people were to be assisted to mobilise safely and how to minimise falls. The risk assessments we saw had been reviewed every two to three days due to the rapid changes in peoples needs at the end of life. We saw one person had not consented for the use of bedrails and these were not utilised. Appropriate equipment and prevention methods were followed for people at risk of skin damage from pressure. We saw evidence that staff checked the condition and safety of mattresses on beds on a daily basis.

There were sufficient numbers of staff on duty to keep people safe and meet their needs; the staff rota that confirmed this. People's needs were responded to in a timely way. We observed staff were available to help people depending on their wishes and people received care from staff who were unrushed, patient and caring.

People told us the numbers of staff on duty was 'good' and calls for assistance were answered promptly. People said, "You press your buzzer, they (staff) are here straight away," "Staffing levels are very good, if you need anything staff come" and "I ring my call bell and they (staff) are here within seconds, they are really fast."

The hospice employed a range of health and social care staff to meet people's physical, psychological and social needs. In-patient care was provided by a specialist team of doctors, nurses, healthcare assistants and nursing auxiliaries, therapists and social workers. They were supported by housekeeping and maintenance teams, administration staff and volunteers.

There were four part time consultants of palliative medicine in post .One consultant also worked alongside the community palliative care teams and two with the hospital palliative care team. The hospice

participated in a General Practitioner (GP) training programme. Trainee GP's spent six months at the hospice to enhance their knowledge of palliative care. Doctors from the local hospital also worked at the Hospice for six month periods as part of a rotation scheme.

On the day of our inspection, 10 people were receiving in-patient care and support. There was a senior qualified nurse, two qualified nurses, two healthcare assistants/auxiliary nurses and a student nurse on duty providing care. The registered manager and deputy patient services director, both nurses, were also on duty in a supernumerary role. In addition there were medical, domestic, administration and reception, social work, catering, maintenance and volunteer staff providing support.

The registered manager had systems in place to calculate how many staff were required to provide appropriate levels of care and support for people. The calculation took into account people's need for spiritual, psychological and cognitive support as well as their physical care needs. The registered manager said they had sufficient staff to increase staffing levels at short notice should people's increasing needs require this. Staff working within all areas of the service told us staffing levels were appropriate for people's holistic care needs. Staff told us, "We are really well staffed" and "Staffing levels are really good, we have time to spend with people and their families."

We reviewed staff recruitment records for four staff members. The records contained a range of information including the following: application, 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. 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 who were of good character.

We looked at the systems in place for medicines management. We assessed five prescription records and spoke with staff including two nurses, a doctor, and the deputy patient services director.

Medicines were supplied by a local pharmacy under a service level agreement; the service was available seven days a week, although advice was not always available outside of normal working hours. 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 stock checks.

Medicines requiring refrigeration were stored appropriately and records were maintained in accordance with national guidance. However, the action taken when temperatures were logged outside of the recommended range was not always recorded. The registered manager gave assurances that they would address and rectify this issue as a priority within the next week.

Prescriptions and administration records were completed accurately, and people were given their medicines as they had been prescribed. People and relatives 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. One person said, "Nurses bring me my tablets, the tablets are locked away. If I need a tablet for pain, they check to see what I have and they come back straight away with a tablet."

One person received medicine via a transdermal patch which was placed on the person's skin. There was written evidence that these patches were rotated to different sites; this is good practice to minimise skin irritation.

Medical staff reconciled (checked) peoples' medicines on admission to the service by checking with their GP. A pharmacist visited the inpatient unit twice weekly to review prescription charts to ensure medicines were prescribed safely and in accordance with best practice recommendations.

There were adequate supplies of emergency medicines and equipment, and a procedure was in place to ensure they were fit for use. The service held blank prescription pads and had a system in place to track their use; however logs were not always completed when prescriptions were issued. National NHS guidance identifies the tracking of prescription pads as a good practice measure to prevent misuse. The registered manager gave assurances they would address and rectify this issue as a priority within the next week.

Policies and procedures were available to all staff via the intranet, and covered all aspects of medicines management. There was also a self-medication policy in place, however staff told us nobody was currently self medicating. Arrangements were in place to ensure medicines incidents were reported, recorded and investigated through the service's governance arrangements.

We asked staff about their policy on how often nurses should be checking the syringe drivers. We were advised that this should be every four hours but if a person was asleep, particularly during the night, then they would not normally disturb them unnecessarily and may go six hours between checks. We discussed this with the registered manager about amending policies to reflect the decreased frequency of checks during the periods when a person was sleeping, and if national and local guidance deemed this safe practice. The registered manager gave assurances they would address this issue as a priority within the next week.

There was no structured training programme in place for nursing staff and no formalised supervision of practice was undertaken to ensure staff were performing to the necessary standards. This was contrary to the service's training policy which stated medicines management training should be undertaken every two years and observation of practice every three months.

We discussed with the registered manager and deputy patient services director the systems which were in place for medicines management and the omissions we had found. They said they were reviewing the provision of structured training and supervision for nursing staff and this would be reflected in the updated staff supervision policy. We saw evidence that the hospices staff supervision policy was under review.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks that included clear guidance for staff to follow.

Staff understood how they should respond to a range of different emergencies including fire, and fire training was part of their induction and on-going training. Staff took part in fire drills which helped them to remember the procedures and there was appropriate signage about exits and fire equipment throughout the home. The registered manager said the frequency of fire drills was being increased after consultation with the local fire and rescue service. Evacuation policies were also under consultation with the fire service. 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 premises were secure for people because there was a robust security system in place. This system identified visitors and monitored access to the In-Patient Unit.

There was a housekeeping team and an infection control lead nurse. The infection control lead nurse kept up to date with national guidelines and research to ensure people were receiving safe care. They were involved in ensuring that clinical staff were up to date with their annual mandatory infection control training and they carried out regular audits.

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. These areas were regularly audited including hand washing.

Is the service effective?

Our findings

People told us staff were well trained and knew how to meet their needs. People said, "They (staff), are clearly well trained, they do what they do and do it well," "All the staff know what they are doing here" and "Staff know their stuff, you ask a question and they know the answers."

Staff had undertaken appropriate training to ensure they had the skills and competencies to meet people's needs. All staff's essential training was up to date and included safeguarding, food hygiene, fire safety and moving and handling. There was also specific clinical practice training such as nutritional support and wound care management for clinical staff. Staff received additional training around end of life care and specific health conditions such as dementia care. This ensured people were cared for by staff who had the necessary knowledge and had the skills to carry out their role effectively.

Staff said, "Training here is very good" and "There are lots of learning opportunities working here," "As well as training we have link nurses in diabetes, infection control, and for manual handling. The link nurse has an interest in their field and cascades training to other staff," "All my end of life courses are done at degree level, everyone here has done some modules" and "Every member of staff has a budget for training, that's good I think."

New staff undertook a comprehensive induction programme which included essential training and the shadowing of experienced care staff. Staff told us they worked for two or three weeks in a supernumerary role so they could get to know the people who used the hospice services, other staff and the general management and running of the hospice. Staff said they found their induction training was very good. They said, "I got to know patients and staff and it gave me the opportunity to build relationships" "I had a mentor to work with and was given a booklet. I can also always ask the staff nurses and senior nurses" and "My induction was 'really good', and I was supernumerary for two weeks. I met different people from the fundraisers to the warehouse staff in the shops. It gave me good idea of what everybody does that works for the hospice."

Staff we spoke with demonstrated a sound knowledge of specialist palliative care in keeping with their roles and responsibilities and the service specification.

The hospice operated an annual appraisal schedule in place for staff. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. Staff told us and records showed staff were receiving appraisals from a mentor and/or manager on an annual basis.

Staff spoke positively of the group supervisions and support provided by their peers and managers and told us that this enabled them to carry out their roles effectively. Supervision is a regular, planned and sometimes recorded session between a staff member and their manager or peers to discuss their work objectives and well-being.

Group supervision included clinical supervision which gave staff the opportunity to discuss the emotional aspects of their role and ensured they received the support they needed. The registered manager said staff also had access to counselling services but these sessions were confidential and were not always recorded. We saw evidence staff had opportunities to reflect on their experiences following incidents.

Staff told us about 'Schwartz Rounds' which had been introduced at the hospice. These were a forum for clinical and non-clinical staff from all backgrounds and levels to come together and explore the impact their job has on their feelings and emotions. These meetings were open to all care staff and offered staff reflective sessions to discuss their own personal experiences. Records were kept of who attended the meetings, but to maintain confidentiality, full minutes of discussions were not recorded.

Staff told us weekly team meetings for all care, clinical and ancillary staff and weekly senior manager meetings took place. Staff confirmed there was regular group and clinical supervisions available for them to attend.

Staff told us some individual supervision sessions with their manager did occur but these were more on an adhoc basis and were not always recorded. We saw some records of individual staff supervision sessions that took place at the end of 2015. The registered manager said the service were currently developing their staff supervision policy, we saw a copy of this draft policy. The registered manager said they had identified that improvements in the frequency and recording of supervision on an individual basis were required. The registered manager said they planned to implement these improvements and increase the consistency and frequency of individual staff supervision within the next three months.

Staff said, "We support each other really well," "Support is really good" and "I am really well supported, we are a good team."

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 care homes, hospices and hospitals 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. When people were first admitted to the hospice they were asked if they were happy to be cared for at the hospice. If people were not happy then staff at the service were to consider the persons capacity and consider a DoLS. At the time of our visit, there had been no applications to place a restriction on a person's liberty. We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated a good awareness of the code of practice and confirmed they had received training in these areas. Procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to make decisions.

We saw evidence that Mental Capacity assessments were conducted and recorded and also evidenced in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

Documentation relating to DNACPR decisions was present in people's in care records. These showed discussions had been held with the person and their family where appropriate. The rationale for DNACPR decisions was clearly identified and recorded who had been involved in the discussion. If the person themselves had not been involved, the reason why was documented. The decisions were reviewed at weekly multi-disciplinary meetings.

Staff we spoke with understood the importance of seeking consent before providing any care or support. People confirmed staff always asked for consent before care being offered or provided. People said, "Staff always involve me in discussions about my care" and "Staff always ask me first before doing anything." The three people's care records we reviewed showed there was agreed consent acknowledged on the computer system.

There was strong emphasis on the importance of good nutrition and hydration with focus on provision for people at the end of their lives. There was a flexible approach to meal times in that there were no set meal times and the hospice was able to meet people's special dietary requirements as well as likes and dislikes. There were also kitchen facilities for family and friends and opportunities for family to enjoy meals with people. Catering staff said they provided snacks for relatives and often served them bacon sandwiches, jacket potatoes and soups.

People, their families and friends praised the choice and quality of food that was served. Their comments included, "Staff come and ask me what I fancy to eat and that's what you get," "They cater for all my choices," "[Name of person] always liked their sandwich done in a special way, and that's how they do it for them here," "Plenty of drinks always offered. You or your family can help themselves too and the food is really really good."

We saw one lunchtime meal service commenced at 12.30pm. There were pleasant interactions from the staff towards people. It was not a rushed event. Housekeeping staff wore protective aprons and offered each patient a choice of meal.

The catering staff were aware of each person's individual dietary needs and allergies and had access to people's nutritional details. The catering staff told us people were consulted when menus were planned and specific requests were taken into account. Staff told us there were no set times for meals and although there was a three week rolling menu plan people could have any alternative to the menu they requested. Catering staff told us people's dietary requirements were updated on a daily basis by the nursing staff. People had special diets such as 'smoothies', pureed meals or a soft diet when appropriate. The catering staff were also involved in monitoring how people were managing with their food and recording what was eaten every meal. They could then offer different choices and suggestions for individuals.

There were vending machines and water machines located around the hospice for people, their family and visitors and staff to use. Catering staff told us they were responsible to keep the vending machine stocked.

Stakeholders we contacted before our inspection said they had no concerns about Barnsley Hospice. Some stakeholders were able to share their personal experiences about the hospice after a member of their family had been an in-patient there. One care professional said, "On a personal note the care and staff were absolutely brilliant the atmosphere was very calm, very clean and they supported us at a very sad time."

There was evidence in people's care records that they had access to other healthcare services and on-going support where appropriate. Other health care services included physiotherapy, MacMillan nursing, tissue viability nurse and the community dietician for care in the hospice but also on planned discharge.

There was a social worker and assistant social worker based at the Hospice. Part of their role was to facilitate people's discharge home. They told us they had good links and communication channels with other social workers, the community nursing and continuing health care teams as well as GP practices and other health professionals. This helped ensure that people had a well-managed discharge.

Is the service caring?

Our findings

People on the in-patient unit were very complimentary regarding the caring, polite and kind nature of the staff. People frequently used words such as 'exceptional', 'fantastic', 'brilliant' and 'wonderful' when describing the care and support they received from the staff team. People said, "The staff here are very caring and kind, they can't do enough for you," "I cannot fault them" and "Staff are very good at what they do, absolutely top class." People told us how the staff had spent time getting to know them and their family and listening to what they wanted out of their stay at the hospice or when they returned home. People said, "At night it can be very quiet, I get a little lonely and staff will come and sit with you and have a chat. They really care about you."

People's families said, "They (staff) can't do enough for [name of person], I cannot fault it here," "Staff are not just here for [name of person] but here for me. All the staff, from the receptionist when you walk through the door ask how I am" and "Everyone I have come across here has been lovely."

We saw people could choose where and how to spend their time. We saw people using the various lounge spaces around the hospice. People spent time with their families either in their own room or in the lounges. People said, "I am not tied here, not fastened to my room, I walk to the day room. The gardens are beautiful if I want to go out. You have freedom. That's what I need" and "It's a lovely garden to sit in and watch the fish in the pond."

People's families told us they could visit at any time and were always made to feel welcome by the staff. A relative said, "I can visit when I want and stay as long as I want, I can stay overnight if I want. The staff are lovely." Families said they were provided with tea and coffee when they wanted and they had access to a kitchen and a fridge where they could store food for themselves and their relative.

Barnsley Hospice's philosophy is comfort, care and dignity. One person said, "I'm proud to have Barnsley Hospice in Barnsley." Staff said, "It's a nice atmosphere here, we are a good team and work well together for the benefit of our patients" and "It's a privilege to work here."

We observed positive interactions between the staff and people on the in-patient unit even though staff did seem very busy. We saw this when staff administered medication and offered aspects of personal care to ensure people's comfort and wellbeing. Support was given in a patient, respectful and caring manner; people were not rushed and staff took time to explain what they were going to do and waited for consent before proceeding. Staff took time to listen and to respond in a way that the person they engaged with understood.

Social support included people bringing pets in from home and christenings and weddings ceremonies held at the hospice. A staff member told us how privileged they had felt to be asked and been able to cater for the wedding reception following the marriage ceremony.

The layout of the in-patient unit provided people with privacy and people had their door closed to their

room if they so wished. Staff knocked before entering and waited to be advised they could enter.

People told us their privacy and dignity was respected at all times. One person said, "There is comfort, quietness and dignity here" and "Not much left for me but dignity and that's what I get here."

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in 'advance care plans'.

There was an End of Life advanced care plan in place for when a patient was considered to be in their last days of life called 'My Care Plan'. Staff said that it was a multi disciplinary decision when a person's end of life care plan was commenced and each person was reviewed daily.

These advanced plans gave people the opportunity to let their family, friends and professionals know what was important to them for a time in the future where they may be unable to communicate their wishes. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline and who they wished to be their legal representative. These advance decisions were recorded, effectively communicated to staff and respected. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes.

The service took account of people's cultural, religious, spiritual, emotional and physical needs and these were met by the hospice team. People and their family members could access a range of support services across the hospice and community setting to provide the care and support they needed and wished to receive. This included pastoral support, bereavement and counselling support, social therapy (including complimentary therapies), day hospice and access to a family support team.

There was a counselling service for people and their families which was based at the hospice, providing support to people from hospital and community as well as the hospice.

There was a range of clear and comprehensive information available to people who used the service and visitors about the services provided. Information included who the medical and nursing staff team comprised of, how people could be supported with group or individual therapies and also the outcomes of surveys and audits. Information was available about such topics as life limiting conditions, advanced care planning and financial welfare and benefits.

Staff told us how they supported families at the time of death and after; this included families or carers being able to stay with their loved one as long as they wished. The staff had access to bereavement information and leaflets were given to the family explaining what they needed to do next such as registering the death and arranging the funeral.

Bereavement support was available to anyone whose family or friend was previously or currently being cared for by Barnsley Hospice. The bereavement service included pre and post bereavement support and child support was available for children aged five and upwards.

Is the service responsive?

Our findings

People staying at the hospice confirmed that they were involved in discussions about their care and staff listened and acted on their views. People's comments included, "They involve me in discussions about my care. The doctor asked me which tablet made a difference with my pain relief. They took my view on board and gave it me. They came back later to see if it had worked," "Staff go through with you everything they are planning to do," and "Everything is explained, and me and my family are kept up to date and involved in those talks."

People and their relatives told us that the way staff responded to their needs was, "Brilliant", "Top class" and "Really fast, without delay."

On the day of inspection we did not hear call bells ringing for any length of time. We observed people that required medicines were administered them promptly and as a priority.

We looked at the care records belonging to three people. These were standardised care plans on the computer and included relevant care needs. The care plans were updated on a daily basis and were discontinued where they were no longer required (as the patient's condition changed).

There was regular monitoring of people's condition. People's vital signs and pressure areas were recorded and monitored to enable staff to respond to any changes in the person's physical treatment.

Each person had an individualised care plan and people at the end of life had a document called 'My Care Plan'. The 'My Care Plan' was a joint pilot scheme launched in April 2015; between the hospice, hospital and community who devised the care plan and made it personalised. The 'My Care Plan' was a folder, the first page of which was for the person's comments and concerns. There was an assessment for the last day of life care and this included a capacity assessment, multi-disciplinary team discussions, contact details for the person's family, spiritual support, a medical management plan, assessment of comfort needs and if pre-emptive medicines were prescribed. There was a 'personal need and aims of treatment and care' and a page for multi-disciplinary team evaluations. There was a 'family tree' in the paper notes and which listed family and friends important to the person.

Within the plan was a list of palliative care drug stockist; (local chemists). A particularly useful resource as people often required medicines out of working hours.

There were leaflets in the folder with information on oral hygiene management. These described sore or ulcerated, coated or infected mouths and photographs accompanied the conditions.

There was supporting information and leaflets on care in the last days of life and information for people and their families and friends.

We attended a staff handover meeting where people and their relatives' care and support were discussed

and how staff could respond to peoples' needs. This was attended by staff coming on duty and staff who were going off duty and included qualified, auxiliary and student nurses. The handover contained detailed discussion about each person's care and support needs. Staff discussed people's social circumstances, DNACPR status, physical conditions and the medical plan. Staff discussed how other healthcare professionals were involved in people's care and support. For example staff discussed referrals that had been made for people. This included referrals to the physiotherapist, the MacMillan nurse, the Tissue Viability Nurse and the community dietician for care in the hospice but also on planned discharge.

The involvement of family was apparent from the details discussed as was preferred place of care which in all people discussed was Barnsley Hospice.

The hospice also responded to some people's specific medical conditions through support groups and clinics. A Lymphoedema clinic and 'Upbeat' group were held on a weekly basis. We saw information about 'UpBeat'. It was described as an informal group for adults with symptoms of heart failure that affected their daily lives. The group was held once a week at the hospice and it offered information, practical support and specialist advice with symptom management and treatment issues from hospice staff. The staff team consisted of registered nurses, a doctor, a complementary therapist and volunteers.

Staff told us how they responded to people's planned discharge from the day or inpatient service with a system at the hospice called 'Stepping Stones.' Staff said 'Stepping Stone's' aim was to provide extra support for people. This was done through volunteers visiting people in their own home for a few weeks after discharge.

People staying at the hospice told us that if they had any concerns or complaints they would feel comfortable raising them with a member of staff. A complaints leaflet gave information and contact details of people to contact if they wished to make a complaint.

A complaints monthly log was maintained and we were able to look at records of complaints that had been made over the last year and how they had been addressed.

We saw complaints that had been made had been appropriately investigated and written feedback provided to the complainant. We saw there was a clear system for sharing complaints and developing actions where lessons had been learnt to ensure improvements were implemented. The management team had captured a number of compliments and positive feedback in their records and quality assurance audits. This showed the registered manager had robust systems for the management of people's feedback.

Is the service well-led?

Our findings

There was an open and positive culture at Barnsley Hospice which focused on people who used the service. People's relatives and other care professionals spoke very positively about their experiences with the hospice staff and the atmosphere at Barnsley Hospice. Comments included, "The care and staff were absolutely brilliant the atmosphere was very calm," "The service the hospice offers is brilliant, absolutely brilliant," "All the staff here, I mean all, can't do enough for you, nothing is too much trouble" "It has a homely feel, it's relaxed but we can still laugh with all the staff," "I cannot fault it here," and "An absolutely top class service."

The hospice had a registered manager who had been in post for just over 12 months. The registered manager was also the Chief Executive. The registered manager was open and honest with us and had a good overview of the service provided and areas where improvements could be made. All staff spoke positively about the registered manager's style of leadership and told us they led by example.

There was an effective leadership team responsible for the running of the hospice that included the chief executive and registered manager and the senior medical, nursing, administration and ancillary staff. There was a board of trustees who had variety of experience. The registered manager said they had regular meetings with the Chairman and board of trustees and said the board were very proactive in the management of the hospice. Trustee visits took place regularly at the hospice. During these visits and at fundraising events trustees spoke with staff members and checked on areas around improving the service. This ensured that staff had the support they needed and checks were carried out to drive improvement.

Staff we spoke with said they felt valued and motivated to provide a high level of care. Staff told us, "I feel we are moving forward, we have two more consultant doctors and two new beds this has allowed us to have more specialist palliative care and become more proactive," "Some staff have been here for years which is reassuring, I feel really well supported," "The management are really good" and "Communication is really good, we have the support and resources to do our jobs really well."

Staff we spoke with told us how proud they were to work at Barnsley Hospice and how fulfilling their job was, comments included, "It's a wonderful place and atmosphere to work in," "I love volunteering here," "It is a privilege to work here and to be with people and families, I'm passionate about my job," "It's not a job, it's a journey we share with families" and "We all go the extra mile. We want to see people have quality at the end of life."

Comprehensive audits were carried out for every aspect of the service to identify how it could improve. Where the need for improvement was identified, remedial action was taken to improve the quality of the service and care. The service worked in partnership with other organisations to drive improvements at regional and national level, participating in quality monitoring and research projects and end of life care awareness which positively benefitted people in their care.

The hospice had a clinical governance committee and a clinical effectiveness group for overseeing areas

such as policy reviews, the risk register, systems and process for auditing, patient and family experience, medicines, DoLS, tissue viability and staff development/ training. Progress and actions to date were recorded during the meetings.

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.

Weekly team leader, staff meetings and management meetings took place to discuss every aspect of the service, including staff training and policy and guidelines reviews.

The hospice policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated continually. Staff were made aware of updates and knew where to locate the policies for guidance. Staff could view policies at any time via the IT system at the Hospice.

People and family members were encouraged to give feedback on the services offered. Feedback was gathered through an inpatient unit survey. There was also a suggestion box within the hospice where people and relatives could post comments or suggestions anonymously. The survey forms recently returned were being collated before the findings were fed back to people who used the service, staff and the board of Trustees. We viewed previous satisfaction surveys from 2015 and some from 2016 which had not been collated yet which contained very positive findings.

The feedback included comments that people had confidence in the staff caring for them and they were treated with respect.

Barnsley Hospice maintained strong links with partner agencies and the local community. The registered manager and staff told us nursing and medical staff provided guidance and advice to care professionals and people and their families.

The hospice had a system called 'Pall Call' in place. This is a Specialist Palliative Care telephone advice line for health care professionals and is open 24 hours 7 days a week. It is also for patients and carers to call. Calls go directly to the inpatient unit at the hospice, a member of staff takes the call and there is support from the hospice practitioner or consultant if the staff member is unable to answer the query.

'Pall Call' provides specialist palliative care advice to those providing general medical and nursing services. These can include district nurses, General Practitioners, hospital doctors, ward sisters and charge nurses, rapid response and Hospital at Home staff, supportive care at home staff, and nursing home and residential staff managers.

The referral criteria for 'Pall Call' is if the patient has a life threatening or life-limiting illness where curative treatment is not possible and a palliative care approach has been decided upon. This service is not just for a cancer diagnosis but any life limiting condition.

Barnsley Hospice has a key role in the local community and was actively involved in building further links. There were many organised events such as races, night walks, galas, dances and sales. 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 local press.

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.