

Mary Stevens Hospice(The)

The Mary Stevens 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

This inspection took place on 10 and 11 May 2016 and was unannounced.

Mary Stevens Hospice is registered to provide specialist palliative care and clinical support for adults with life limiting illnesses. The service provides care on their in-patient facility which catered for up to ten people. At the time of the inspection there were six people using the service. People could also access support from specialist nurses in day hospice. The services provided included counselling and bereavement support, day hospice care, family support, chaplaincy, occupational therapy, physiotherapy and complementary therapies. The day hospice could cater for eighteen to twenty people daily some of whom had also used the inpatient facilities.

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

People told us they felt safe. Staff were trained and understood their responsibilities in keeping people safe from harm or abuse. They knew how to recognise and report any concerns about people's safety. Care was centred on the needs of the individual and included the management of any risks to their health or well-being

There were clear systems in place to review and analyse accidents and incidents and take action to reduce the reoccurrence of these.

Staff were recruited safely and doctors, specialist nurses, care staff and volunteers were qualified, supported and trained to meet people's needs. The provider had lone working arrangements to ensure staff or volunteers who worked in the community were safe. People spoke highly of the availability and skills of staff to meet their needs.

There were systems in place to safely manage and administer medicines to people. People received their medicines for pain relief or symptom management without delay. A dedicated internal pharmacy lead supported medical staff to ensure people received their medicines in a safe and timely manner.

The rights of people to make important decisions about their health or wellbeing were protected because staff followed the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People enjoyed the meals provided which catered for a range of people with specialist diets. People were supported to eat and drink and staff worked with other health professionals to promote people's nutritional welfare.

Staff knew each person well and understood how to support them when they were unwell or approached the end of their life. People were at the heart of the service and fully involved in the planning and review of their care. This included the management of their pain and symptoms and their preferences and wishes with regard to their end of life care including their preferred place of death. People's emotional and spiritual needs were explored and respected and people had access to complementary therapies to help manage their symptoms.

People told us staff were very caring, kind and receptive to their needs. People's independence was encouraged and their privacy and dignity protected. Staff worked hard to provide lasting and memorable experiences for people and their family members so that they experienced compassionate care.

Leadership was strong and consistently looked at ways to promote the provision of palliative and end of life care for people. There was a clear management structure with good communication so that everyone, including the trustees, shared the same vision and plans for the future. The monitoring of the service was consistent and links with local and national organisations ensured the provider was sharing best practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were kept safe by staff who had been trained to recognise and respond to any potential abuse.

People were confident that staff managed risks to their health and safety and measures to reduce risks were in place.

People had no concerns about the availability of staff to meet their needs.

Medicines were well managed and people had access to pain management medicines when they needed this. Staff were trained and qualified in safe administration of medicines.

Is the service effective?

Good ●

The service was effective.

People were cared for by staff who were specifically trained to meet their needs and who had received support to develop their skills and knowledge via the dedicated training team within the service.

Staff understood and followed the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making decisions about all aspects of their treatment and care.

People were supported to eat food and drink food of their choice to maintain their diet. People had access to healthcare professionals to ensure the best outcomes for them.

Is the service caring?

Good ●

The service was very caring.

People were overwhelmingly positive about the caring approach and nature of staff and volunteers and valued their relationship with them.

People were supported to express their choices and to be involved in all aspects of their care.

People were supported in a caring way with dignity, respect and kindness.

Is the service responsive?

Good ●

The service was responsive

People and their families experienced personalised care that reflected their wishes and what was important to them.

People were supported in planning their end of life care. Advance care plans included their end of life care preferences and choices so that care was responsive to their needs.

People knew how to make a complaint and were confident staff and managers would be receptive to their feedback.

Is the service well-led?

Good ●

The service was well-led

The staff and management team placed people at the heart of everything they did. There was a very inclusive culture with people, families and staff feeling involved, listened to and appreciated.

There were systems in place to monitor the quality of the service and these focused on the continual improvement of the service.

The provider worked in partnership with other organisations to ensure they followed best practice and provided a high quality service.

The Mary Stevens Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 May 2016 and was unannounced.

The inspection was carried out by one inspector, a pharmacy inspector, a specialist advisor and an expert by experience. The specialist advisor had the experience of working as a healthcare professional within the field of end of life care. The expert by experience is a person who has personal experience of caring for someone who has used this type of care service.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The registered manager had submitted the information as we requested. We sent out questionnaires to community professionals seeking their views about the service. We took this information into account when we made the judgements in this report.

We also reviewed the information we held about the service including notifications of incidents the provider had sent us. Notifications are reports the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We spoke with twelve people who used the services provided and five relatives. We also spoke with fifteen staff to include the registered manager, clinical nurses, doctors, health care assistants, the medical director, pharmacist, family support staff, education and practice development staff, the audit and quality assurance lead, three volunteers, the chief executive and two trustees. We reviewed five people's care records to see how their support was planned and delivered. We spent time observing staff interacting with people and their relatives in both the inpatient ward and day hospice. We looked at other records related to people's care and how the service operated. This included medicine records, four staff recruitment records, quality assurance and clinical audits, staff training records, records of complaints and compliments.

Is the service safe?

Our findings

People were consistently positive about their safety at the hospice. One person told us, "I feel really safe; the staff really look after you and I have full confidence in them". Another person told us, "There's feeling safe and being safe; I can tell you it all depends on the staff and you couldn't find more committed staff who willingly sit with you in your dark moments, reassure you and make you feel confident".

People had been provided with information leaflets. These provided clear information for people about their right to be protected from harm or abuse and how to report this. All of the staff we spoke with were aware of how to report concerns of potential or actual abuse. A staff member told us, "Everyone who works here volunteers included, undergo safeguarding training. We all know how to report any concerns we have whether this is about an inpatient or a patient attending the day hospice". Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns and were fully aware of the provider's safeguarding policy. This included reporting issues to the appropriate authorities outside of the organisation such as the local authority. Staff told us they could also approach the hospice social worker for advice.

Training in relation to how to protect people from abuse or harm had been provided to all staff and volunteers. We saw there were regular opportunities to discuss any concerns they had regarding people's safety and take action to support the person. One volunteer told us they were aware of and knew how to recognise warning signs about people's safety for example where a person may be vulnerable to self-harm or feeling depressed. The provider had demonstrated that people and staff safety was given high regard. There was a designated safeguarding lead and the provider told us in their Provider Information Return (PIR) that a second lead person had been identified and training planned for them to undertake this role. There were no safeguarding concerns about this service.

People told us that they were happy with the arrangements to safeguard their possessions. Information leaflets were available for people and their families about the security of their possessions and the safety of the hospice environment.

Staff safety with regard to lone working was well understood and practiced so that the whereabouts of volunteers and staff were known. We saw appropriate risk management plans were in place to minimise the risk of potential harm to staff when lone working. For example the family support worker provided an example of a situation when providing bereavement support to a person in their own home. Following a risk assessment two staff were assigned to conduct the support demonstrating that people and staff safety was given high regard.

People had individual risk plans in place which showed how risks to their welfare and safety were managed. People who used the hospice confirmed that they had been fully consulted about risks and provided with a means of managing these. One person told us staff supported their mobility with the hoist and their fragile skin with pressure relief cushions. A second person told us, "My condition has put me at risk of other medical complications but the staff have managed these really well. The problems were anticipated and dealt with

before they caused me further pain or complications, and the staff fully explained this to me". Risk management plans were in place for potential risks such as pain, medicines, falls, moving and handling, nutrition and hydration as well as pressure sores. Staff we spoke with were aware of the individual risks people faced and we saw that preventative measures were taken by them to ensure people's safety. For example by using the correct equipment and additional staff to provide the support people needed with their deteriorating mobility, fragile skin, pain and symptoms and difficulties in breathing. Staff told us and we saw that people's rapidly changing needs were discussed and reviewed by a team of doctors and professionals on a regular basis via multi-disciplinary meetings. This enabled staff to review and update risk management plans so that people had the right support to meet their changing needs.

The safety of the hospice was regularly checked. Equipment such as hoists had been serviced and audits were undertaken to make sure the building was safe and well maintained. Audits on incidents, accidents, falls and pressure sores were undertaken and shared with the board of trustees. We spoke with two trustees who spoke confidently about the safety of the hospice and demonstrated how information was shared with them, reviewed and actions taken to improve where needed. For example we saw the management team had identified a pattern/theme in relation to falls and taken appropriate action to reduce these. Additional staff had been put in place and sensor alarms to alert staff to the person's movement. The medical director told us of their recently implemented significant event analysis system. We saw this would enable them to capture all the information regarding a significant event, review and reflect on any learning identified and identify actions and a time to review if their actions had led to improvements.

The provider had ensured that staff and volunteers were recruited safely. A staff member said, "I had to produce documents and have police and registration checks done before I was able to start work here". We saw checks with the Disclosure and Barring Service (DBS), references and professional registrations were documented which demonstrated a commitment to employing appropriately qualified people with the skills to meet people's needs.

People were overwhelmingly positive about the availability of staff. A person on the inpatient unit told us, "They answer the buzzer in seconds." A second person said, "The staff are marvellous; always available but more important always willing to help". A relative who visited regularly told us, "I've never had concerns about the number of staff; there is staff around and they always have the time for you". Staff we spoke with expressed no concern about staffing levels. One staff told us, "If we need extra staff it is provided, if we know someone's needs are increasing we discuss and plan for it". The provider told us in their PIR that, "Patient dependency levels can change quickly on the inpatient unit and although staffing levels are fixed, senior staff are aware of their responsibility of ensuring that extra staff are booked in response to need as appropriate". Staff we spoke with in the day hospice demonstrated that people's dependency levels were taken into account when booking them in for the day. A nurse told us, "We try to ensure we have a balance so that when people attend we can ensure they get the most from their day". We saw people had access to a range of staff; doctors, nurses, health care assistants, volunteers, therapists, catering and domestic staff. All of the staff valued the fact that staffing levels enabled them to take the time needed to respond to people's individual needs. We saw several examples of where staffing had been increased to support people to undertake events that were personal and important to them. We saw staff took an inpatient to the pub to celebrate their family member's birthday. An activity the person described to us as, "An event I can no longer do independently, but is crucial to me". We were able to observe that staffing levels were needs led and had accommodated people's wishes.

We spoke with a person on the inpatient unit about their medicines who told us they were fully informed and involved in any decisions about their treatment saying, "I would give them 10 out of 10". A dedicated specialist Palliative Care Pharmacist based at the service was actively involved in all aspects of people's

individual medicine requirements. They regularly attended clinical meetings to ensure good clinical practice was followed. Any concerns or advice about medicines were discussed with the prescribing doctor or with the prescribing nursing team. The pharmacist ensured that all policies and procedures for the safe prescribing of medicines in palliative care were available and kept up to date. The pharmacist ensured that both the medical and non-medical prescribing team were kept up to date with developments. The medical and nursing staff team we spoke with told us that having a specialist pharmacist with palliative care knowledge was an invaluable resource of information. The Medical Director commented that the pharmacist, "Acts as our anchor in ensuring medicines are prescribed and handled safely."

The pharmacist was part of a National Palliative Care Pharmacy network to ensure they were kept up to date. They ensured that the nurse prescribing team were also kept up to date with developments in medicines and treatment in palliative care. The administration of medicines was recorded onto a specific medicine prescription chart developed by the hospice team. We saw that it was specific to end of life care for people requiring pain management with reminders of correct doses printed onto the chart. This was helpful for prescribers to ensure they followed safe prescribing guidelines.

New innovative ways of working were being developed. For example, a local End of Life Steering group with a particular interest in medicines had recently been set up within Dudley. The group had been developed together with local pharmacies, community prescribers, hospital teams and the hospice to improve communication in the transfer of information about people's medicines between the different teams.

Medicines were stored securely for the protection of patients. The pharmacy was secure with medicines stored within the recommended temperature ranges for safe medicine storage. Daily temperature records were available which recorded the temperatures for the medicine refrigerator and the medicine room temperature. The storage and recording of controlled drug medicines which require extra security storage arrangements were stored securely and recorded correctly according to safe practice.

We found an open culture of reporting medicine incidents with arrangements in place to ensure they were documented and investigated. Medicine incidents were discussed every two weeks at the Clinical Services meeting and then also at the Governance Committee to discuss outcomes from the incidents. Medicine incidents were discussed as soon after the event as possible with the appropriate clinical lead Matron or Medical Director then every two months at Clinical Services meeting and quarterly at the Clinical Standards Governance Committee. We were shown one example following an incident where a full investigation and discussion about outcomes took place. Lessons were learnt and new systems for medicines safety and therefore patient safety were implemented.

Is the service effective?

Our findings

All of the people we spoke with were highly complimentary about the skill and competency of staff. One person told us, "My care has been excellent; they are clearly trained and I have had no concern about how they care for me". Another person told us, "They are very good; they know when I need help or I am in pain, they explain everything to me so I know what to expect, and more importantly; they listen".

Staff had received a comprehensive induction which had included shadowing more senior staff and attending training. A staff member told us, "My induction covered all the key areas and training, I had time to be introduced to the hospice and there was an emphasis on a positive and caring culture". All of the staff and volunteers spoke positively about the support they received. External counselling services to support staff with the emotional aspects of their work were evident and staff told us they felt they had opportunities to reflect on their practices. Volunteers had participated in a training programme 'Community Volunteering' which they told us covered the key areas and prepared them for supporting people as a befriender.

Staff told us training was encouraged and they had received support and supervision from their line manager. Competency frameworks were in place which showed staff had been assessed and were competent to deliver care including palliative and end of life care, clinical care and communication skills. There was a training structure in place which was led by a Clinical Education Lead and a Clinical Educator which had expanded the provision of palliative and end of life care training to staff. The training structure in place had enabled the provider to share their skills and knowledge with external individuals and organisations. Staff had been supported to develop their specialist skills. For example plans were in place for the Clinical Educator to be registered with the UK Resuscitation Council. This would ensure their competence as a trainer in delivering training to other staff. Some people who used the service told us how staff had supported them, 'at difficult times' and 'when discussing difficult issues' and said staff were skilled in this area. Staff told us they had been trained in using communication skills to support people who may have to make difficult decisions about their care or treatment. People told us that staff demonstrated knowledge about their specific health conditions and how to manage their symptoms and pain.

Some staff had lead roles with responsibility for infection control, wound care and nutrition which were supported with specific training to develop their expertise in these areas. We saw that the nutrition training had led to protected mealtimes and use of coloured dishes to ensure people with nutritional needs had the support they needed. Study leave opportunities were described as 'very good' with protected time for training. The daily handovers with nurses, care staff, doctors and the pharmacist ensured that important information was shared effectively amongst the team. People received care from staff who had the skills needed to carry out their roles and who were knowledgeable about their needs.

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, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS).

The provider was working within the principles of the MCA. At the time of our inspection people using the service had capacity and did not require any DoLS. People were encouraged to make decisions and choices for themselves and their consent to care was obtained and noted in their care plan. Staff had received training in relation to the principles of MCA and DoLS and they were able to demonstrate how this was applied in practice. A staff member said, "We must always gain consent and can't restrict people, but also we need to be fully aware if someone is losing capacity to make their own decisions". People's capacity was assessed if there was any concern about their ability to consent and we saw people's care records included reference to their capacity.

A person using the service told us, "I am fully involved in all decisions about my treatment; they explained the options but it is my decision whether I consent to treatment". We observed that choice and consent was implicit in everything that happened within the hospice. We saw all staff consulted with people and their relatives about proposed care and treatment. A person told us, "Yes they come round every day and discuss my symptoms, if I have any pain, how I am and so on. They will explain if they think I need any changes to my treatment". Staff described their role in applying the MCA and understood the need to act in a person's best interests if the person they cared for was unable to make a decision about their treatment. Where people approached the end of their life and may have lost capacity staff described how medical staff would assess the person's mental capacity and they would discuss whether decisions in the person's best interest should be made. Records we reviewed showed the multi-disciplinary team considered people's mental capacity throughout their stay at the hospice.

Where people had chosen to have a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) we saw these were in place. A person on the inpatient ward confirmed they had been fully involved in the decision making in relation to their DNACPR. The provider had worked collaboratively with the local hospital and Clinical Commissioning Group (CCG) to develop a joint DNACPR. This was held by the person and was valid in any care setting. This meant that any unnecessary distress was reduced for people as their choices regarding resuscitation were known between services. We saw DNACPR records were signed by a doctor, completed in full and were with the person's and a relative's knowledge, participation and agreement.

All of the people we spoke with were happy with the meals provided. We saw a choice of three main meals was provided and we heard from people that staff would cook them something else if they didn't want a menu dish. One person told us they had 'salads and omelettes cooked especially for them'. Another person told us sandwiches and snacks were 'always available'. Staff were aware of the importance of nutrition and hydration during people's treatment and at the later stages of end of life care. People's nutritional and hydration needs had been assessed and identified if they required additional support to eat and drink. There was a focus group that had looked at nutrition and hydration which ensured that this was given high priority. People whose appetite had reduced were offered choices as well as specific high calorie drinks or snacks if they were unable to eat a meal. Meals were offered in various consistencies so that people who found it difficult to swallow could manage these more easily. Relatives told us that they were very happy to see that food and drink was always on offer and that people had the support they needed to eat and drink. We saw that mealtimes were 'protected' and a person told us this was, "A good thing because we want to keep our dignity". Speech and language therapists and dieticians provided additional support and any concerns about eating and drinking or distressing symptoms this might cause were referred for discussion with the multidisciplinary team and the person's family. People had fresh drinks in front of them throughout the day. Choices of hot or cold drinks were offered. One person told us, "I've just enjoyed a glass of Baileys here this morning, so yes they do promote drinks".

People's health needs were met by staff that helped them to stay as comfortable and free from pain as possible. The people on the inpatient unit rated the management of their pain as 'good'. One person told us that in addition to getting their usual medication they had access to, "Immediate pain relief when I need it day or night". A second person on the inpatient unit told us, "I've been quite ill and they've done everything for me". The person told us that since being at the hospice they felt much more comfortable and said they had rapid access to extra pain medication when they felt they needed it. A third person on the inpatient unit told us staff had 'got their symptoms under control'. We saw they had equipment in place to improve their symptoms and comfort. Information about people's treatment, pain and symptom management was evident in their care plans. A person told us how their difficulties in breathing had been managed by the doctor who saw them 'straight away' and altered their respiratory equipment. People's health, their condition, their mood and appetite were recorded and planned for. Staff said there was good communication between all staff and where people's condition deteriorated this was discussed at multidisciplinary team meetings (MDT) each week. There was daily liaison with the Macmillan nurses and weekly MDT meetings so that people had access to a range of services both internally and externally to meet their needs. This ensured that people had effective continuity of care and treatment to manage pain and symptoms.

Is the service caring?

Our findings

People were very complimentary about the compassionate nature of staff. They consistently described staff as being; friendly, very approachable, kind and good listeners. One person said, "You could ask them anything and they will come back with an answer or try and get what you need". All of the people and their relatives that we spoke with rated the caring as 'ten out of ten'.

People and their relatives told us staff treated them with compassion and kindness and 'made time to listen and talk' to them. We heard that staff reassured them when they were anxious or frightened. One person said, "No one wants to be in a hospice, but honestly you have no idea how lovely the staff are and how well they care for us, I can't praise them enough". A person in the day hospice told us that, "The atmosphere of the place made it caring". They said they would sum it up as a place of, "Care, love, attention and touching". They told us that physical contact was, "Very important" to them and they had enjoyed staff holding their hand saying that it gave them "Reassurance and comfort".

We saw staff were readily available to stay and talk with people, offer them comfort or advice or just enjoy each other's company. People said they had good relationships with staff. A staff member told us, "I really value that aspect of our work; we always have time with people; time to get to know them, what's important to them and time for them to express themselves". Our discussions with staff showed they knew people and their families very well and were able to describe the support offered to people in detail. A visiting family member told us that staff were "always friendly and caring" towards them. They said that staff had taken the time to explain the side effects of medication to them as well as to their family member and, "always answered any questions we have about his care".

People's needs were reviewed daily by the doctor, nurses, care staff and pharmacist and information was shared with all staff at handovers to ensure they were kept up to date with people's changing needs. Staff were aware of people's needs and knew how to manage and respect these. People we spoke with praised the staff for how they enabled them to have a good quality of life. One person said, "They have made me comfortable and my pain is managed. I won't be cured but whilst I am here they are interested in me, listen to me, that's so important". We observed staff were calm and reassuring when responding to people's increased pain or distress. We heard from a person that staff had provided them with the necessary equipment that kept them comfortable. They said that this had helped them manage their anxiety because they felt this was reducing the risk of other symptoms occurring.

People told us that there were many things staff did that made them feel they mattered. A person told us they felt "very well cared for" and, "staff just cannot do enough here for me". They said their family were well cared for too. The person's family member was receiving relaxation therapy and they told us they were, "really happy" about the care shown to them all. A second person told us how their relatives had been supported with concerns about travelling costs to and from the hospice as this had impacted upon the family. The hospice staff had arranged for volunteer drivers to drive the family to and from the hospice to reduce the financial burden and stress. We observed staff being kind and compassionate, showing concern for people's comfort. A relative told us, "People's comfort is priority; for me it's not all about what they do

but the way that they do it. I've seen the gentle way in which staff moved the blankets until he was comfortable".

The provider had ensured that people and their family had the emotional, spiritual, religious and bereavement support they wanted. There was a strong focus on people's well-being and well established support networks were in place such as the Family Support team which enabled staff to support people and their families on both an emotional and practical level. People's well-being was seen as key and all of the people we spoke with from both the inpatient and day hospice had received complementary therapies. A person from the day hospice told us they had received therapy (reflexology) on two occasions and a person on the inpatient unit told us their wife was, "having her hair done today." Everyone was offered complementary therapies as well as some beauty treatments and could have these therapies in the garden, the lounges or at a person's bedside, "Wherever the person feels more comfortable".

People and their family members had access to a chaplain for spiritual care and support. Some people found comfort in the meditation provided by a visiting monk. A person told us that staff had spent a lot of time with their children to help them understand what was happening to their parent. A staff member told us how they had arranged access to external counselling for the children as well as art therapy to support them. Staff talked about the importance of 'caring for the family' when supporting a person with end of life needs.

There was a creative and dedicated team of volunteers who had been 'matched' to people. Volunteers worked in a 'befriending' capacity and one told us how they had supported a person whose wish was to organise their extensive personal collection before their death. The volunteer supported the person to complete this over a number of weeks and told us of the 'pleasure' the person had from this experience. Some trained volunteers undertook work with people using their own skills such as providing complementary therapies, occupational therapy or art for people. We saw the provider had recently nominated a volunteer for an esteemed award; 'The Order of Mercy' which they won. This was from the League of Mercy Foundation in recognition of their distinguished voluntary work over many years.

People were 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 and wishes in regard to their care and treatment. A person told us, "I talked to the staff about my treatment and my end of life wishes and my family were involved in that as well". We saw from records that people at the end of life phase had been supported to develop an individualised advance care plan to be followed as they neared the end of their life. This included their wishes and preferences with regard to where they wished to die. These had been agreed by the multidisciplinary team and the person or their representative. A staff member told us, "We will always listen to people and support them to make their own decisions about their care, treatment and wishes".

Information was available to people about the services provided by the hospice. A directory of all the hospice services had been developed and introduced by a group of staff and was available in each patient room. Information was also displayed via a digital screen in the inpatient unit lounge. This included information about advocacy services, family support, use of interpreters and bereavement services. Where people had no next of kin or relative to represent their views the provider had appointed a volunteer who worked in advocacy to educate staff in the coming year. People were enabled to ask questions or comment on their experiences via a questionnaire within a few days of their admission. Staff told us that people's feedback allowed them to identify and address any issues that people may raise.

We saw staff treated people with dignity and respect each time they delivered care or interacted with them. One person told us, "They are very respectful; will knock the door, cover me when bathing me and more

importantly they are aware when I just want 'quiet time' and no disturbances". Care was provided in individual bedrooms and 'Do not disturb' and 'Free to enter' signs were in use to protect privacy. People's independence was promoted; self-help continued where people were able, one person said, "My routine is decided by me but they help me if I need it". People had been supported to leave the inpatient unit to pursue their social needs, for example to go out for family meals. Relatives were able to visit without restriction and facilities were available for them to help themselves to drinks and they had access to quiet areas for privacy.

Is the service responsive?

Our findings

People were overwhelmingly positive in their comments regarding their care and how staff consistently responded to their needs. One person told us they had been admitted to the inpatient unit because they had been suffering shortness of breath and pain. The person told us that the nursing staff were 'very caring' and 'very quick' to respond to their requests for pain relief. They also said, "The doctors listen to me when they ask about my pain". The person told us their pain had improved and changes in treatment had been made to improve their shortness of breath. They described their treatment as, "Marvellous; nothing is too much trouble". A second person on the inpatient unit told us, "They have really helped me; I was admitted without delay and they have done everything to manage my symptoms. They have helped me achieve things I want to do for me and my family before I die".

People told us that on arrival at the hospice either as an inpatient or attending the day hospice, they had been fully involved in an assessment of their needs. A person told us, "They (staff) asked about my pain and the symptoms I was having. They offered me therapies which have eased me and relaxed me". Another person told us, "We discussed my condition and treatment. I am very happy with the support they have given to me". People told us their care and support was planned in partnership with them and they felt in control of their own treatment. On first contact with the service it may be the doctor, specialist nurse or nonmedical prescriber who admit people to both the day hospice and the inpatient unit. They spent time with people and encouraged them to ask questions and discuss their options.

People's care plans included details about each person's specific needs expectations and wishes. One person shared with us that staff were excellent in how they met their needs. They said, "I get the care I need when I need it, they are all excellent; they know the times I am low, always anticipate my pain and make time to sit and talk to me as I do get scared". We saw staff spent time with this person when they were experiencing pain and responded to their anxieties.

Staff understood what they needed to do to make sure personalised care was provided. Staff had recently supported a terminally ill person's wedding within the inpatient unit. A birthday party was organised for a young terminally ill parent to include children's entertainers so as to create lasting memories for the person's children. Staff had also helped to arrange a holiday with transport and nursing support for a person and their family as part of the person's last wishes. Two people on the inpatient unit told us they received person-centred care and valued the availability of male staff. Both people told us that they had expressed a wish for male staff. One of these people said, "For me it helps me to cope with my emotions because they understand how men react and express them". This view was echoed by another person who told us they felt, "More comfortable talking about feelings with other men".

Staff we spoke with were able to tell us the needs of all people who were using the service and how they responded to people's care, emotional needs and wishes. For example, one person told us how sometimes they were fearful of having seizures and how staff had provided them with equipment to ease this side effect and had explained to them what was happening to them. A person in the day hospice told us how staff, "Helped with my symptoms and they arranged for support with my dressings when I'm at home".

Staff told us people were supported to develop an advance care plan which included details of their end of life care wishes. One person we spoke with confirmed they had been supported to make choices about their future care and in relation to where they wished to die. We saw people's care at the end of their life was personalised. One person told us, "I've had complementary therapy massages which really helps me to relax". Another person told us how they were supported to go out to lunch with their family with the support of nurses. We saw that staff had accommodated the needs of a person who was too distressed to leave their dog when they were admitted for end of life care. Staff admitted the dog with the person and provided a 'care plan' for the dog; this enabled the person to receive their care and die at peace knowing their dog was cared for.

We heard from staff how they had worked closely with other organisations to ensure that they were responsive to a person's end of life wishes. They demonstrated the importance of listening to the people so that care was centred on them as an individual. For example after settling a person in on their first day of admission to the inpatient unit, the staff member asked, "Is there anything else we can do for you?" We saw that the person had been supported by staff and the family support worker who had worked with an external organisation to re-unite a family. The person had expressed to staff how happy this had made them. This example showed the systems in place had enabled staff to be responsive and they had focused on the person's needs.

All of the staff demonstrated how they put person-centred care into practice and made people the central focus of their care. They had supported people in a very personalised manner to achieve their goals. This had enabled a person to visit their country of birth before returning to England. They were then supported to return to their own home and spend their last days in their own bed as they had wished. The chief executive told us how proud they were of the achievements of the staff team; "A true collaboration of the multidisciplinary team; hospice, the community care team, GP, out of hours doctors, and district nurses".

Each person's care and treatment was reviewed at regular MDT meetings. All aspects of the person's care had been assessed and discussed with the person and their family. This included their pain management, symptoms, and their emotional and psychological well-being. People's spiritual needs were also explored with them. A person told us, "We have discussed everything to include my on-going treatment and plans for my end of life care and wishes before that happens, I'm happy everyone knows what I want". We saw people's care and treatment plans were regularly reviewed and updated to include the most up to date discussions and decisions they had made. Our discussions with staff showed they knew people well and understood their individual needs.

People told us if they wanted to raise complaints or any concerns they would be confident to do so. One person said, "The staff are very receptive; I would have no qualms about sharing any concerns". Information was available for people in the lounge areas and included information about how to make a complaint. Staff we spoke with were all receptive to people's feedback and told us they would support any person to raise their concerns. Arrangements were in place for recording, acknowledging, investigating and responding to complaints. The management team reviewed actions and these were shared with the board of Trustees to ensure effective action was taken. For example the provider had as a result of a complaint reviewed their practice and made changes therefore showing that feedback was used to improve practices. A variety of compliments which contained very positive feedback was evident and these were displayed, collated and shared with staff by the audit and quality assurance lead.

Is the service well-led?

Our findings

People who used the hospice and its services were consistently positive in their feedback. They valued the friendliness of staff at all levels and described a culture within which their views were valued. People said that staff were attentive, caring and communicated with them well. A person told us, "This is a lovely hospice where staff put you and your family first". A relative said, "I am so relieved (name of person) is here, they have been cared for by wonderful staff who have explained everything to us and gone out of their way to help us".

There was a clear management structure; a registered manager, medical director and hospice physicians who had particular experience and expertise in leadership, nursing and palliative care. Staff were aware of the roles of the management team at the hospice. They told us that the managers were approachable and had a regular presence. We heard staff refer to the Chief Executive Officer (CEO) on first name terms which showed he had regular contact with staff and people who used the service. Staff described his management style as; 'refreshing, open and extremely supportive'. The CEO had a vision for the hospice which focused on putting people first and creating a compassionate service within which people are cared for by skilled staff who have time to listen and support them in the way they want and need. We found managers, doctors, staff and the board of trustees shared the same values. They showed they were passionate about promoting the hospice services. The board of trustees had an excellent understanding of the care provided which showed communication within the service was good. They described the CEO as, "A breath of fresh air with a true commitment who worked non-stop for the benefit of the hospice".

The clinical capability of trustees had been specifically targeted at recruitment and as a result they told us they had the skills to 'interpret' and 'challenge' the information presented to them at board meetings. This ensured all aspects of the performance of the hospice and future plans were appropriately reviewed. This benefitted people in a number of ways. For example plans were in place to provide overnight accommodation for relatives and a major refurbishment of the current day hospice. We heard improved IT sharing with other healthcare providers had been agreed which would allow shared access to people's care records. The plans for 2016 included provision of care to people with dementia and provide training to staff. To address the inequality of access by minority groups to the service the Spiritual Care Coordinator was heading a project focusing on the Muslim Community.

The provider encouraged involvement in the development of the service from staff at all levels. Multi-Disciplinary Team (MDT) meetings demonstrated clear team working and showed clear, transparent communication with a holistic approach to people's care. Regular meetings and Q & A sessions took place as well as seeking staff feedback and suggestions via the new staff forum which had representation from each area of the hospice. The forum allowed information to be passed to all staff but also provided a means for staff to raise ideas or concerns with the executive board.

Staff were overwhelmingly positive about working at the hospice. One staff member told us, "We have the most fantastic team; it is a pleasure to come to work". A person's observations on the inpatient unit confirmed what staff had told us, the person said, "I have never seen so many smiles; staff seem really happy

and chirpy". Without exception all of the staff we spoke with told us they were supported in their roles and happy in their work. They were very well motivated and had confidence in the way the service was managed. They said their immediate line managers were available for guidance and support.

Staff were encouraged to report any concerns and were aware of the Whistle Blowing Policy which was also available on a staff app. This enabled staff to access information via the computer and share it directly with managers. Staff were fully confident in each other, one staff said, "There is a clear framework for staff and there is no uncertainty about recognising and reporting concerns. I have no doubt about any of my team members". There was an open and transparent culture. Safeguarding investigations were reviewed and presented to the board to ensure that any lessons could be learned. The registered manager had notified the Care Quality Commission of any significant events that affected people or the service.

An analysis of surveys returned to us showed that people commented very favourably on their experiences of the service. Managers were described as accessible and approachable and staff as knowledgeable and competent. The provider had systems in place to seek people's views. Feedback was presented to the board who were responsible for reading and actioning suggestions made. We saw a variety of feedback that was positive and this was displayed on the walls to share with people as to how the hospice was performing and responding to their comments.

There was an effective system in place to check and monitor the quality of the service. A range of audits were undertaken with a clear plan of the frequency these should be repeated. Different areas were focused on such as medicines, hydration and nutrition, admissions and reviewing the impact of support services such as bereavement support. These were fed into the governance meetings and were also reviewed by the trustees. Various heads of department and the clinical governance teams met and discussed findings at each meeting. We saw as a result of their quality monitoring there had been specific benefits for people in the service. For example the provider had introduced a new tool to improve the recording of people's pain. We heard from nurses that this would ensure their assessment of and response to people's pain was more robust. A second example had been the introduction of protected mealtimes and the use of coloured plates to ensure people with specific dietary needs received the correct meals and level of support with their nutrition. The board of trustees were actively involved and undertook monitoring checks which focussed upon areas identified through consultation with senior managers. This included speaking with people who used the hospice, staff and visitors. Their findings were analysed and shared with staff.

The provider worked in partnership with key organisations to support care provision, service development and joined- up care. The management team spoke with us and showed us how they continually sought ways to improve their service provision. This included membership of a number of local and national organisations related to the provision of palliative and end of life care and attending conferences to share good practice. In addition the hospice medical director and CEO had additional advisory roles and active involvement with key organisations such as Macmillan.

The provider told us in their PIR that the hospice is, "One of six Macmillan pilot sites nationally looking at improving specific outcomes for people. The objectives for the project locally are: to improve patient experience by having just one referral to palliative care locally through a single point of access". The medical director told us that this had improved collaborative working with Macmillan via hospice MDT meetings every day. This had enabled a more streamlined service for people. An objective to introduce a new volunteer buddy service into the local population was evident as we saw the beginnings of this with the volunteers in place at the hospice. The project is being evaluated externally by Nottingham University.

The hospice medical team had registered to the Antibiotic Stewardship Initiative Programme. The hospice

pharmacist and one of the doctors had established a strong link between the hospice and a hospice in Rwanda and with the full support of hospice trustees and the Rwandan government had delivered a teaching programme there to educate their pharmacists on palliative care prescribing to improve patient outcomes. We also heard the hospice pharmacist is one of twelve pharmacists nationally to pilot a study guide for pharmacist prescribers. Plans to host and deliver on 'The Healthy Schools Programme', and teacher training for supporting children facing loss were also in place. In a new initiative for 2016 the hospice will be educating care home staff for the CCG, specifically in Advance Care Planning.