

Weldmar Hospicecare Trust

Joseph Weld Hospice

Inspection report

Joseph Weld Hospice
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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Good 

Summary of findings

Overall summary

This inspection took place on 8 and 9 March 2016 and was unannounced. We previously inspected the service on 11 March 2014 and found no breaches of regulations in the standards we looked at.

The inspection team included two inspectors, a pharmacy inspector, a nurse specialist in palliative care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Weldmar Hospicecare Trust is a registered charity. All services to patients are provided free of charge. Some funding is provided by the NHS but most is provided through fundraising and charitable donations. The service is for adults with life-limiting illnesses or advanced progressive conditions, their families and others close to them.

Joseph Weld hospice is in Dorchester and the inpatient unit is registered for 18 beds, although a maximum of 14 beds are used at any one time. It cares for about 300 people a year. The hospice accepts people with a diagnosis or medical condition that significantly limits their life to less than two years or where they have complex symptom management problems. Also, if the person or other family member has psychosocial, emotional or spiritual needs. Admissions to the inpatient unit were usually for symptom control, and for end of life care.

The hospice is purpose built over two floors. The inpatient unit has four single rooms and a family room, all with ensuite facilities. There are four single sex bays, each with its own bathroom, which can accommodate a maximum of four beds, but are only ever used to accommodate three people. The rooms have lovely views of the landscaped grounds and surrounding countryside. There are ample car parking facilities including disabled access spaces near the main entrance. More recently Joseph Weld has benefitted from the addition of an orangery which provides a bright and welcoming space, with quiet areas for people and relatives to relax in. This includes a café opened to the public at lunchtime each day and a play area for children.

People can access the service in a variety of ways, via referrals from local GP's and consultants in the NHS, or from people and/or family members/carers (with the person's permission). Services are provided up to and at the time of death, and after death, for the bereaved.

The hospice has three specialist teams of community specialist palliative care nurse teams across central, south and north Dorset, known as Weldmar community nurses (WCN's). These nurses are skilled and experienced in supporting people with the management of their pain and symptom control. They provide physical, emotional and social support for about 650 people and families each year. It is a five day a week service, with emergency cover at the weekend. The WCN's visited people at home, in nursing or care homes and in community hospitals. They also worked closely with 45 GP surgeries, district nurses and other community based staff providing advice about managing people's symptoms and prescribing.

The hospice provides day services to about 350 people each year, which include social respite, social groups and wellbeing services. These services were held on various days of the week, at Joseph Weld hospice in Dorchester, Trimar in Weymouth, and at community hospitals in Blandford, Shaftesbury and Sherborne. Some people we met at these services shared their experiences of being admitted to Joseph Weld hospice for pain management and symptom control.

The hospice has a large team of volunteers, who work in the inpatient unit, day hospice and wellbeing services, and as volunteer drivers. They offered befriending services to people and provided respite for carers. Some volunteers had professional qualifications and offered counselling and complementary therapies.

The service has a registered manager who is the Director of Nursing and Patient Services. 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 and families received outstanding care from exceptional staff and volunteers who developed positive, caring and compassionate relationships with them. The service promoted a culture that was caring and person centred. Staff worked together as a multidisciplinary team to provide seamless care for people.

People received excellent care, based on best practice from experienced staff with the knowledge, skills and competencies to support their complex health needs. The hospice education department was a regional centre of excellence for staff training in end of life care. They worked with staff in the NHS, in care and nursing homes and domiciliary care agencies to improve their skills and knowledge in end of life care. This meant more people could have end of life care in their preferred place of home, or in the hospice, which helped reduce admissions to hospital.

People were partners in their care, and were consulted and involved in decisions about their care and treatment. They were asked about where and how they would like to be cared for when they reached the end of their life. Staff treated them with the utmost sensitivity, dignity and respect.

The hospice offered an array of bereavement services. In particular, a child support worker was doing innovative work, to provide individual support for children and young people facing bereavement. They worked with schools, district nurses and with child and adolescent mental health services to ensure more children received bereavement support.

People received exceptionally personalised care which responded to their individual needs and preferences. Staff used a range of creative ways to help people to manage some of their symptoms and to promote as good a quality of life as possible. Staff supported people with practical needs, such as any equipment so they could remain at home, this included electric beds, moving and handling and pressure relieving equipment.

People had access to high quality food and drink, for as long as they were able and wished to. Excellent catering services met people's individual nutrition and hydration needs.

People said staff made them feel safe and cared for. Staff knew how to recognise and report signs of potential abuse, and any concerns reported were investigated. People received care at a time and pace convenient for them because there were enough skilled and experienced staff. Staff could spend time with

each person offering them assistance, support, comfort and reassurance.

People's human and legal rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). People knew how to complain and any complaints received were thoroughly investigated with lessons learned. Staff were open and honest when things went wrong and were committed to learning from people's feedback and experiences.

People received their medicines on time and in a safe way. All appropriate recruitment checks were completed to ensure fit and proper staff were employed. They were cared for in a clean and hygienic environment. Staff reduced the risks of cross infection for people through good hand hygiene, and regular cleaning.

People received consistently high quality care because senior staff led by example and set high expectations for staff about standards of care. The provider had a range of robust systems to monitor the quality of care provided, which included feedback surveys, audits and quality monitoring checks. They continuously made changes and improvements in response to their findings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People were supported by enough staff so they could receive safe care at a time and pace convenient for them.

People were protected because staff and volunteers understood the signs of potential abuse. Concerns reported were investigated and dealt with.

People felt safe at the service. Individual and environmental risks were reduced as much as possible. Accidents and incidents were reported with positive actions taken to reduce the risks of recurrence.

People received their medicines on time and in a safe way.

Robust recruitment checks were undertaken before staff and volunteers began to work for the service to ensure they were suitable to work with people.

Good 

Is the service effective?

The service was effective.

People received effective care, based on best practice from staff with the knowledge and specialist skills to manage their pain and physical symptoms.

The hospice education department was a regional centre of excellence. They provided a range of innovative end of life care training, to hospice and other health and social care staff. This meant more people received skilled end of life care, in their preferred place.

People's human and legal rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, advanced decisions were taken account of, and families and other professionals were consulted in their 'best interest.'

Outstanding 

People had access to high quality food and drink, for as long as they were able and wished to. They service had excellent catering services which met people's individual nutrition and hydration needs.

Is the service caring?

The service was caring.

People received outstanding care from exceptional staff who developed positive, caring and compassionate relationships with them and their families.

A strong, person centred culture shone through when staff spoke about people. They treated people with the utmost kindness, caring, dignity and respect.

People were comforted because they knew hospice staff would continue to support loved ones following their death through a range of bereavement services. In particular, a dedicated child support worker helped children and young people in innovative ways.

Outstanding 

Is the service responsive?

The service was responsive.

People received exceptionally personalised care which responded to their individual needs and preferences.

The introduction of wellbeing services provided people with access to information, advice and sessions and promoted self-management of their symptoms. An extensive support programme was provided for carers.

People were empowered to have as much control and independence as possible. Their views were known, respected and acted on.

People knew how to raise a concern or complaint. Staff were open and honest with people when things went wrong and were committed to learning from people's experiences.

Outstanding 

Is the service well-led?

The service was well led.

The service was effectively led by the senior management team. Staff worked together as a team to provide seamless care for

Good 

people.

People, relatives and staff views were sought and taken into account in how the service was run.

A range of quality monitoring systems were used to monitor the quality of care. The service continuously made improvements to people's care in response to their findings.

Joseph Weld 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 checked 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 8 and 9 March 2016 and was unannounced. The inspection team included two inspectors, a pharmacy inspector, a specialist nurse in palliative care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR, previous inspection reports, notifications and all contacts we had about the service. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

During the inspection we spent two days at Joseph Weld hospice in Dorchester, visited Weldmar day hospice in Weymouth and day services at Shaftesbury. We telephoned people and relatives at home to get their feedback about the hospice community services. We also visited Hammick House in Poundbury where training, human resources and estates staff were based.

At Joseph Weld hospice, five people were being cared for at the inpatient unit. In total, we spoke with 30 people, and 19 relatives/friends or other visitors across all areas of the service. We observed staff interactions with people and looked at 15 people's care records, including six people's medicine records.

We met with the chief executive, medical director, registered manager, and three assistant directors covering the north, south and central community areas. We also met with 42 other staff and volunteers which included medical staff, nurses and nursing auxiliaries, a psychologist, occupational and physiotherapy staff. We also spoke with a social worker, chaplain, complementary therapy and counselling staff, volunteers as well as catering, facilities and housekeeping staff. We looked at 15 staff records which

included training, supervision and appraisal records.

We sought feedback from staff working with the hospice from the local NHS trust, community district nursing services and GP's practices, and commissioners. We received a response from of four of them.

Is the service safe?

Our findings

People said staff made them feel safe and cared for. One person said, "They are always trying to watch out for me to make sure I am OK." Another said, "I don't get the chance to feel unsafe, I am never alone here, they are so attentive and look after us well." A health professional said, "The Weldmar team are very professional and work in a safe way."

People were cared for by sufficient numbers of skilled and experienced staff. Staff could spend as much time as needed offering people and relative's assistance, support, comfort and reassurance. People said staff were attentive, checked on them regularly throughout the day and night and responded immediately to call bells. A relative said, "Staff have time to chat, the difference is noticeable between the hospice and the hospital." A staff member said, "It's nice to have the time to support the patients and relatives at what is a very difficult time."

40 staff worked in the inpatient unit, and there were no vacancies. A team of seven doctors provided 24 hour advice and support. The duty rota was completed six weeks in advance and showed recommended staffing levels were maintained. In the morning there were seven to eight staff on duty which included nursing and nursing auxiliary staff plus the senior nurse, with five or six staff in the afternoon. A twilight shift provided extra staff support in the evening and at night there were three staff on duty, two nurses and a nursing auxiliary. A dependency tool was used each day to check staffing levels were adequate for the needs of people, and these were adjusted as their needs changed. Where more staff were needed, existing staff and bank staff did extra shifts, to provide continuity of care, and no agency staff were used. This meant people always received care from skilled and experienced staff.

In the community, when we visited, sickness issues were affecting a Weldmar Community Nurse (WCN) team, as all five nurses were on sick leave. The service had implemented an effective contingency plan to ensure people's safety and minimise risks. All available WCN nurses were working flexibly across Dorset to provide people's care, and some inpatient staff were also working the community. A multidisciplinary daily triage system and care pathway was introduced to review people newly referred to the service and prioritise those in need of urgent assessment. For example, people receiving end of life care at home and those who needed support with pain control or other complex systems. These arrangements meant the specialist skills of available WCN's were focused on the people most in need of their support.

Others had less face to face visits by WCN's. Instead, staff made more telephone contact with people to check their progress, review their needs, and offer them ongoing support and advice. WCN's continued to advise other community professionals such as GP's and district nurses about people's care. People confirmed they had been informed of these temporary service changes and the reasons for them, and seemed happy with them. For example, one person said, "The nurses are coming every other Wednesday, I'm not ill enough to be fussed, I have their number if I need them." We concluded the contingency plans meant there were enough suitably skilled and experienced staff to support people safely and meet their needs.

Staff said some staff more recently appointed to WCN posts were less experienced, which they thought may have contributed to some of the sickness issues. We followed this up with the registered manager, who acknowledged some recruitment mistakes had been made. In future, they said they would personally be involved in all WCN recruitment decisions. For less experienced WCN's, return to work plans included providing additional support to increase their skills and confidence. They also included further training and development, spending some time working in the inpatient unit, and being mentored and coached by more experienced WCN staff and line managers.

Robust recruitment and selection processes ensured staff and volunteers were safe to work with vulnerable people. Staff and volunteers completed application forms and interviews were undertaken. Appropriate pre-employment checks were done, such as Disclosure and Barring Service (DBS) checks which highlighted any criminal convictions and obtaining references from previous employers. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people who use care and support services.

People were protected by staff and volunteers who were knowledgeable about the signs of potential abuse and understood how to keep people safe. Staff attended a range of safeguarding training, dependent on their role, and the service had a safeguarding lead, who was a specialist palliative care social worker. They provided practical day to day support and advice for staff, as well as contributing to their safeguarding training. Appropriate safeguarding policies were available including contact details, of the local authority, police and other agencies. This meant staff knew how to report potential abuse to outside agencies.

For example, a staff member told us about a family situation where they suspected potential abuse. They sought advice from their manager and contacted the local authority safeguarding team, who took further action to protect the person. This included liaising with the police, and attending a multiagency safeguarding meeting. This showed staff understood their role and worked in partnership with other agencies to safeguard people from abuse. We followed this example up with the registered manager, as we had not received any safeguarding notifications from the service in the past 12 months. They said this was not a recent example, and confirmed no safeguarding concerns had been raised.

A whistleblowing policy was in place so staff could raise concerns in good faith, in the knowledge they would be followed up and their confidentiality maintained. A staff member told us about an example of an issue raised by a member of staff, whose concerns were taken seriously and actions taken in response to protect people.

People were protected because risks for each person were identified and managed. Comprehensive individual risk assessments were completed, such as in relation to their risk of falling, malnutrition and dehydration, and about moving and handling risks. Detailed care plans identified measures taken to reduce those risks as much as possible. For example, pressure relieving equipment used to reduce the risk of developing pressure sores. A suicide risk policy was recently developed to help staff identify and reduce suicide risks, following one person's experience. The policy had just been approved and a programme of staff education was planned to support its implementation.

People received their medicines on time and in a safe way and were kept comfortable and pain free. Medicines were supplied through an agreement with the pharmacy department of the local NHS hospital trust, who also provided staff with up to date information on the safe use of medicines. The service included supplied medicines for inpatient use and dispensed individual medicines for people to take home when they were ready for discharge. Staff had access to an out-of-hours service, which meant staff could always obtain any emergency medicines or advice needed.

Medicine prescription charts were all signed and dated correctly, with allergy details completed. Staff signed to confirm when medicines were given, and clearly recorded the reasons for any omitted doses. A separate section of the form was used for doctors to prescribe medicines to be given by injection, in syringe pumps, which is good practice. A syringe pump helps control symptoms by delivering a steady flow of liquid medication through a continuous injection under the skin. Records showed staff documented regular safety checks of each syringe pump to make sure the equipment was operating correctly.

People's medicines were reviewed regularly, and medical staff were always available for advice. A pharmacist checked the inpatient prescription charts and medicines weekly, which helped ensure people received their medicines safely and correctly. Extra medicines, which people may need to help control their symptoms, were clearly prescribed, with a maximum safe frequency, so nurses could safely administer them. This meant nurses could treat people's pain and symptoms in a timely way.

Medicines were stored safely, in a secure treatment room and were checked regularly. Medicines which required cold storage were kept within a monitored refrigerator in the treatment room to ensure their effectiveness. There was a supply of medicines for emergency use, which were rarely used, and we found two out of date items in the box. Staff replaced these immediately and put additional checks in place to ensure these medicines were checked more regularly to make sure they were safe to use.

Staff completed E-learning medicine training, and did practical training on intravenous medicines and syringe drivers. Staff competence in medicines management was assessed using a competence framework to check they could administer medicines safely. Staff carried out regular medication audits to check medicines were being managed safely and any recommended improvement actions were followed up.

Accidents and incidents were reported directly onto an electronic database including medicine incidents. All accidents/incidents were reviewed by the line manager, health and safety lead and the registered manager. The chief executive signed off all significant incidents when they had been satisfactorily dealt with. We sampled accident and incident reports and saw examples of actions taken in response to reduce individual risks to improve people's safety. For example, when a staff member made a drug error, the staff member received support and retraining and had their competence reassessed. The staff member said they felt well supported and confirmed the extra training and supervision helped them improve their practice and regain their confidence.

Environmental risks were assessed and actions were taken to maintain the safety of the premises and equipment. For example, external contractors regularly serviced and tested moving and handling and fire equipment, and undertook gas and electrical testing and lift maintenance. The service had an ongoing programme of maintenance and refurbishment, and repairs were responded to in a timely way. Contracts were in place to service and maintain all specialist clinical equipment. Contingency plans were made to ensure continuity of the service, for example, in the event of staff sickness or the loss of utilities such as electricity, heating or water.

The facilities department worked in partnership with nursing, occupational therapy and physiotherapy staff. This was to ensure all furniture and equipment purchased for the hospice was suitable for the needs of people who used it, and met health and safety and fire regulations. For example, furniture, and medical equipment such as syringe pumps, electric beds, and moving and handling equipment.

People were cared for in a clean, hygienic environment. Housekeeping staff had suitable cleaning materials and equipment. Staff had access to hand washing facilities and used gloves and aprons appropriately to reduce cross infection risks for people. The service had infection control policies and procedures and a

designated infection control lead monitored and audited infection control. For example, staff hand washing practices, housekeeping/ cleanliness and antibiotic use. A weekly report was produced to provide updates for staff and management on infection control issues.

Is the service effective?

Our findings

People received effective care because staff offered evidence based end of life care in accordance with best practice. All training reflected national best practice such as, 'One chance to get it right', the five priorities for care, and 2015 NICE guidance on end of life care.

People and relatives consistently praised the care and support they received from staff using words such as "excellent" and "outstanding." One person referred to the hospice when they declined further treatment for their cancer said, "That was when I came across these wonderful people." A family said the hospice was "a wonderful place that provided excellent care for their relative." They said staff had done marvellously well to get on top of the persons' symptoms, which had improved their quality of life. One person spent a week in the hospice, they said, "I can't believe the care they give, the attention to detail, the experience has changed my mind about where I want to have care at the end of my life. Far from being sad and tearful, it is happy, and staff have all the time in the world for you."

The hospice was committed to providing people with excellent care through staff education, training and professional development. In 2015, the hospice education department became the regional centre for the Gold Standards Framework (GSF). The GSF is a national training programme which enables frontline staff to provide an excellent standard of care for people receiving end of life care. They were building capability within other organisations to deliver end of life care for people. For example by doing 'train the trainer' courses and establishing networks with the hospice. During 2015 they provided training for 489 staff across Dorset, 63% of who were staff from NHS trusts, nursing and care homes and domiciliary care agencies. A health professional who attended a communication skills course on end of life care said, "Wow, this one course changed my clinical practice. Not only did this course give me skills in difficult communication, it gave me confidence."

A GSF programme trained 12 staff from local care and nursing homes on each course. Staff were taught how to improve people's care, by keeping them comfortable, through effective pain relief and regular mouth care, and by providing support and reassurance. This meant people could die in the home where staff knew and cared for them, and reduced the need for hospitalisation.

Another GSF programme for domiciliary care agency staff, provided 'train the trainer' courses. Participants championed end of life care within their own organisation and trained their staff to improve people's end of life care at home. A participant said, "A brilliant course, I feel more confident talking to people about dying." Another said, "I have changed the way I do things and taught new care workers how to deal with death and dying. The training meant more people could remain at home, because staff had the skills and confidence to care for them."

The hospice education department, also provided all statutory and mandatory training, through e-learning, training days and courses, such as moving and handling and fire safety training, They provided a wide range of other courses relevant to people's end of life needs such as communication skills, advanced care planning, and symptom management in palliative care, such as breathlessness, confusion and

agitation. Staff had access to books, journals, and other online resources to keep them up to date with current best practice.

All new staff and volunteers underwent a thorough induction, which gave them the skills and confidence to carry out their roles and responsibilities effectively. Staff received regular support with their practice through regular individual supervision every six weeks and informal supervision day to day through staff handover, and multidisciplinary team meetings. All staff had annual staff appraisals, during which they received feedback on their performance and identified further training needs.

Hospice staff gave us consistently positive feedback about their training which they said helped them give people high standards of care. A staff member said, "We have a brilliant medical team, they do lots of staff teaching." A GP trainee doctor and another doctor in training working at the hospice both said they had learned a great deal. Their experience helped them develop their assessment and communications skills, which they planned to use to improve people's care when they returned to work at the hospital and GP practice.

A practice educator taught staff in clinical practice and assessed their skills. They explained medical advances had meant people's clinical care had become much more complex over the past few years. They worked closely with Dorset County Hospital to train and update hospice staff to meet people's nursing care needs, such as related to blood transfusion and PEG feeding. (This is where a feeding tube is placed through the abdominal wall into a person's stomach to allow staff to administer nutrition, fluids and/or medications). This meant nursing staff could provide people with more care in the hospice, so they didn't have to stay in hospital.

In October 2015, the hospice was commended in the 'wonderful workforce solution of the year category', of the Health Education Wessex SHINE Awards. This was in recognition of the development of a rolling six month rotational post for NHS community nurses. An article, published in the British Journal of Community Nursing showed how the initiative improved the quality of end of care of people receiving end of life care from community nursing staff.

A community nurse said, before they started the secondment, their confidence in providing people with palliative care was low. They said, "I had a fear of the patient or relative asking me a question I would not be able to answer and that would lead to a difficult conversation." Since doing the rotational post, their confidence had increased, as they saw how other professionals managed these situations and adopted their communication styles. This meant the community nurse improved their communication and interactions with people. They were also able to give people advice on pain and symptom control, and provide them with emotional support. They shared their learning with the rest of their staff team, so more people benefitted from their improved practice.

The hospice developed an assistant practitioner role, with a supporting education programme, as part of the Cavendish care pilot to give support staff the skills and confidence to extend their role. An assistant practitioner is, 'A worker who competently delivers health and social care and have a level of knowledge and skill beyond that of the traditional nursing auxiliary or support worker. (Skills for health). The first staff to have completed the programme was doing innovative work in setting up and running community day services in North Dorset. These services offered more individualised programmes of care that people could dip in and out of, as their needs changed. The assistant practitioner had just set up a new service at Blandford, which was due to start the following week and had further plans to set up more local services.

They spoke enthusiastically about their role and the benefits for people. For example, they had arranged

programmes to help people manage their symptoms of fatigue and breathlessness, arranged a 'drop in' advice service and set up support groups. This meant more people in North Dorset could access to a wider range of local day and wellbeing services. The pilot was effective because it gave non registered staff more confidence to run services and innovate in response to people's local needs. These initiatives were also in accordance with principles of 'One chance to get it right.'

People's pain and physical symptoms were well managed to make sure they were kept comfortable. One person said the doctor explained sensitively to them they would only have a short time, news which staff were supporting the person and their family to come to terms with. A person admitted from hospital the previous day for end of life care was unconscious but looked comfortable, peaceful with no signs of uncontrolled symptoms.

Each person had a detailed assessment of their care needs, discussed treatment options and were given information about risks and benefits. From these discussions, an individualised end of life care plan was developed, which detailed each person's preferences for care and treatment, including their preferred place of end of life care. Personalised care plans provided detailed instructions for staff about how to meet each person's physical and emotional support needs, including managing any pain or symptoms. People's care was reviewed daily by nursing and medical staff, and treatment plans were reviewed and updated as their needs changed.

People praised the support they received from hospice staff. One said, "They speak in a language you can understand and tell you what they can offer." Another said, "She watches my pain control, she works very closely with my GP and advises him about prescribing for me." Others said hospice staff kept in regular contact with them as their needs changed. One said, "They will be checking in with me next Thursday, to see how my scan went. Another person said, "The physio came and was fantastic." They went onto describe how the physiotherapist gave them information leaflets about their condition and taught them breathing techniques, which helped them manage their breathlessness.

Health professionals consistently gave us positive feedback about how hospice staff shared their knowledge and expertise for people's benefit. One health professional said, "I have a high level of confidence in hospice staff." A GP surgery said, "The Weldmar team have an excellent local reputation. The medical director is incredibly approachable and supportive." Where needed, medical staff from the hospice also did joint home visits with GP's to help them manage people's symptoms and pain relief. Another GP said, "Patients of ours who have been admitted for end of life care are provided with very good and supportive care."

People's consent to care and treatment was sought in line with legislation and guidance. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found they were.

The hospice had policies and procedures in place in relation to consent, assessing mental capacity and Deprivation of Liberty safeguards. Staff had undertaken relevant training and demonstrated a good understanding of their responsibilities. The hospice had an MCA lead to guide and support staff. At the weekly multidisciplinary team meetings, each person's mental capacity to make their own decisions and

consent to their care was reviewed. Where people lacked capacity, there was evidence of respecting any wishes they had expressed in advanced care plans. Staff also consulted relatives, staff and other professionals in making 'best interest' decisions about the person's care and treatment.

For example, staff told us about a person with a learning disability who had a lengthy admission to the hospice for palliative care. The person had wanted to go home, although they could not safely manage at home. A mental capacity assessment was undertaken, which showed the person lacked capacity to weigh up the risks/benefits of where they received their care. As staff felt they were depriving the person of their liberty, by keeping them at the hospice, they sought advice and submitted a DoLS application to the local authority deprivation of liberty team. They arranged for an independent mental health advocate to meet with the person and involved them in the multidisciplinary 'best interest' meeting about the person's future care and treatment plan. This ensured the person's human and legal rights were upheld. Since then, the person has moved to live in a nursing home and hospice staff continue to support them.

People consistently praised the quality of food and choices available. One person said, "The food is excellent here, it's as good as a hotel." Another said, "You can have more or less anything." One person said, "Sometimes I get to the point I can't be bothered to eat, it's just too much trouble. I didn't eat all my dinner, so they bought me two puddings and it was really lovely." A relative said, "Last week [the person] fancied a Guinness, and a short while later staff came back with a small glass of Guinness." Another person fancied some roast chicken, which wasn't on the menu. The chef made it especially for them and said, "It's no trouble at all, we can easily do that." Sometimes people fancied a takeaway, which staff arranged.

People were supported to eat and drink what they wanted for as long as they wished to. The catering services were excellent, food was freshly cooked food each day, using local seasonal produce. It was attractively presented and looked appetising. The chef met with each person when they were first admitted and asked them about their food preferences and any specific dietary needs, so they could plan the person's meals accordingly. One person said, "We can choose from the menu and get a mains and dessert. I like tiny portions and they give me that." Staff arranged a supply of build-up drinks for another person, as they weren't eating much, which helped improve their nutrition.

People could choose to eat in their rooms, or join family to have a meal in the orangery restaurant. Mealtimes were protected, so no visitors or doctor's ward rounds were permitted, so people could enjoy their meal without interruptions. If a person didn't wish to eat the main course offered, they were offered an alternative, such as salad, jacket potato, omelette or sandwiches. Relatives could bring in favourite meals, including hot food, to tempt people. Out of hours, staff prepared snacks such as cereals, toast, soup, yoghurts and ice creams. All hotel services, ward staff and volunteers had nutrition and meal assistant training, known as the 'Meal deal.' This was so they could help make people's dining experiences positive, pleasant and safe.

People individual needs were met by the environment of care at the hospice. One family said, "The hospice is a beautiful environment with beautiful people." They had facilities for people with disabilities such as wide corridors suitable for wheelchair access, a height adjustable jacuzzi bath and wet room facilities. There were plenty of quiet areas where people could talk, overnight accommodation was available, should relatives need to stay. In the orangery, people confined to bed could access the outdoors, if they wished to. At Trimar, people attending day services had benefitted from an upgraded lift, so disabled people could access the service.

A planned closure of Joseph Weld hospice was arranged for July 2016 for a period of three weeks to redecorate and upgrade the service. Plans were well advanced to manage people's care in the community

over that period. The refurbishment plans included improving signage, so people living with dementia, would find it easier to locate toilet and bathroom facilities independently. Physiotherapy and occupational therapy facilities were being relocated. This was to improve facilities for people with motor neurone disease, when they attended a joint clinic at the hospice. Other improvements included better security and storage of confidential records, new kitchen flooring to make cleaning easier and better facilities for administration of medicines. This showed the hospice was continuing to improve the environment of care to meet people's needs.

Is the service caring?

Our findings

People said they received outstanding care from the hospice because staff and volunteers developed exceptionally positive, caring and compassionate relationships with them. Staff provided exemplary care and support to each person and those close to them. The person knew the support would continue beyond their death, which comforted and reassured them.

People valued the relationships they had built up with the staff. One said, "I had no experience of the hospice before, and suddenly these wonderful people popped in to my life." Another person diagnosed with inoperable cancer felt "all alone," but this changed when hospice staff got involved in their care. They said, "From that moment on, my life has changed. I can't praise them enough." A couple praised the support staff gave them. They said, "It's been a struggle, it's a lot of stress. Friends break away from you, because they know you're going to die. It's great to have to people you can talk to who and are willing to listen and help you."

One person said they were grateful there was always someone at the hospice they could talk to. For them, this meant they weren't afraid of dying because they knew they would be supported. A relative said, "Joseph Weld is not a sad place, we laugh and cry, it's not doom and gloom, we know what's in front of us. We know he will be looked after and they will be there for the bereaved as well, it's wonderful." A relative described the close relationship the person had developed with their Weldmar community nurse, with whom they had a shared interest in walking, and liked to discuss routes. They said, "[Name of person] is down sometimes but when she comes, he is smiling when she goes out."

A strong, person centred culture shone through the ethos and values of staff, who were highly motivated. Their approaches in the hospice and the community enabled people to find sustainable support from one another and forged links between bereaved people beyond the person's death.

Staff spoke with compassion and enthusiasm about ways in which they supported people and families. They admired people's attitudes towards an uncertain future which they faced with dignity, humour and a smile. One person said how much they appreciated the nurse visiting their sister and their mother, which reduced the burden on them. A member of staff said, "If there are things we can't help with, we find someone who can." Another staff member with personal experience of the service said this gave them an insight into what it was like for families, which helped them in their practice.

At Joseph Weld, Trimar and Shaftesbury, people told us about the community support they received. They described the welcoming family atmosphere, the kindness of staff and volunteers and the mutual support available. When people arrived they were greeted with big smiles. In one group a person had been admitted to the hospice for a few days. Others and staff arranged to send them flowers, and a card. In another group they arranged a rota to visit another person recently discharged from hospital, to keep in touch with the person until they were well enough to attend the day centre again. This meant people felt supported, developed positive relationships with staff and each other through their shared experiences.

Carers praised the support they received from staff at a carers group. The said, "I can't speak highly enough about them, they help with the worry and emotion. Another said, "Carers help each other, you can talk about what you don't want to talk to family about, [staff name] is there is to advise us, it's a lifeline." Volunteers also told us about the many ways they supported people in different aspects of their care. For example, through social and befriending services, day to day support of people and families in the hospice and day services, and through bereavement and complementary therapy services.

People were consulted and involved in decisions about their care and treatment. A person met with their doctor the previous day to review their care plan. Another person said, "It's all there, I have a book with everything in, my wishes about resuscitation, an advanced care plan, I feel involved." Another person who completed their end of life care plan with their Weldmar Community Nurse (WCN) said, "I wanted to know what's going to happen."

People were asked about where and how they would like to be cared for when they reached the end of their life. Each person's preferred place of care was documented and audits showed people's wishes were accommodated wherever possible. A person said their wish was to die in the hospice, although their doctor said their death was not imminent. So, staff were arranging for the person to go home for short periods with support. Another person with a life limiting illness was receiving care at home. They said, "I've suffered breathlessness for years but I could have weeks, months, or years. They are going to nurse me at home for as long as possible," which was in accordance with their wishes.

People were treated with sensitivity, dignity and respect, they said staff were always popping in to check they were okay and ask if they needed anything. People were asked whether they wished staff to refer to them by their first name or surname. A staff member gently greeted a person who had just arrived. They welcomed and reassured them, offered them a cup of tea and tried to make them feel at ease. After a little while the person appeared more relaxed. Curtains were used in bed bays to offer each person privacy during personal care and when family visited.

Staff used touch to offer comfort such as by gently holding a person's hand, or offering a relative a hug when they became upset and tearful. Volunteers chatted to people, and added personal touches like a fresh flower arrangement for each person. Staff discreetly helped people with personal care. A person appreciated that staff supported them to maintain their independence. They said, "I like to do what I can, I like to dress myself." Another person liked to have a bath, when they went to the day service, as they were unable to do so at home. This was because they felt reassured by having staff available to assist them.

We asked staff about how they manage death and dying in the shared bed bays. Staff said they responded to people's needs on an individual basis. Some people preferred to have the company of others but towards the end of their life, wherever possible, they moved the person to a single room for privacy.

At the hospice, people and families were welcomed, in the orangery people and visitors could make tea, coffee, and cold drinks. Freshly baked cake was provided each day as a added touch. People and visitors wandered in whenever they liked and sat chatting.

Staff were knowledgeable about how to meet people's spiritual, religious and cultural needs. There were arrangements in place to cater for any cultural or religious food preferences, for example, catering staff knew where to obtain halal meat. A hospice chaplain provided spiritual guidance and support to people, and family members. They were available to all, from any faith or none. They described themselves as, "A friendly face with time to listen." At Joseph Weld hospice, people had a non-denominational room for quiet reflection.

The chaplain had contacts with local ministers and other faith groups. Through these they were able to meet people's spiritual and religious needs. For example, recently they had made contact with the nearest Buddhist temple for a person. They were also studying other faiths to ensure they had a deeper understanding of people's beliefs. They regularly gave talks to community groups in the community about death and dying. For example, they recently gave a talk which 60 people attended. They said this allowed them to deal with a difficult subject and provided an opportunity to present palliative care in a positive and hopeful way.

They told us about events they arranged at the hospice to meet people's individual needs and wishes. For example, a person with a terminal diagnosis wanted to get married and was not expected to be well enough to leave the hospice again. So, the chaplain applied for a special license so a civil ceremony could be held, which they followed with a blessing. This meant the person's dying wish was made possible. They also arranged a pre-wedding ceremony for a couple who were getting married, but where the father of the bride was too ill to attend. This meant people were able to participate in special occasions and important family events.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Following death, the person usually remained on the inpatient unit with their family for a while so they could say their goodbyes. A 'viewing room' was also available so families could return and spend more time with their loved one. A relative speaking about their experience of their loved one dying at the hospice said they appreciated being able to stay with the person throughout. They said, "The staff were wonderful, so kind, amazing care. When he died, he knew we were all there. Afterwards, we went to see him in a lovely room, he looked so normal, he looked asleep."

The chaplain planned some people's funeral with them, and officiated at some of them. Speaking about a person's death, they said, "I always think it's important for people to know they will be remembered." They spoke about a young person who recently died at the hospice. The person wanted to spend time in the non-denominational reflection room after their death, which the chaplain arranged for them.

The chaplain arranged a quarterly 'Time to remember' memorial event at the hospice, and invited bereaved relatives and friends to remember their loved one. Other countywide remembrance events include a 'Sunflower' event in the summer, a 'Light up a life' event at Christmas, and a 'Snowdrop' event in February. These events gave comfort to bereaved families and friends.

The hospice had a comprehensive bereavement service which offered different types of support. A relative told us how much they appreciated a bereavement support group they attended. They said, "You meet other people, I've made a friend. Staff talk, they listen, it's absolutely superb. What would we do without them? It's an amazing service, so kind and dedicated. I have the booklet, about the stages of grieving, I found that reassuring, that how I was feeling was normal."

Bereavement services included in-depth counselling, emotional support and monthly bereavement support groups. A trained counsellor explained how they helped a bereaved person who was finding relationships at home difficult. Through the sessions they could display their emotions in a safe environment and talked through ideas and strategies to put into practice at home. An emotional support volunteer told us about how they helped a relative who had lost their mother to find a sense of purpose again. They said, "Unless you have lost someone, you don't realise how deep the hole is, anyone who can help you find a way to climb out is appreciated."

A child support worker was doing outstanding work supporting children and young people through

bereavement. They met with the child's parents to find out about each child and explain the various ways in which they could support them. For example, by helping families to tell children a loved one was dying, helping them to say goodbye and to make lasting memories. They spoke with sensitivity, passion and enthusiasm about their role and said, "I feel very privileged, I love my job, it's very rewarding."

Their office was filled with a variety of toys, games, pictures, books designed to appeal to children of different ages. They used these to establish a rapport with the child, so they could get to know them and find out about their hobbies and interests. For example, if a child was a fan of a TV character or liked the dolls' house, they used those to personalise their approach to support that child. They helped children compose goodbye letters, make family trees, create videos and memory boxes.

Each year, they arranged a Christmas and spring/summer remembrance event where children and families were invited to come together to remember the person. At Christmas, this included an art activity where each child designed and wrote a tag to their special person, which they hung on the Christmas tree. A beautifully decorated tag, said, 'To grandad, we are all missing you.' They held a two day workshop for children with an art therapist and a social worker, where children expressed their feelings through putting on a puppet show for their families. They had recently set up a support group for teenagers. This was because they felt that age group would benefit from opportunities to talk and share their experiences with peers and gain mutual support. Where more specialised support was needed, for example, a child with a learning disability, they put the family in contact with a specialist bereavement counselling service.

People's feedback consistently showed how much they valued and appreciated this service. A parent said, "The boys had a lovely afternoon at the Christmas event, my oldest found it beneficial to talk to other children of a similar age who had the same grief." Another parent said, "We are so very happy with all the support we have had so far with me and the children. We came to the Christmas memories party. The staff were brilliant, the children felt at ease and peaceful. [Staff name] is an outstanding lady who is full of compassion, sparkles love, peace and delight, she is our guardian angel, she truly is."

Through their network of staff in local schools, child and adolescent mental health services (CAMHS) and district nurses, the child support worker was building sustainability in Dorset so many more children could have good bereavement support. They provided staff training and shared ideas on supporting children through the stages of grieving. They set up a group who met regularly to share good practice ideas and gain ongoing support for their work. They described the mutual benefits of these networks. For example, through their contacts in schools, they could meet with children at school. They said children were often better able to open up about their feelings away from the home environment. Through CAMHS, they accessed a course in anger management and on building relationships without words, both of which they found very useful in their own practice.

Is the service responsive?

Our findings

People received exceptionally personalised care which responded to their needs, wishes and preferences.

Since April 2015, the innovative addition of Wellbeing services has provided people with personalised information and advice. They have empowered people by promoting self-management of their symptoms/illness such as by teaching them coping strategies which have enhanced their wellbeing. Therapy staff ran groups in day care services to teach people about managing symptoms such as breathlessness and fatigue in a positive way. A hospice social worker helped people access benefits and services rapidly. Other talks were arranged in response to people's requests, such as about making a will, a talk from a funeral director and from the citizens advice bureau. A person who had done a fatigue course said they found this very useful. A relative said they had particularly appreciated a session about benefits. They said, "The blue disability card has been invaluable, it has helped him with his independence."

People and carers had access to an extensive range of complementary therapies. These included massage and aromatherapy, reflexology and head massage, hypnotherapy as well as specialised therapies for pain management. These measures helped to reduce people's anxiety and distress. One therapist offered 'Jam-Che', a very gentle stroking type of massage which barely touches the person. Staff said people living with Parkinson's disease (a neurological disorder) found this therapy particularly effective. They said, "Within minutes you can see the shaking has significantly reduced or even stopped, which is such a relief for the patient." Another therapist was providing regular massage sessions for a relative of a person receiving care on the inpatient unit.

Dogs and other family pets were welcome on the inpatient unit. Dogs from the 'Pets for therapy' and 'Pat a dog' schemes visited whilst we were there, which some people found very therapeutic. The hospice had a music therapist, art therapist and drama therapist. This meant people and relatives had access to a wide and varied range of media to support them to express their feelings.

At a day service, a person said, "I enjoy coming so much, I like all the things we do, but I think painting is my favourite." Another said "Coming here gives me some independence, as I don't have much of that now." Several people enjoyed a seated exercise session, during which there was a great deal of laughter. Another person spoke movingly about how much they appreciated staff organising for them to go sailing on a local boat, and the experience of being followed by a dolphin. This showed people's care was personalised to their wishes.

Community staff also identified a need to offer local support to carers providing end of life care for family members. In consultation with carers they devised an extensive programme of support to meet their needs. This included practical advice and information about services, symptom management as well as emotional support and relaxation. A social worker said carers valued spending a couple of hours together at a fortnightly carer's support group. They said, "Sometimes it can be a really heavy session, other times just frivolous stuff. What is important is they can come together."

Men only sessions were also offered, which had been successful with further plans to arrange a monthly 'men only' carer's lunch club. A volunteer said, "The men were very apprehensive at first but they are set at ease so quickly because the group is very inclusive." This meant carers had some relaxation time, and got support from one another, which helped them to continue caring for the person.

One person said, "Attending the day centre allowed my carer to have some time off when they didn't have to worry about me. They can do what they want knowing I am well looked after." A relative told us about a volunteer who visited her husband each week, so she could go out and access support for herself from the hospice. She said, "The volunteer is really good, they get on well together and they love talking about airplanes."

A relative said staff were providing excellent care for the person, and were attentive to their every need. They also appreciated how staff supported them when they had weepy moments. The relative of another person admitted for respite care said, "Excellent, I couldn't wish for any more, he goes in, primarily for managing pain relief. He has been in four times, and they have chopped and changed his medication several times to make him more comfortable." A person admitted to the inpatient unit the previous week for symptom and pain control, said these were now well controlled.

Staff worked proactively with each person and family to develop personalised care plans. These reflected how each person wished to receive their care, treatment and support. Individual care plans had comprehensive detailed information about each person's needs, wishes and preferences, as well as information about their family, life history and their interests. This meant staff had detailed information on how to meet people's individual physical, psychological and emotional needs.

Staff supported each person, if they wanted to, to develop an advanced care plan, which captured their wishes about end of life care. This captured their views about any further treatment, or resuscitation. This meant the person's wishes were known and staff could carry them out, even when the person was no longer well enough to communicate them. People's care was reviewed regularly with them, to check it was meeting their individual needs and to agree and document any changes needed.

All medical, nursing and therapy staff recorded their assessments in one record, which meant changes in people's care needs were communicated quickly and effectively between the staff team. Care records were updated regularly, as people's needs changed. Records also demonstrated effective communication and joint working with external professionals providing care for the person.

People received holistic care because staff understood the importance of working together as a team to provide seamless care for people. Weekly multi-disciplinary team meetings held were attended by medical and nursing staff, a social worker, psychologist, occupational and physiotherapy staff, the chaplain and bereavement lead. Comprehensive discussions took place about the care of each person and those of close family members. A future plan of care was agreed, and decisions made about changes were immediately documented in people's electronic care records. This meant people's pain and physical symptoms were actively managed.

Other multi-disciplinary meetings were held as needed. For example, 'best interest' meetings, discharge planning meetings, or in response to any incidents or concerns. At weekly meetings, staff also reviewed the care of each person who had died in the previous week. They discussed what aspects of their care had gone well, and identified any areas for improvement. A bereavement support plan for families of those who had died was agreed. This showed the service was committed to continuously reviewing and improving the quality of people's care.

People received co-ordinated person centred care which responded to their changing needs through outstanding partnership working. There were local multiagency arrangements where hospice staff co-located themselves with other health and social care staff to form a team around people, rather than people having to separately identify and approach those professionals. For example, hospice staff worked with the learning disability team to provide end of life care to a person. This included undertaking joint visits, and working together to plan the person's care.

Hospice staff were able to respond rapidly to people's changing needs and arrange for them to have appropriate care. For example, when a person's health deteriorated, the Weldmar community nurse contacted the continuing healthcare team (CHC), so more care and support services were provided for the person at home. Subsequently, when the person needed to go into the hospice for symptom control, hospice staff arranged transport for the person. Their relative said, " By the next morning he was feeling so much better."

The service participates in a Dorset wide audit to monitor whether people's wishes are being met about their preferred place of death. Multi-agency work, led by Weldmar, to improve end of life care in the home has identified a lack of community care provision, particularly in North Dorset. This meant people who wanted to have end of life care in the community did not always get their preferred choice, because their care needs could not be met by care agencies. This issue was being fed back to commissioners responsible for ensuring services are available to meet the needs of the local population.

The registered manager said they were proud of the close working relationships they had built with a consultant neurologist to provide high quality care for people living with motor neurone disease (MND). They ran a joint clinic with a visiting consultant neurologist, so that people could receive all the care and advice they needed locally at one appointment.

People and relatives said they had no concerns or complaints about the hospice. Information about how to raise concerns or complaints was provided to each person and was available in communal areas around the service. They included details of how to access advocacy services to support a person to complain, and of other organisations people could contact such as the ombudsman and Dorset Healthwatch, a consumer champion for health and social care. We received feedback from Healthwatch showing 37 of 38 people reported extremely positively on their experiences of hospice services.

The service had a robust system for investigating and learning from complaints. A complaints log was used to monitor any complaints received. The log showed seven complaints were received in the last 12 months. We sampled some of the complaints received, and found each one was thoroughly investigated with positive actions taken to address areas needing improvement. Written responses offered unreserved apologies where any aspect of care fell below the standard expected. Staff were open and honest with people when things went wrong and were committed to learning from people's experiences. Full explanations were given about the investigation, its findings and any actions being taken to address concerns. Where concerns related to other services, it was evident hospice staff worked with those services to help resolve issues, such as complex concerns involving continuing healthcare.

Is the service well-led?

Our findings

The service promoted a positive culture that was caring and person centred. People, staff and external health professionals consistently gave us positive feedback about the care. One person said "I'm so well looked after, it's unbelievable. I'm very, very lucky and I'm very grateful." Another said, "The whole place is run professionally for people like me who need it."

A health professional said, "The support and services they offer to patients is very wide and holistic. People have nothing but praise for the staff. Patients admitted for end of life care are provided with very good and supportive care, and families are very happy with the service." A GP said, "Last week I had a palliative care dilemma and just called in at the hospice. The medical team gave me 15 minutes of quality medical advice, it made all the difference....to me and the patient."

Staff worked together as a multidisciplinary team to provide seamless care focused on the needs of people. When we asked staff what the best thing about the service was, their responses included words such as "dynamic"; "sincerity;" "enthusiasm" and a desire to do their best for everyone. Staff said the hospice was a great place to work, with a fantastic team who supported one another well, like a "family." A staff member said, "We know who everybody is and what is happening for them."

The service was well led by the senior management team. A staff member said, "Weldmar runs like a well-oiled wheel." A manager said, "We believe in setting boundaries and empowering staff."

Weldmar hospicecare trust had a written strategic plan, (Making progress in uncertain time 2015-2020), which set out the vision and values of the service and a commitment to ensure people received end of life care in their preferred place. The strategy was in accordance with best practice guidelines in the Gold Standard Framework (GSF) and recent NICE guidelines on end of life care.

A board of trustees, headed by a chairman, was responsible for implementing the strategy and monitoring the work of the trust. The board met quarterly and received reports from various sub committees such as the audit, education and clinical governance committees. The registered manager was the Director of Nursing and Patient Services who worked with the medical director to provide clinical leadership for the service. Three assistant directors provided operational leadership in the central, south and north community teams. In the inpatient unit there was a senior sister (nurse in charge), and several sisters/senior staff nurses who led the team on each shift.

A new chief executive started working at the service in February 2016 and was visiting all areas of the service and meeting staff as part of their induction. They said their first impressions were positive, and the organisation had a lovely feel. A staff member said, "The chief executive asks good questions, listens well, and is accessible and decisive, they make me feel confident." The chief executive planned to review the current strategy in consultation with local people and partner agencies. This was to ensure the service had clarity of purpose and was using feedback and data to provide people with the maximum benefit. They said staff would continue to need to work differently and more flexibly to utilise scarce specialist skills more

effectively. This was so they could meet the growing demands of an ageing population and the local demographic challenges.

Most staff said they felt well supported by their line manager. A staff member said, "I am able to have my say and am listened to." Another staff speaking about management said, "On the whole, they get most things right." However, in the community, we identified some tensions amongst Weldmar community nurses (WCN'S), related to managing change. A recent reorganisation of the WCN teams, had resulted in changes in job roles, regrading, with associated changes in terms and conditions. These changes had adversely impacted on staff morale in some teams.

Other staff raised concerns about differences in ways of working between WCN teams and 'silo' working, and said some staff were resistant to change. The tensions meant staff and managers were spending large amounts of time and energy dealing with these issues. Staff sickness within WCN teams also meant the management team had to make changes and decisions quickly about contingency arrangements, to minimise disruption for people. This meant some staff didn't feel sufficiently consulted about the changed working arrangements.

We followed these issues up with the registered manager. They explained the background to the reorganisation of the WCN teams was to create an affordable skill mix in the community in order to face the demographic changes. This also related to having a more flexible community workforce, so people could receive end of life care where they wished to receive it. They explained the differences in working arrangements were, in part, due to geographical differences and variations in health and social care provision in various parts of Dorset. Originally, the reorganisation was planned to take place at the same time across the three teams. However, difficulties with terms and conditions, protected pay arrangements and negotiations with unions, meant the changes had been implemented at different timescales.

We asked how the service was monitoring the impact of the changed community arrangements on people and families. The registered manager explained people and GP practices had been sent a letter explaining the changes and the reasons for these. A system was implemented for triaging all referrals so the service prioritised care for people who urgently needed home visits. Managers used feedback and data to monitor and identify any risk areas at their weekly meeting. This included looking at complaints and referral rates, accident/ incident data and decisions made at daily triage meetings. Each week they reviewed available staffing resources, referral rates, the number of visits carried out, including whether they were face to face or telephone contact visits. Minutes of the clinical leadership group and integrated governance committee showed board members were aware of the community staffing issues and were monitoring them.

We concluded managers were being proactive, and data showed the impact on people was minimal, which was consistent with what people and families told us. The registered manager said, once the immediate difficulties with staff in the community had improved, they planned to undertake a review to consider what lessons could be learned and to try and prevent a future similar occurrence.

The hospice had sickness absence, capability and disciplinary policies and procedures. Sickness absence and staff performance issues were well managed, and monitored. Managers sought advice and guidance from staff occupational health services and human resources and kept in contact with absent staff. A phased, supported return to work was planned for staff members close to being fit to return to work, which addressed any support, updating and training needs.

The hospice had robust governance and quality monitoring arrangements. A wide range of audits were undertaken to monitor the quality of care provided. For example, audits of falls, drug errors and pressure

area care. In the provider information return, the registered manager highlighted the hospice used the national Hospice UK benchmarking tools to compare their practice to other similar services. They compared their audit results on pressure area care, falls and medication errors. This meant the service was prompted to explore reasons for any variations in practice.

For example, a previous audit had identified prevention of pressure ulcers (known as bedsores) as an area for improvement. In response, staff were given additional training on pressure area care, which improved staff assessment skills. A quarterly audit of pressure area care, October to December 2015, highlighted staff practice in pressure area care had improved and there was a measurable reduction in avoidable pressure damage. The practice educator told us about other recent practice initiatives to further improve people's standard of care in response to audit findings. These included improving people's care, comfort and quality of life by additional staff training on mouth care, managing nausea, vomiting and constipation.

An organisational risk register captured seven key risks and outlined actions being taken to reduce them. For example, in response to difficulties recruiting senior experienced managers, an in-house leadership and management development programme had been developed to nurture and develop existing staff for more senior management roles. The service had also commissioned a review of the human resources department and had created a new head of human resources post to develop a future workforce strategy.

The service used the NHS 'Friends and family test' to survey people and families satisfaction with the service and to identify areas for improvements. Monthly figures for 2015 consistently showed 90-100% of people asked were extremely likely to recommend hospice services to friends and family. A 'Reflections' comments and compliment system captured people's feedback and suggestions at regular intervals. For example, in response to feedback in a day service, staff changed the order of activities to include a more restful period in the afternoon when people were getting tired.

The 2015 annual staff survey reported positively on good departmental team work and support from line managers. Also on training, support and development opportunities, and the organisation's systems and procedures. Areas for improvement highlighted included better communication within the organisation. In response all clinical staff had attended communication training relevant to their role. A monthly staff newsletter 'Weldmar in the news,' kept staff informed about wider service developments and an electronic 'Rumours board' provided speedy interactions and feedback between staff and management on a variety of topics.

Staff could also raise issues of concern and contribute suggestions through a joint staff consultative committee. Minutes of the most recent meeting on 20 January 2016 included discussions about the introduction of a dependency scoring tool to assess staffing levels in the inpatient unit, a briefing from the board, and a health and safety update. Staff had regular team and department meetings, where they could air their views and receive regular feedback about the service. A further staff survey was due to be carried out in April 2016 to monitor progress of the improvement measures being taken, and to identify areas for further improvement.

Trustees carried out twice yearly provider quality monitoring visits. The reports were detailed, thorough with an action plan to address any issues raised. For example, the most recent provider visit report, October to December 2015, showed staff spoke to trustees about the importance of a 'good death' for people in their care and the importance of hearing laughter, and knowing people had fun and went home feeling safe. The report also highlighted inequities within Dorset for people accessing continuing health care, which was fed back to commissioners to inform commissioning decisions. The registered manager met quarterly with NHS commissioners to monitor a service level agreement to provide rapid access to people having continuing

healthcare who needed symptom management and end of life care. A range of key performance measures showed the service was performing well.

Accidents/incidents reported were analysed and monitored quarterly at the clinical governance steering group to identify any themes or trends. Data showed the most commonly reported incidents were falls, communication issues and drug errors. For example, additional staff training was provided in managing falls, to raise awareness of further ways to reduce falls.

All policies reflected evidence based practice and were reviewed and signed off by a corporate governance committee. They were accessible to all staff via the hospice computer system. We sampled some policies such as consent, accident/incident and risk management, infection control and medicines management and found they were well written. Staff were aware of recent best practice guidance such as One Chance to Get it Right (five priorities for care of the dying), six ambitions for palliative and end of life care 2015-2020, and recent NICE guidance on end of life care.

The hospice used lead roles to champion good practice in a particular area of practice. For example, a nurse on the inpatient unit was a champion for caring for people living with motor neurone disease. They had compiled information for other staff to refer to help them care for people with this condition and provided advice on their care and updates on changes in practice. A number of other similar lead roles, were used to improve standards of care for people's specific health needs.

The hospice used a competency framework system, to set out expectations of the knowledge, skills and attitudes people could expect from each staff role. A standardised framework meant there was ongoing assessment to ensure people received effective care from staff. Staff training, supervision and appraisal systems were regularly monitored and reported to the board. A new 'training tracker' system had been introduced, through which staff could update records of their existing qualifications, and book courses and training. The database also provided information to inform future workforce planning. Regular checks were made to ensure people were cared for by staff whose nursing and medical staff registrations were up to date with their professional bodies.

The registered manager sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly.

The service was continuously looking for ways to improve the service. For example, between October and December 2015, a 24 hour advice line was piloted from Joseph Weld in-patient unit for a 10 week period. This was so staff working on the unit could provide advice to people, relatives and health professionals having end of life care in the community. The pilot hadn't yet been fully evaluated, due to other staffing pressures in the service. A nurse said, "I think it went well, we may need to manage expectations, as some callers expected someone to come out."

The chief executive spoke about plans to pilot the use of telehealth. Telehealth uses telecommunications technology to enhance health care, and health education delivery. This would reduce the need for people and health professionals to travel long distances, so consultations could be held via an electronic link. This would also be a more effective and efficient use of the specialist skills available in a rural area. Other planned improvements included developing a rotational post between the inpatient unit and the community, so staff work more flexibly between both settings. This would provide more flexibility to cover sickness and annual leave. The practice educator was also getting involved in supporting less experienced community staff.

The service worked proactively in partnership with other agencies to ensure the people of Dorset received joined up care. They had a shared consultant post in palliative care between Dorset County Hospital and the hospice. This meant there were close working relationships between the two services, with the hospital consultant attending the weekly multidisciplinary team meeting at the hospice, to discuss the care of people newly diagnosed as approaching end of life. Hospice staff ran joint clinics with a neurologist, so people with motor neurone disease could have all their care at one appointment. Other partnership working included the child support worker, working schools and other services to support bereaved children.

In North Dorset hospice staff were part of the "Better Together" initiative whereby health and social care staff were co-located in offices so they could work better as an integrated team. The WCN explained this worked really well because they could talk face to face with other health and social care staff about people they cared for, and could refer them and get a quick response. For example, NHS mental health nurses, district nurses, social workers, and therapists in the community rehabilitation team. The service also worked with Macmillan (a national cancer charity) to develop a three year pilot whereby a psychologist was funded to work with the service, which improved the psychological support provided to people and families. They also worked closely with Marie Curie cancer care services, which provided end of life care home care services to some people in Dorset, and helped fill some of the gaps in local social care provision.

The hospice education department was part of the Hospice Education Alliance (HEA), who worked with other providers to provide equitable access to end of life education and training. This included other universities and colleges, so hospice and other local health and social care staff were supported to further develop their skills and expertise. These initiatives meant local people received better end of life care from knowledgeable and skilled staff through partnership working. Shared training promoted good partnership working, and established useful contacts. For example, an employee of a domiciliary care agency said, "I can now contribute more to the assessment of palliative patients and I attended a multidisciplinary team meeting with hospice staff recently." Others said, "I am more aware of what should be in place, like the do not resuscitate (DNAR) orders," and, "I feel better able to work with other providers and hold my own (in discussions about their clients)."