

St Joseph's Hospice Hackney

St Joseph's 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?	Requires Improvement ●

Summary of findings

Overall summary

This inspection took place in 27, 28, 29 July and 1, 2 August 2016 and was announced. When we last visited the hospice on July 2015 we rated the service as Requires improvement. Three recommendations were made regarding improving the culture among staff in the hospice, improving staff awareness of how to escalate concerns and whistleblowing, and the management of medicines.

St Joseph's Hospice, Hackney is registered to provide end of life and palliative care for up to 61 people at the main site and a community palliative care team to approximately 350 people. The on-site service is split into three wards including one respite ward where people stay for a short length of time and are supported to gain skills to better support themselves in the community. The provider also runs a day hospice three days a week on-site which both people living on site and in the community can attend. At the time of inspection there were 20 people using the on-site services.

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

While we were carrying out the inspection we received a number of whistleblowing concerns that there was still a bullying culture among staff at the hospice. The registered manager confirmed that while they had made progress on addressing these issues further work needed to be done to improve the culture among some staff groups within the hospice. Staff spoken to directly while we were inspecting the hospice said this was not an issue and felt supported by management.

People were supported to make choices about how their needs were met. People and relatives were involved in decisions about their care. Where people were unable to make decisions about their care their human rights were protected in that best interests decisions were made on their behalf.

People were kept safe. Risks to people were identified and staff took action to reduce those risks. Staff were available and had the necessary training to meet people's needs. Staff responded to people's needs promptly.

There were systems in place to ensure that people consistently received their medicines safely, and as prescribed.

People were supported effectively with their health needs.

Care was planned and delivered in ways that enhanced people's safety and welfare according to their needs and preferences. Staff understood people's preferences, likes and dislikes regarding their care and support needs.

People were provided with a choice of food, and were supported to eat when this was needed. There was a strong emphasis on the importance of good nutrition and hydration and a commitment to providing people with what they wanted to eat and drink in a flexible manner.

People and their relatives told us that the hospice provided excellent care, and that staff were caring, kind and compassionate. People who used the service comments were, "The service is amazing" and "I'm very happy with the care here." One relative said that staff were, "Exceptionally kind, I have recommended this service to others." The hospice provided people with multi-professional and person centred care that ensured their physical, emotional, psychological, spiritual and social needs were met. People were treated with dignity and respect. People and relatives told us they consistently received care that met their individual needs.

There was an accessible complaints policy which the registered manager followed when complaints were made to ensure they were investigated and responded to appropriately.

People using the service, relatives and staff said the registered manager was approachable and supportive. Systems were in place to monitor the quality of the service and people and their relatives felt confident to express any concerns, so these could be addressed.

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 provided was safe. People received safe care both at the hospice and in their own home.

Staff followed the procedures that were in place to protect people from abuse.

The risks to people who used the service were identified and managed appropriately

Staff were available in sufficient numbers to meet people's needs.

People consistently received their medicines safely and as prescribed.

Good ●

Is the service effective?

The service was effective. People were positive about the staff and felt they had the knowledge and skills necessary to support them properly.

People told us they enjoyed their meals. Staff were aware of any specific dietary needs that people had and ensured these were met.

People were involved in making decisions about their treatment and care needs. Safeguards were in place to ensure that people who were unable to make decisions about their care had their human rights protected.

People's healthcare needs were monitored. People were referred to the palliative care consultant and other healthcare professionals as required.

Good ●

Is the service caring?

The service was caring. People and their relatives spoke consistently about the caring and compassionate attitude of staff.

Good ●

Staff were respectful of people's cultural and spiritual needs.

The service provided appropriate end of life care to ensure they were enabled to experience a comfortable and dignified death.

People and relatives told us they consistently received care that met their individual needs.

People and their representatives were supported to make informed decisions about their care and support.

Is the service responsive?

The service was responsive. Care plans were in place and gave detailed information about people's care and support needs and staff followed these.

Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People knew how to make a complaint as there was an appropriate complaints procedure in place.

Good ●

Is the service well-led?

The service was not always well-led. Some staff did not feel safe in their roles because they felt there was a culture of bullying that the provider had not addressed.

People and their relatives were consulted about how the provider could make improvements to the service.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

Requires Improvement ●

St Joseph's Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 27, 28, 29 July and 1, 2 August 2016 and was announced. We gave 48 hour's notice of the inspection due to the complexity of the service. The inspection team consisted of a lead inspector, a pharmacist inspector, a specialist professional advisor 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 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 improvements they plan to make. We reviewed the information we held about the service. We also received feedback from two external palliative care professionals, Hackney Healthwatch and one commissioning officer.

During the course of the inspection we spoke with, either in person or on the telephone, 10 people who used the service, 12 relatives and two visitors. We also spoke with 35 members of staff and two volunteers. This included the interim chief executive, chair of board of trustees, registered manager, directors of corporate services and quality and care, health and safety officer, director of human resources, head of education, pharmacist, manager of the community palliative care service, volunteer and community engagement manager, in patient unit managers, eight nurses (including clinical nurse specialists), two senior healthcare assistants, a care coordinator, and eight healthcare assistants. We spent time in the inpatient and day care units, observing care and support. We joined a multi-disciplinary meeting and met with the and Specialist Community teams. We also spoke with three doctors including medical lead, Consultant in Palliative Medicine and a Junior Doctor.

We looked at six people's care records and 15 medicines records. We looked at other records relating to the management of the hospice. This included nine recruitment records. We also looked at duty rosters,

accident and incident reports, complaints, compliments, health and safety, maintenance, governance and quality monitoring records.

Is the service safe?

Our findings

People who used the service felt safe and were confident that staff would respond to any concerns they had. People said that the service was "safe" and one person told us, "If there's something you're not happy about how staff treat you can talk with the ward manager and it gets sorted out."

At our inspection of July 2015 we found that people were not always protected against the risks of poor practice as staff did not always know how to escalate concerns as the details of agencies and who staff could whistleblow to were not included in the whistleblowing policy. Following the inspection the provider sent us an action plan and told us they would make the necessary improvements by September 2015 by ensuring that staff were aware of how to whistleblow and updating the policy. At this inspection we found that the whistleblowing policy had been updated to include contact details of the local authority safeguarding team, the Care Quality Commission (CQC) and the police.

Staff were able to explain what they would do if the hospice did not respond to their concerns and the external organisations they could contact. One member of staff said, "I know who to contact if I felt this organisation was not protecting patients. You can call the police, the local authority or CQC." The registered manager explained that the new whistleblowing policy had been discussed with staff and staff also could contact with the hospice's own Guardian Service, which gave staff a platform to raise concerns anonymously. Staff told us that they had contacted the Guardian service when there were issues of concern about the hospice.

Staff and volunteers understood how to recognise and respond to potential abuse. This included who to report safeguarding concerns to. One member of staff commented, "Safeguarding is about preventing and reporting abuse. If there was anything like this I would report it immediately." Staff and volunteers had completed training on safeguarding and the registered manager told us that further training was planned. They understood that racism or homophobia were forms of abuse and gave us examples of how they valued and supported people's differences. The provider had taken reasonable steps to ensure that people who used the service were protected against the risk of abuse, as systems were in place to identify and prevent it from occurring.

At our inspection of July 2015 we found that there were not enough permanent staff employed at the hospice to meet people's needs. Following the inspection the provider sent us an action plan detailing how they would make improvements by September 2015 by recruiting more permanent staff. At this inspection we found that the provider had recruited more permanent staff. The registered manager explained that there was an ongoing recruitment drive as there were still a few vacancies to be filled. Records showed that there were now 3.5 full-time equivalent vacancies. Staff confirmed that there was always enough staff to meet the people's needs.

People told us that there were enough staff to meet their needs both in the inpatient wards and in the community. One person said, "I can't praise the staff enough." People who used the service told, and we saw, that call bells were responded to quickly. The staff rotas showed that there was a consistent level of

staffing maintained in all areas of the hospice. The registered manager was in the process of reviewing staffing levels and told us that where this showed that more staff were needed a plan will be put in place to address this.

The provider's recruitment procedure was thorough and they ensured that this was followed so only staff and volunteers who were suitable were recruited to work with people. Staff records contained criminal records checks, two references and confirmation of the staff member's identity. Checks had been completed to confirm that staff who had a nursing qualification were registered with the Nursing and Midwifery Council. We spoke with one member of staff who had recently been recruited to work at the service and they told us they had been through a detailed recruitment process that included an interview and the taking up of references. There was evidence in staff records to confirm that all they were legally entitled to work in the United Kingdom.

Risk assessments were in place that ensured risks to people were addressed. There were detailed risk assessments covering areas of potential risks, for example, risk of falls, pressure ulcers and malnutrition. These were being reviewed monthly and any changes to the level of risk were recorded and actions identified to address the risks were highlighted. Staff were able to explain the risks that people might experience when care was being provided. Risk assessments identified the action to be taken to prevent or reduce the likelihood of risks occurring. Where necessary professionals had been consulted about the best way to manage risks to people.

Medicines were managed safely in the hospice. A pharmacist and pharmacy technician work out of a pharmacy department that is situated within the Hospice. The service is delivered under contract from Guy's and St. Thomas' NHS Foundation Trust under the leadership of a consultant pharmacist specialising in palliative and end of life care. Medicines orders were facilitated by the pharmacy team and we found that all medicines were in stock for people. The requisition used to supply controlled drugs to the hospice was not signed by a doctor as is required in legislation, however individual ward orders were. When we brought this to the attention of the provider they told us they would make the necessary changes. Nurses described to us how they accessed medicines in an emergency and told us that the service they received was so effective that this allowed them to spend more time with patients as the medicines were taken care of. Medicines were stored securely and appropriately, including controlled drugs and those requiring cold storage.

When patients were admitted, their medicines were checked by the pharmacist or nurses who had been specifically trained to ensure they were safe and appropriate to use. Prescriptions written by the doctors or non-medical prescribers were clear and the administration records showed that medicines were administered as prescribed and any omissions were coded and the reasons recorded. Patients were encouraged to manage their own medicines where they were able to and wished to do so. This was particularly noted on the respite ward, where we saw robust risk assessments and reviews in place to ensure this happened safely. Medicines for discharge were ordered separately where needed and this included controlled drugs and medicines for short term leave. Blank prescriptions used for this were stored securely and their use tracked.

Nurses were trained in medicines handling on induction and assessed as to their competency. They also had training and regular updates in specific areas of medicines use including syringe drivers and intravenous administration. Learning events for all clinical issues were led by consultants and pharmacists.

Incidents were reported to the medicines safety improvement group, which reviewed the incidents and developed action plans. Medicines safety improvement group reviews and monitors medicines management in order to improve the safety of medicines administration to people. Nurses described to us

how they received the learning and were involved in these actions, for example we saw improved recording for medicines supplied in patch form after errors had been noted. Alert information was disseminated to the ward teams in a timely manner. The pharmacist attended ward rounds and nurses' meetings and we were told of the contribution they made to safe prescribing and patient care.

Is the service effective?

Our findings

People who use the service told us that they received care and support from skilled and competent staff. People's comments were, "Staff are really great, they understand what I need," and "I am satisfied with the care and support the staff give me they really do a good job both here at the hospice and when I'm at home." Community-based palliative care professionals told us that the skills and knowledge of the hospice's staff understanding of palliative care needs was highly valued.

The hospice had its own education centre which offered a wide ranging education and training programme to staff, volunteers and external health and social care professionals. The Centre provided courses and study days on wider aspects of palliative care. This included the Gold Standard Framework, which is a practical, evidence-based approach to delivering high quality care for all people nearing the end of life. The education centre offered a multi-session foundation in palliative care which was available to the hospices staff and volunteers and external professionals. The education centre offered a library of resources about meeting people's palliative care needs to help promote this topic.

Staff and volunteers had completed an extensive induction programme that prepared them for working in the hospice. The induction included the Care Certificate induction. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. This also covered aspects of end of life care and the relevant skills such as dealing with bereavement and communicating with people at the end of their lives. The staff training matrix showed that all new staff and volunteers had completed this training. The induction programme had recently been reviewed in order to establish what improvements could be made to it. As a result the registered manager was in the process of introducing modules on enablement and governance to improve the induction of new staff.

Staff and volunteers had an extensive training programme that covered a range of topics that were relevant to meeting the needs of people at the end of their lives. These included working with loss and grief, the management of pain and breathlessness, and advanced care planning. Staff had also completed training on diversity and equality issues and meeting the emotional and spiritual needs of people. The training records showed that refresher training had been provided so that staff and volunteers could maintain their skills and knowledge. This included the direct observation of staff and volunteers practice in their work with people who used the service to make sure they put in to practice what they had learnt.

Staff told us that they received regular management and clinical supervision (one-to-one meetings with their manager or a clinical expert to discuss their skills and development needs). Records showed that supervision sessions were taking place regularly. Clinical supervision was available to staff from clinical, therapies and social care services within the hospice. A pilot project was being run with the support of Tavistock Centre to run supervision groups for clinical and other staff. All staff had a mentor to discuss their developmental needs. The mentor was usually someone senior to them and worked in the same area of expertise. Staff told us, and records confirmed that they had annual appraisals to identify how we could further develop their understanding and knowledge.

The staff explained that the hospice had implemented Schwartz Rounds; these provided a reflective session to share and consider the emotional and social impact of caring staff. Schwartz rounds were being held monthly, to support the philosophy that there was an important relationship between the improvement of the well-being of staff and the well-being of people who used the hospice. The Schwartz Rounds provided staff with a safe place to discuss their experiences and give each other support. There was also an external counselling service that staff could access if needed.

People said they were provided with a variety of meals and that they chose what they wanted to eat each day. One person told us, "The food is quite good." Another person observed that, "Even though there are lots of choices on the menu, they will still make you something different if you asked for it." Food and drink was available 24-hour a day. There was a four week menu that included a range of main meals as well as alternatives that people could request if they wished to. Snacks, smoothies and milkshakes were available throughout the day. People told us, and we observed that they were encouraged to request alternatives to the menu if they had specific preferences. Drinks were provided regularly (a minimum of seven times a day) and people were seen to have access to water at all times.

People's nutritional needs were assessed and this highlighted if they needed to be referred to the dietician and speech and language therapist. Nutritional assessments identified if people had any specific nutritional requirements with regard to a special diet for medical reasons, dietary allergies and intolerances, or for cultural and religious reasons. For example, one person said that they could have kosher food to meet their cultural dietary needs. A relative told us, "My relative is Muslim and they arrange Halal meals when they are at the Hospice." The nutritional assessment was incorporated into people's individualised care plan. Where people were at the end of life their eating and drinking was assessed at regular intervals.

When people's nutrition was supported by enteral tube (a tube going directly into the stomach for feeding with a special feed) feeding this had been assessed and a feeding regime had been put in place to support their ongoing nutrition. Where people needed oral supplements these were agreed with the person's doctor and recorded. Supplements were administered at specific intervals based on the doctor's instructions and the person's preferences.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us that staff asked them for their consent before they supported them. People said they were able to make choices about some aspects of their care. We observed staff asking people what they wanted in terms of their support. The registered manager and the staff we spoke with had a good understanding of the principles of the Mental Capacity Act 2005 (MCA). They told us they always presumed that people were able to make decisions about their day to day care. They said some of the people who used the service had been diagnosed as having dementia and they took extra care when communicating with them to involve them in making decisions.

Staff explained that if the person could not make certain decisions then they would have to decide what was

in that person's "best interests" which would involve asking people close to the person as well as other professionals. Staff understood that people's capacity to make some decisions fluctuated depending on how they were feeling and how well they were.

Staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff were able to describe people's rights and the process to follow if someone was identified as needing to be assessed under DoLS. Staff understood people's rights to make choices for themselves and also, where necessary, for staff to act in someone's best interests. Where staff were required to act in a person's best interests there was evidence that DoLS authorisation had been put in place.

People in the community could have access to the care from both the hospice and external health and social care professionals. One person said, "I was being supported by the community palliative care team, but needed more help and they referred me to St Joseph's. The nurse visited that day and arranged for me to come here." Staff understood that people's healthcare needs could change and knew how to respond by working with other professionals. People's care records showed that different professionals had been consulted to address their support needs.

Both staff in the inpatients and community services of the hospice adopted a holistic approach when they responded to people's needs. People had access to a range of palliative care professionals, including specialist palliative care doctors and nurses, physiotherapists, occupational therapists and counsellors. Multidisciplinary team meetings (MDT) were held regularly for each of the services provided by the hospice. MDT's are meetings of professionals to discuss individual's needs holistically. During the inspection we had the opportunity to attend an MDT meeting, which included a consultant (palliative care specialist), a nurse, a clinical nurse specialist, a physiotherapist and the social worker. We were able to hear how the health and social care professionals work together to meet the needs of people referred to the hospice.

People had access to a range of complementary therapies, such as Reiki (a healing technique based on the principle that the therapist can channel energy into the patient by means of touch), relaxation and meditation, art therapy and yoga. People and relatives told us that they found these therapies helped with the management of symptoms. One relative told us their relative, "Had never participated in an alternative therapy session before, but to our great surprise they enjoyed it thoroughly." People's needs for alternative therapies were included in their care plans and staff understood that they were an essential part of the care provided by the hospice.

Is the service caring?

Our findings

People and their relatives told us that the hospice provided excellent care, and that staff were outstandingly caring, kind and compassionate. Some of people's comments were, "The service is amazing" and "I'm very happy with the care here." One relative said "Staff were exceptionally kind, I have recommended this service to others." Another relative said, "We are so pleased with the staff we deal with, they are fantastic, anything that we want or think we need they support us with it." Healthwatch commented that people had reported that they were happy with the service and had described the service as brilliant, excellent and caring. We observed that staff and volunteers responded to people with kindness, compassion and respect and demonstrated a caring and supportive attitude towards them.

People and relatives were provided with detailed information regarding the services available at the hospice. They were able to access these in the form of leaflets, on the website or via telephone or face-to-face meetings. We observed that leaflets were available in the reception area of the service and that information was signposted on the hospice is the website. People told us that they knew about the services provided by the hospice and how to contact them if they needed them.

The hospice had a telephone triage system and a 24 hours telephone contact for people and relatives. This acted as an initial triage of people's needs so that they were pointed in the direction of services that were able to support their needs. An out of hour's service was available which was staffed by nurses and supported people who may be in crisis by referring them to services in the hospice or from other providers. People told us that staff at the hospice contacted them when they were having specific issues with their care. One person said, "They call you when they know that you might be feeling down. They want to know how you are on what's going on, it really helps."

The hospice provided people with multi-professional and person centred care that ensured their physical, emotional, psychological, spiritual and social needs were met. Staff understood and responded sensitively to the needs of people and their relatives. This included supporting people to prepare advanced care plans and make their wishes about their end of life needs clear to their relatives and professionals. Care records showed that advance care planning had been put in place where people were willing to discuss their needs. Staff understood that discussing with a person how they wished to be cared for at the end of their life was a sensitive matter. They told us that they would be led by the person who used the service in when and how much detail they would discuss this.

Staff were trained in advanced communication skills enabling them to facilitate conversations. This helped to ensure that staff had the skills that enabled people to share their worries. This training also gave staff the understanding and skills needed to have conversations with people about advanced care planning and end of life care. This enabled staff to better address and meet these needs. One person told us that they had discussed their needs with staff and said, "You can talk to staff about anything they listen and help you to decide the way you want things to be."

People and relatives told us that staff understood how to meet their care and support needs. One person

said, "They are looking after me well," and a relative confirmed that, "Staff are really observant and care, any questions are not too much trouble, I can't personally find fault with anything." People's care records showed that their individual needs were identified and plans put in place that ensured these needs were met. Care plans showed that people and their relatives had been consulted about how people wished to be supported. Relatives had been involved in decisions and received feedback about changes to people's care where appropriate.

People and their relatives had access to both psychological and bereavement counselling support. People told us that the counselling services were accessible and supported them to maintain their emotional well-being. One person said, "Since having counselling I have been more positive, I enjoyed what I've got now and I don't worry about the future." People's need for counselling was established with them as part of the assessment of their needs. We spoke to staff who explained that they provided people with a range of psychological, counselling and psychotherapy support depending on their needs and wishes.

People were supported by staff to maintain and promote their privacy and their dignity. One person commented, "They are looking after me well." We saw that people were addressed in the manner they wished, for example, their preferred names. Staff knocked on people's room doors and waited to be asked to come in. There were a number of family rooms on each of the wards. These provided spaces for people and relatives to spend time together in private. We saw that staff respected people's privacy by not entering these rooms or people's bedrooms when they had visitors. In this way the hospice supported people to maintain intimate relationships with their families, friends and partners. Staff understood the importance of affirming all relationships that were significant to people.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender and supported them in a caring way. Staff told us and records showed that they had received information and training on this. Care plans and observations of MDT's showed that promoting and meeting the diversity, cultural and religious needs of people were central to the care and support provided by the hospice.

People and relatives had been asked about their cultural and religious needs. A relative confirmed that, "They (staff) understand that we are all different." All members of staff and volunteers knew how to support people's religious and non-religious spiritual needs. People were supported to express their religious beliefs by a multi faith chaplaincy team. The multi faith chaplaincy team consisted of leaders from the Jewish, Muslim, Sikh, Hindu and Christian faiths. Relatives told us that the multi faith chaplaincy team, staff and volunteers supported them by meeting their spiritual needs before during and after death. One relative told us, "We use candles as part of our worship and they helped us to do this. They recognise my relative as a unique individual with a very real personality." One person was of a specific religion, and the staff had contacted a local spiritual leader to visit them.

A relative told us, "I feel my relative's cultural needs are understood. They are Muslim and my relative sees the Imam at the hospice." People and relatives had access to a chapel and a multi faith room if they wished to spend some time in quiet reflection or practice their religious beliefs. Prayer mats were available in the multi faith room and facilities to ritually wash before people prayed.

We found that people's relatives and those that mattered to them could visit them when they wanted to. Relatives and friends were able visit people when they wanted to as there were flexible visiting times to ensure family members who for example worked were still able to visit the person who used the service when they wished to. One person said, "My relative comes whenever they want to, the staff are always welcoming and offer a hot drink." Staff remembered relatives names and this appreciated by relatives. Children were also welcome to visit and there were areas with toys and games provided for them. If relatives

wish to stay overnight with the person who used the service this was arranged. One relative told us that staff never minded when they rang and they, "were never impatient and see if he is awake or has a message for me."

Is the service responsive?

Our findings

People and relatives told us that the hospice was very responsive to their needs. One person told us, "The service is brilliant." One relative said, "Staff here are amazing, I'm incredibly impressed with the care at St Josephs both the medical and emotional support." Another relative confirmed that, "They gave 110% went out of the way to help my relative, staff are all wonderful' made the whole family feel as good as possible." The hospice had a 24-hour helpline that people and relatives could contact for advice. The service also provided advice to health professionals when they were working with people who had complex palliative care needs and life limiting illnesses.

Care records showed that comprehensive assessments had been carried out of people's needs on their referral to the hospice. These assessments were discussed at multidisciplinary team meetings so that the appropriate services were made available to people. Multidisciplinary team meetings meant that a full discussion took place with all the relevant professionals to ensure people's needs were met in a timely way. One person explained about the range of services that had been made available to them and said, "Physiotherapist have been out, we have been given build up drinks (a supplement) and counselling has been offered. If I am in a bad way I ring, all the nurses are very nice and will talk with me. They are not in your face and don't push you to do things, they are all very supportive." The hospice's Living Well Information and Support service provided information that empowers people with end of life care needs to understand about services and options when considering their care.

Staff told us they were aware of how to assess people's needs in a way that did not discriminate and provided at equal access to all people who used the service. One member of staff said about meeting the needs of people from the Lesbian, Gay, bisexual and transgender (LGBT) community, "We don't discriminate. We show that there is equal access to the service for everybody, we use the assessment tool to get people to identify their own needs. If we have to postpone or reschedule visits we make sure that it is for clinical reasons. This meant that people were told why there is a change to their planned service so that they don't worry it is because of discrimination."

People could choose where they wished to spend their last days. If they wanted to stay in their own home the hospice at home service provided them with the necessary support. The community palliative care service planned their work so that they could respond to the changing needs of people. A relative told us that the hospice home team was, "Always on top of everything, they help me stay strong."

People could be admitted to the hospice for a number of reasons. For instance, if they needed emergency stay, respite care support with their pain relief, helping them to deal with long-term life limiting conditions and end of life care. People who used the hospice had care plans that were tailored to meet their individual needs. Care plans showed that people and their relatives had been involved in identifying what was important to them and the outcomes they wanted from their stay. Care plans provided a detailed record of people's needs and preferences. These were reviewed regularly and when people's needs changed. For example, increasing breathlessness or changes to nutritional needs were promptly recorded in people's care plans. Care plans showed that appropriate action was taken to address changes in people's needs.

People and relatives had access to a range of activities and support groups that were available at the hospice. There are activities such as a choir, current affairs group, tai chi and art groups. There were also social and support groups that offered a chance for people with specific needs to discuss what they were experiencing and gain support to help them to manage their conditions. For example, there were MS support group, neurogroup, for people affected by neurological conditions, and bereavement groups. People and relatives told us that these activity and social groups helped them to overcome loneliness or difficulties they were having in coping with their illness.

The day hospice service provided people with access to a range of professionals, therapeutic, social and medical care specialists, and reviewed with a consultant or access to the counselling services provided by the hospice. The day hospice supported people to overcome social isolation by providing a place where people could meet others with similar experiences and engage in activities. One person explained, "I live alone, coming to the day hospice means I can meet with friendly people, it's very helpful." The day hospice provided a range of activities for people, these included pottery, art and discussion groups. One person commented that this was, "Very enjoyable and well-organised."

The hospice had started a Namaste project to respond to the needs of people with dementia. This project aims providing support people living with dementia through stimulation of their senses. The hospice had trained 67 volunteers who work with people living with dementia and their families for 12 weeks. The volunteers showed family carers simple hand massage using aromatherapy oils to scent the room in which the massage takes place. The provider showed us a promotional video of how a person with dementia and their family had benefited from the project. The person living with dementia now reminisces about the past, but before becoming part of the Namaste project they did not speak.

The hospice continually worked to widen access for people who would not normally consider that hospice services could be for them. For example, they had begun to work with people living with dementia and mental health needs. The hospice provided culturally sensitive care via partnership work with specific groups. For example, by working with Bikur Cholim, an organisation that provided care and support to frail, ill and elderly members of the Orthodox Jewish community. The hospice has also developed links with local communities through the hospice's Compassionate Neighbours service. Compassionate Neighbours is a community led initiative that recruit volunteers who offer their time, companionship and support to people living in their community with life limiting conditions. The Chaplaincy team engaged with local faith and community groups and helped to raise staff's awareness of the cultural aspects of end of life care in relation to the local ethnic population.

People were confident that if they made a complaint this would be listened to and the provider would take action to make sure that their concerns were addressed. One person told us, "I would talk to the ward manager and I know they would sort out my complaint." Another person, said, "I know there is a form to fill out if you want to make a complaint." Copies of the complaints procedure were on display in the service. Staff told us that if anyone wished to make a complaint they would advise them to inform the manager about this, so the situation could be addressed promptly.

People and their relatives were confident they could raise any concerns they might have, however minor, and they would be addressed. People were able to give us examples of when they had made a complaint and it had been appropriately addressed. The complaint records showed that when issues had been raised these had been investigated and feedback given to the people concerned. Complaints were used as part of ongoing learning by the service and so that improvements could be made to the care and support people received where necessary.

Is the service well-led?

Our findings

At our inspection of July 2015 we found that teamwork and morale was not always well managed which posed a potential risk to the quality of care. We recommended that the provider seek guidance from reputable sources to improve the culture among staff. The provider sent us an action plan telling us they would develop ways of engaging with staff and would seek guidance on how to improve the culture among staff.

At this inspection we found that the provider had also commissioned a Rapid Review team to look at the dynamics between staff in the hospice and make recommendations for improvement. The Rapid Review team consists of a group of independent professionals who had been asked by St Joseph's Hospice to investigate the concerns regarding staff culture and care practices. We noted that the provider had also introduced a number of ways to work with staff to improve teamwork and morale. These included staff questions and answer sessions and staff feedback through "Your Say". They acted as a two-way communication between the senior management team and staff and where necessary, the senior management team provided formal responses to feedback from staff. The hospice had a staff consultation committee which meets on a monthly basis. The staff consultation committee is made up of staff representatives and provides a forum for staff to discuss issues that concern them and be consulted about changes to working practices. The hospice had its independent guardian service to which staff can raise concerns confidentially.

While we were carrying out the inspection we received several whistleblowing concerns that there was still a bullying culture among staff at the hospice. The whistleblowers felt that they would be bullied if they raised concerns about how they were treated by other staff. The whistleblowers were concerned that the measures introduced to address issues of bullying had not been effective and it remained an issue for them. They were concerned that if they raised issues with the management of the hospice they would not be supported or the issues they raised would not be addressed. The registered manager confirmed that while they had made progress on addressing these issues further work needed to be done to improve the culture among staff within the hospice.

People, their relatives and external professionals were positive about the care provided and the management of the hospice. People and relatives told us that a consultant will always come at short notice to explain care to both patients and relatives. One person said, "It makes it so much easier with every member of staff contributing." A relative confirmed that, "Happiness is seen as a major part of care, this comes from the top management ` It makes it all so much easier when everyone from top to bottom is contributing." Another person told us "It's a good team here. The staff give everything to their job."

The hospice had a clear management structure and senior staff were clear about their roles and responsibilities. The mission and core values of the hospice provided staff with a clear direction of expected behaviours and conduct. These were reinforced throughout the induction, ongoing training programme and the support given to staff. Staff in all parts of the organisation understood their lines of responsibility and accountability for decisions about the management and direction of the hospice. The chair of the board of

trustees worked with the interim chief executive to address all governance matters as required. The hospice had an interim chief executive until the substantive post holder starts in November 2016. The chair of the Board of Trustees told us that they were committed to improving and spreading the service to more people while maintaining the quality of the service.

The interim chief executive and senior management team (SMT) meet monthly with managers to exchange operational information and updates, review governance matters and brief the management team on meeting strategic objectives. The hospice had a strategic plan which identified objectives to be achieved from 2015 to 2018 in a way that would extend and improve the quality of the services provided within the hospice. Staff, people and relatives had been consulted about how the service could continuously improve. One person said, "The management is fantastic, they go above and beyond what is needed."

The provider had systems in place to monitor, evaluate and improve the care people received. People's views were sought regularly for each of the services that the hospice provided. Where these surveys showed that there was a need for improvement action plans were put in place and monitored by the clinical governance team, acting chief executive and the board of trustees. The provider had just conducted several patient and carer surveys as part of service development, and when concerns were raised these had been shared with board members and managers to make improvements to care. People confirmed that they were asked about the quality of the service and had made comments about this. They felt the service took their views into account in order to improve service delivery.

There were a number of mechanisms for the hospice to receive feedback about the quality of the service provided to people. The hospice received continuous feedback from people and relatives by St Joseph's Hospice service user group. The Hospice were commissioned to lead on this survey by Tower Hamlets and City and Hackney CCG. This was a group that allow them to share views of the quality of the service with staff. The hospice also received ongoing feedback from comment cards located around the hospice that were completed by people and relatives. For people who preferred to give electronic feedback the hospice's website provided details of how to feedback to the Director of Care and Clinical Governance Lead. We saw evidence that where necessary the provider responded to feedback and took action to improve the service.

The hospice had an extensive and robust auditing program that was carried out at regular intervals throughout the year. In addition to the hospice own audits there were audits carried out by the clinical commissioning groups (CCG's) that commissioned services from the hospice, and Hospice UK. Hospice UK is the national charity for hospice care, it aims to ensure that everyone with a life limiting or terminal condition gets the very best care. Examples of these audits were audits of, safeguarding, care planning, pressure area care, infection control and falls. Minutes of clinical governance meetings for various services and areas of work in the hospice showed that these audits were reviewed and where necessary improvements made to the service so that people continued to receive safe care.

The pharmacy team conducted regular audits and reported the results to the medicines safety improvement group and the drugs and pharmacy group. These included medicines storage, controlled drugs, high risk medicines. An audit schedule was in place and all audits seen resulted in follow up actions or audits where areas for improvement were identified. All medicines policies were in date and regularly reviewed.

Incidents and accidents were recorded and were reviewed by the registered manager. The took action to make sure that any risks identified were addressed. The provider's procedure to deal with incidents and accidents was available for staff to refer to when necessary, and records showed this had been followed for all incidents and accidents recorded.

The hospice worked with other organisations so that they maintained up-to-date practice and provided quality care to people. Staff provided advice and consultation to other providers of palliative care and end of life care. The St Joseph's hospice was a hub for hosting national and local events that addressed death and dying, for example 'Dying Matters Awareness Week'. Commissioners and other professionals told us that they considered the hospice and its staff to be local leaders to provide the expertise, advice, information and resources for patients, carers and professionals relating to palliative care.

The hospice team had strong links with the local communities from where the hospice got volunteers. Volunteers were involved in a wide range of activities both within the hospice, fund raising and in organising events in the community. For examples volunteers worked in the hospices hub serving hot drinks and food, supporting reception, engaging with people in the community, at the day hospice and on the wards.

The hospice plays a key role in the development and advancement of palliative care and end of life care both locally and nationally. A number of the hospice's staff had carried out research projects on issues relating to palliative care and end of life care. These covered areas such as the use of Schwartz rounds to increase compassion among staff, the extent to which volunteering in the hospice supported community engagement, end of life care for younger adults and advanced cancer care equality strategy. The hospice had research governance and ethics committees to look at proposals for research and determine possible sources of funding. The registered manager showed us details of recent research which the staff at the hospice had been successful in getting external funding to complete and which had been successfully published.