Weston Hospicecare Limited

Weston Hospicecare

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 14 December 2016 and was announced. We gave the registered manager 48 hours' notice of the inspection because we wanted key people to be available for the inspection team.

Weston Hospicecare has a 10 bedded hospice ward, a day hospice service and a well-being centre providing complementary therapies. It provides support for people over the age of 18 who have life limiting illnesses such as cancer, heart failure, lung disease and degenerative neurological illnesses. When our inspection took place the hospice ward was only able to accommodate up to seven or eight people at a time because of the available medical cover. There were five people being supported by the hospice at the time of our visit.

The hospice staff team included doctors, nurses, nursing auxiliaries (NA's), occupational and complementary therapists. The family support team consisted of the chaplain, a bereavement counsellor and a team of trained volunteers. The community nurse specialists were attached to specific GP surgeries and provided support and advice to people living in their own homes or care homes. The various services provided by the hospice worked in conjunction with people's own GP, community district nurses, and other health and social care professionals.

There was a registered manager in post. 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.

We found that some improvements were required with the management of medicines although there was no breach in the regulation. The improvements were in respect of people's individual medicine records, storage of medicines and some of the checking systems that were in place. The service were advised of the need to make improvements in this area during the inspection and assured us that action would be taken.

All staff including the volunteers received safeguarding adults training as part of their mandatory training programme. Ward staff and the community nurse specialists also received safeguarding children training. This was because they may be supporting or looking younger people who have children. This meant they would be able to recognise if people and children they came into contact with were being harmed and would know what to do to report those concerns.

The nurses and NA's were trained how to use moving and handling equipment safely. Safe management plans were written to ensure people were moved correctly and not harmed. Any other risks to people's health and welfare were identified during the assessment of care needs and were then well managed. Safe recruitment procedures were followed to ensure that only suitable staff were employed.

The numbers of staff on duty in the hospice ward was calculated according to the number of people being

supported and the level of complexity of their care and support needs. At the time of the inspection the service did not have sufficient medical cover to look after 10 people at the same therefore the maximum number of people was limited to seven or eight. The hospice had recognised the need to adhere to this limit to ensure safe staffing levels.

The hospice had a programme of mandatory training for staff to ensure they had the knowledge and skills to carry out their roles. The volunteers who gave their time to the hospice also had to attend some of these training sessions. New staff had an induction training programme at the start of their employment. The measures the hospice had in place ensured all staff had the required skills and qualities to provide a compassionate and caring service to people and their families.

On admission to the hospice ward people's capacity to make decisions was assessed. Where possible people were supported to make their own choices and decisions. The name of the staff member completing the assessment appeared on the electronic record when inputting data. Staff received training regarding the principles of the Mental Capacity Act (2005) and ensured consent was given prior to providing any care and support.

People in the hospice ward and those attending the day hospice were provided with a well-balanced and nutritious diet. Alternatives were always available in order to meet people's specific needs. Staff worked in partnership with healthcare professionals and families to be supportive and provide an effective service.

The staff developed close working relationships with the people they looked after and their families. People and their families said the staff were kind and caring and looked after with compassion and sensitivity. The hospice received overwhelmingly positive feedback from families and examples are written in the main body of the report. The hospice service not only cared for the people they looked after but also looked after the staff. Staff were emotionally well supported by their colleagues and the managers.

People were provided with person-centred care and support because their individual needs were assessed. They were involved in having a say how they wanted to be looked after. Their care and support needs were regularly reviewed. People and their families were encouraged to have a say about the service and to make suggestions about how things could be done differently.

The service was well led. There was a team of experienced managers and senior staff, all committed to providing a high quality service that was safe, effective, caring and met people's needs. The was a programme of checks in place to drive forward any service improvements needed.

Feedback from people in the hospice ward and used the day hospice service was gathered and used to measure how people felt about the care and support they received. All feedback was also used to make changes to the service and make improvements. The service worked in partnership with other hospice care providers in order to share good practice with other care providers and improve medical and nursing standards of care for people who were at the end of their lives or living with a life limiting condition.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management of medicines had areas of shortfalls which could potentially lead to errors being made. These shortfalls were in respect of documentation, checking processes and storage of medicines.

All staff received safeguarding adults and children training and protected the people from harm. Any risks to people's health and welfare were well managed. Recruitment procedures for new employees were safe and ensured only suitable staff were employed.

Sufficient staff were employed to meet the maximum number of people they could look after. The hospice were recruiting additional medical staff to increase this number. Staffing levels in the hospice ward depended upon the number of people and their care and support needs.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were well trained, well supported to do their jobs and had the right qualities and skills to provide compassionate care and support.

Staff understood the importance of obtaining consent from people before helping them. They were aware of the principles of the Mental Capacity Act (2005).

People were provided with food and drink that met their own individual requirements. They were supported to eat and drink where needed.

The service worked collaboratively with other health care services.

Is the service caring?

Good

The service was caring.

People were well looked after and treated with respect, kindness and dignity. The staff team were passionate about their jobs and committed to provide a kind and loving service.

People and their families were provided with a very caring and supportive service, at a difficult time in their lives.

The service looked after its staff and provided them with emotional support and guidance.

Is the service responsive?

Good

The service was responsive.

People and their families received the care and support that met their specific needs. The care and support was adjusted as and when required in response to people's changing needs.

People were listened too and staff were all committed to supporting them if they had any concerns or were unhappy.

Is the service well-led?

Good

The service was well-led.

Feedback about the service was consistently positive. The service was well organised, well managed and people were looked after to a high quality standard.

The service worked in conjunction with other hospice services and Hospice UK to influence and improve best practice in palliative and end of life care.

Feedback from people and families and outcomes from reviews of the service were used to drive forward any improvements. People were listened to and all staff, including volunteers, were involved and consulted by the management team.

Weston Hospicecare

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.

The inspection was announced and was undertaken by two inspectors, a specialist advisor and an expert by experience. The specialist advisor was a nurse who had experience in working in a hospice care environment. An expert by experience is a person who has had a family who has used this type of service in the past. The previous inspection of Weston Hospicecare was in February 2014. There were no breaches of the legal requirements at that time.

Prior to the inspection we looked at the information we had about the service. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. The Provider Information Record (PIR) was shared with the inspection team during the inspection. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they planned to make.

We received feedback from five health or social care professionals prior to our inspection. We had asked them to tell us about their views of the service. Their comments have been included in the body of the report.

During our inspection we spoke with two of the five people who were staying in the in-patient unit and five relatives. We spoke with 19 members of staff including qualified nurses, health care assistants, heads of departments. We also spoke with the registered manager and the chief executive officer.

We looked at care records and the newly introduced electronic care records for five people, five staff employment records, training records, policies and procedures, audits, quality assurance reports and minutes of meetings. During our inspection, we looked at the systems in place for managing medicines; spoke to six members of staff involved with prescribing and giving people their medicines and looked at five people's medicines charts.

Requires Improvement

Is the service safe?

Our findings

Both the people who were staying in the hospice and their relatives told us the service was safe. They felt the hospice was a safe environment and they were looked after in a safe and caring manner. People said, "I feel very safe here, staff know what they are doing", "I see the same staff regularly, I can talk to them about anything" and "I know I am safe. I thought I was stronger than I am and tried to get out of bed during the night. I fell but the staff were wonderful, they did everything right. I know to call them now and they come immediately". Relatives said, "I feel at ease now I know my loved one is here", "We are feeling relaxed and relieved now that (named person) is here", "I have every faith in the staff and their ability to care for my loved one" and "My loved one wanted to come here because they knew they would be safe and well cared for and I agree".

Those people who attended the day hospice were also of the same view that the service was safe. One person said the minute they walked through the doors they did not have to worry about a thing, "I have never been so well looked after in my life".

The management of medicines required some minor improvements. The improvements would ensure medicines were stored at the correct temperature, medicine charts contained all the necessary information and there was an external checking system in place to identify these shortfalls. These findings were discussed with the registered manager and chief executive at the end of the inspection .

People were able to self-administer their medicines if they wished to and staff had assessed they were able to do so safely. Suitable systems were in place for obtaining medicines. People brought their own medicines in with them and these were used if appropriate. Staff ordered stock medicines from a wholesale supplier and other medicines from the local hospital pharmacy. The hospice had access to the hospital's out of hours service but staff used a local pharmacy if needed. This meant people could be confident their medicines would be available for them.

An 'external' pharmacist did not visit the hospice to review the prescriptions or advise about the management of medicines. However, staff told us that if they needed advice about medicines they were always able to contact the hospital pharmacy or a local community pharmacist.

The doctors checked the medicines people were taking on admission to the hospice, to make sure they continued to receive the correct medicines. Their regime was recorded in their electronic care records. This helped to ensure people received their medicines correctly.

People's medicines were written on specifically designed prescription and administration charts. Staff recorded medicines administered or used a code to record the reason why a medicine was not given. Staff were able to administer discretionary medicines that had been agreed with the doctor. This meant staff were able to respond to people's symptoms quickly. Records showed that people received their medicines as prescribed.

Some people were prescribed a number of medicines to be given 'when required' but the medicine chart did not have space for the doctor to record the date of prescribing. This did not follow the hospice's medicine policy, which stated that all prescriptions must be clearly dated.

Prescriptions for medicines to be given by subcutaneous infusion via a syringe driver (a needle placed beneath the skin usually in a person's arm) were given over 24 hours however this was not stated on the chart. This could increase the risk of mistakes because the medicine could be delivered by the wrong route. Staff recorded, and made regular checks of the syringe driver to make sure they were running correctly.

Nursing auxiliaries (NA's) supported the qualified nurses by checking some of the medicines they gave in order to reduce the risk of mistakes and enable people to receive their medicines quickly. The NA's had received specific 'second checkers' training for this role and were confident.

Medicines were stored safely within a secure treatment room. All medicines were regularly checked to ensure they were in date and suitable for use. However, we saw one box of injectable medicine which had expired and was not suitable for use. This was discussed with the nurses and the registered manager during the inspection and the medicines were destroyed.

A medicines refrigerator was available. Staff monitored the temperature daily. However the maximum temperature had been recorded as exceeding the recommended range for the previous two weeks and no action had been taken to check the refrigerator was working correctly. This was discussed with the nurses and the registered manager during the inspection who assured us this would be rectified immediately.

Controlled drugs, which need additional security because of their potential for abuse, were stored securely. Suitable records were in place for these medicines to show they were looked after safely. The hospice had an accountable officer who would investigate and report any incidents involving controlled drugs. Quarterly occurrence reports were made to the local controlled drugs intelligence network.

There was a process in place for dealing with any medicines alerts. Staff carried out audits to check the quality of their practice. Systems were in place to identify any medicines errors and action taken to reduce the risk of similar mistakes occurring again.

The service had both a safeguarding adults and child protection policy and these had been reviewed in March/April 2015. The policies contained clear reporting protocols to ensure any concerns were raised appropriately. Although the hospice did not provide services to children, child visitors could be present in the hospice or in the homes visited by the community nurse specialists. All staff received safeguarding training covering both adults and children as part of the mandatory and refresher training programme. One of the community nurse specialists had taken the lead role in safeguarding and told us they would contact the local authority 'duty desk' for advice. They had completed level two safeguarding adults training.

All staff we spoke with knew what action to take if abuse was suspected, witnessed or alleged. They said they would report any concerns they had to the registered manager or the nurses but were aware they could report directly to the local authority, the Police or the Care Quality Commission.

Safe recruitment procedures were followed at all times and these ensured unsuitable staff could not be employed. Appropriate pre-employment checks had been completed and this included written references from previous employers and an enhanced disclosure and barring service (DBS) check. A DBS check allowed employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. Checks were also made with the Nursing and Midwifery Council (NMC) to ensure

nurses were registered correctly and with the General Medical Council (GMC) regarding the medical staff.

All staff received moving and handling training as part of their mandatory training programme. This meant those people who needed assistance from the staff to move and transfer from one place to another were not harmed by being moved incorrectly. Care plans were written which detailed the level of support each person needed and stated the equipment to be used and the number of staff required.

As part of the care planning process those people in the hospice ward a range of risk screening assessments were completed and regularly reviewed throughout their stay. The staff completed a manual handling risk assessment, used a nutritional screening tool to identify any risks of malnutrition and assessed the risks of pressure damage to skin. People were also assessed regarding the likelihood of falls.

The service ensured the maintenance of the building and all equipment was monitored and kept up to date. There was a programme of daily, weekly, monthly and quarterly checks and actions to complete in respect of fire safety and water safety. Maintenance personnel had to complete weekly maintenance checklists and these ensured that all checks were completed and any remedial works were reported so that action could be taken. Service contracts were in place for all equipment and managed by the maintenance team. The fire safety risk assessment had been updated in December 2016. Full health and safety audits were completed regularly. In the last audit some action points had been identified and the appropriate remedies had been taken.

The services business disaster plan was kept under review. The plan set out what would happen if there was an untoward incident that affected service provision at the hospice. The plan covered fire, flood, failure of the IT system and utility services and contained a set of emergency contact telephone numbers.

The registered manager told us that staff turnover was low and generally they did not have staff vacancies. At the time of out inspection there were sufficient nursing staff employed by the service however there was a vacancy for medical staff (consultant in palliative care). The hospice ward team consisted of the doctors, the lead nurse and a team of qualified nurses, nursing auxiliaries (NA's) and volunteers. The care team were supported by catering staff, housekeeping staff and all the other staff involved in the running of the hospice. Staffing levels on the ward were adjusted as necessary in order to meet each person's care and support needs. Because of the current shortfalls in the medical cover (the unfilled consultant post), the number of people who could be looked after on the hospice ward at any one time was limited to seven or eight.

The day hospice service was provided three days a week for up to 12 people a day. Staffing levels were arranged dependent on the number of people attending on any given day. The day hospice lead, one qualified nurse and an NA plus volunteers was the general number of staff on duty.

Good

Is the service effective?

Our findings

People in the hospice ward told us they were asked what they would like help with, and the staff checked with them before they carried out any intervention. They said they were treated with dignity, and their privacy and modesty were maintained. Staff suggested to any visitors who were present they might like to go to the relative's room and make themselves a drink while they provided care to their loved one.

One health care professional who contacted us said Weston Hospicecare was well regarded locally and provided a vital community service to people with life–limiting illnesses as well as cancers. They said the hospice staff worked in an integrated way with GP services, the community nursing teams and other community service providers (including the voluntary sector).

All staff had a programme of mandatory training they had to complete at the start of their employment and then on a refresher basis (some yearly, some three yearly). The training administrator told us there was a different training programme for different staff. Computer based training programmes followed by a knowledge based check were used to deliver some training. Other training was delivered by DVD or taught sessions. The administrator was able to keep an eye on who needed refresher training in order to ensure all staff remained up to date. All staff we spoke with confirmed their training was up to date. We were told the day after our inspection an outside speaker was visiting the service to talk to staff about people who were living with dementia as well as their life limiting illness.

Newly recruited staff had an induction training programme to complete at the start of their employment. All nursing auxiliaries (NA's) were registered for the care certificate training. The Care Certificate was introduced in April 2015 as the new minimum standard for induction for those commencing a career in health and social care. The programme consisted of 15 modules to be completed. A member of staff who worked in the hospice ward supported the NA's as they worked through the modules. We were told that even those NA's who had worked at the hospice for many years were enrolled on this training. New members of staff were initially supernumerary to the staff team and shadowed an experienced member of staff. Those staff we spoke with said their induction training programme had prepared them to do their job well.

Weston Hospicecare was not a training centre however did provide training to the nurses and care staff who worked in local care and nursing homes. Examples of training that had been provided included syringe driver training. The registered manager told us they had recently been involved in a new initiative and had delivered training to the North Somerset Community Partnership and Homeless charities regarding palliative care and end of life care for people who did not have a home.

All staff were supported to do their jobs effectively by means of regular individual supervision, group supervisions, staff meetings, de-briefing sessions and spiritual support from the chaplain. Nurses told us they worked alongside the nursing auxiliaries and were always on-hand to offer advice and support.

As part of the overall assessment of each person's needs there was no formal assessment of their ability to

make decisions for themselves. However the hospice doctor explained the person and their next of kin was always involved in making decisions and 'best interest decisions'. The electronic care records had an area where the reason for admission was documented along with a note regarding the person's mental capacity and any advance care planning threads. During the inspection we discussed with the registered manager and others, how a paper copy of the assessment could be scanned in to the electronic care records.

Staff had received face to face training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They understood the principles of the MCA and DoLS and the implications for their day to day practice. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty of people who lacked the capacity to consent to the treatment or care they needed.

During our inspection we found no evidence to suggest that people were unwilling to be there or that families were unhappy or concerned about the care provided. Staff knew the importance of gaining consent before they provided any care, support and treatment and we heard people being offered choice and informed about things that were going to happen. We found that the service was aware of the principles of the MCA and would apply for the authorisation of a DoLS where required.

People in the hospice ward and the day hospice were provided with sufficient food and drink and those we spoke with praised the quality of the meals. Where people had a poor appetite they were encouraged to ask for a 'wish diet'. All meals were home-made and kitchen staff were informed of any food allergies. There was a four week menu plan but alternatives were always available. Comments we received about food included, "The food is excellent. Each day we have a choice", "My loved one can no longer manage to eat independently and the staff are sensitive when they support them with their meal", "Food is brilliant you can have as much or as little as you like". Families told us they were offered meals and drinks throughout the day and night and we heard one relative being asked, "Are you eating with us tonight (name)".

Hospice staff told us they did not use food and fluid charts as a rule to record how much people had eaten and drunk. They did not feel this was necessary unless the person was receiving subcutaneous or intravenous fluids (called an IV drip). Staff were however able to tell us about the nutritional and fluid intake for those people on the ward.

Medical cover for the hospice was at the time of the inspection compromised because of the vacant post of consultant in palliative care medicine. Medical cover was provided by one full-time and one part-time specialist doctor and one GP, with an interest in palliative care. Out of hours on-call support was provided to the hospice ward but also to community district nursing services and GPs and care homes. The hospice ward did not admit people out of hours. Following feedback from people and their families the provision of the community nurse specialist team had commenced a quality improvement project to assess the benefits of working six days a week. The hospice had made this improvement because people reported they became increasingly anxious towards the weekend when no-one was around to offer advice and guidance.

Good

Is the service caring?

Our findings

People and their families were overwhelmingly positive about the care and support provided by the hospice. Comments we received included, "Staff are wonderful, they are angels, they cannot do enough for me, I just ask, it is done", "Even at night time I just press my buzzer and they are there", "I could not ask for better care, I can be repositioned at any time, day or night, I get full care morning and night, it is absolutely wonderful and it feels so good, it is truly compassionate care" and "The staff just knew when the end was near and they respectively withdrew in to the background and left us to be with mum. That was so special". One person who was attending the day hospice said, "The volunteers are fantastic. We are all in the same boat and I have made new friends".

Relatives said, "Staff are wonderful, both to my loved one and me. We have been shown such compassion and care, all the staff are exceptional, in all areas. During a recent difficult time, the doctor stayed with us late at night until they had the test results they needed to be sure of treatment", "They really understand how I am feeling too. They are lovely, they explain everything and do not make you feel silly" and "Staff are more than capable, they just know what to do, my loved one is getting all the care they need, they are fantastic, their caring and empathy is amazing".

One family had recently (beginning of December 2016) written on the 'I want great care' website the following about the hospice (Jackson Barstow House – JBH), "Reluctantly we were unable to cope at home any longer and our loved one was admitted to the JBH. We very quickly saw it was the right decision. JBH is a lovely environment. A peaceful place with all the facilities and dedicated staff with expertise to provide highest standard of care. The kindness, compassion and support given to all the family was so needed and wonderful. We want to thank the staff and express our gratitude for all the care provided at this most difficult time. Forever grateful". Another had written, "Everyone was: Compassionate. Kind. Knowledgeable. Caring. Helpful. Fantastic. Friendly. Kindhearted. Lovely. Trustworthy. Wonderful. Nothing could be improved".

One of the health care professionals who told us about their experience of the service, said their patients received a "very caring service" and this was extended to the family members too. They added that the community specialist nurses looked at "the wider picture", not just from the illness point of view and truly cared. A GP described the service as "very responsive when we need to call on them". Other health care professionals told us, "The care provided is holistic" and "Our patients and their families tell us the service is very caring and the staff are excellent".

The staff talked about how they had supported people to achieve things they had on their 'bucket list'. One person had requested a visit to the seafront therefore staff had arranged a private ambulance to take them there. Visits from pets were allowed and whist we were in the hospice ward, two family dogs visited with a family member. The family told us the visit had been beneficial to the person and provided a period of happiness. The hospice were able to accommodate relatives who wanted to stay with their loved one, in their final days and there was an overwhelming view from families that they were cared for by the hospice staff, as well as their loved one.

All staff we spoke with were passionate about their jobs and committed to provide the best possible care and support to people. The staff were all supportive of each other and had good working relationships. They supported each other through the sensitive and emotional parts of the job. In addition the chaplain and counsellor provided de-briefing sessions to support the staff team emotionally and spiritually. All staff spoke about the people they were supporting in a kind and respectful manner. Those interactions we saw during the inspection between people and staff (including volunteers) were loving and kind. We observed and then overheard a member of staff discussing matters with family members and this was done in a sensitive and kind manner. All said they would recommend the service to others.

The hospice had a family support team made up of a qualified counsellor, a companion coordinator, a chaplain and a small team of trained volunteers. The chaplaincy team offered spiritual and emotional care to people and their families who were staying on the ward or using the day hospice service. They could also visit people in their own homes who were known to the hospice staff, for example supported by a community nurse specialist. The support they offered may be listening to people's concerns, helping with prayer, or assisting with preparations for 'the next step'. They had links with the local faith community and were able to make arrangements to bring services in as needed by people.

The hospice had a chapel and people and their families were able to use this to light a candle, to pray or just as somewhere to go for peace and quiet. The chapel had recently been used for the wedding of a young person who wanted to marry his long term girlfriend. The chapel was registered as a wedding venue, the day hospice was used for the reception and the catering team supplied the wedding breakfast. Hospice staff then supported the person and the family to go to the pub to finish off the celebrations. Hospice staff had worked with others to arrange the wedding quickly to support the person's wishes and they had died several days later having achieved this.

In the chapel there was a tree of hope and families were able to hang a card from the tree with a message to their loved one. The previous week a special 'Light up a Life' remembrance service had been held in a local church, the registered manager told us this had been attended by about 400 people. In the chapel there was also a book of remembrance, listing those people the hospice had looked after and a book of celebration.

Families the hospice supported were offered pre-bereavement and post- bereavement support. Post-bereavement support was not time limited and families were supported for as long as was needed. The bereavement counsellor told us when the hospice looked after younger people with children they may talk with the children, with or without their parents and will liaise with the school where agreed. When a parent had died, the hospice would signpost the surviving parent to specialist children counselling services when this was needed. A coffee morning for bereaved relatives was held each month at the hospice, in the well-being centre (where the complementary therapies were provided). This service however was not confined to those families who had used the hospice service.

The hospice also arranged 'Buddy' friendship groups which met on a monthly basis for up to 12 bereaved people. These were initially hosted at the hospice but the group were then encouraged to meet up away from the hospice. This meant the hospice were then able to set up another buddy group for other bereaved people. This evidences the caring approach of the service towards the families of people who had used the hospice.

The companion service was offered to people who needed someone impartial to talk to about what was happening to them. The hospice put companions in touch with people so they could decide together how and when the person wanted to meet up. Companions were volunteers from all walks of life who could provide a link with the outside world, make a difference to the person's and also report back any concerns

to the hospice staff. Companions were matched with the person to make sure they had similar interests. Companions visited people in the hospice, in their own homes (which could include care homes).

The hospice staff used a booklet called planning ahead, advanced care planning, to assist people to record their wishes about their future care. The booklet had been prepared in conjunction with another hospice and the local clinical commissioning group. This helped people think about identifying someone to make decisions on their behalf when this was necessary, a 'list for living', and any advanced decisions they wanted to make (for example refusal of treatments of interventions).

Good

Is the service responsive?

Our findings

Both patients and their families told us they have the opportunity to speak to any member of staff, including the manager, chaplaincy and bereavement services. They said they were consulted over their care and treatment, and were able to make requests for things they would like to do. People were supported to make a wish list if they wanted.

Visitors were welcomed at all times and this included children. The hospice had a special 'child friendly room' called Pepsi's, where children could spend their time whilst visiting and could speak with a member of staff if this was indicated. One person had asked to see the Christmas Tree in the reception area but was not safe to be moved therefore staff took photographs of the tree and showed them to the person. The person appeared to be happy with this compromise. Both the staff on the ward and the chef told us that special requests for meals were treated positively and special meals were cooked to order.

People who attended the day hospice were very positive about the facilities offered. They could choose to participate or not in the activities arranged. Some people attended to give a family member a break and just wanted peace and quiet. Sessions offered included, arts and crafts, Qi Gong (a type of tai chi), a well-being group, hand and feet massage for example. There are also quiet times. People attended the day hospice for 12 to 16 weeks. There were then opportunities for them to attend booked appointments in the well-being centre for further complementary therapies. People were asked to complete a questionnaire after the first session and again after the last. Those people were spoke with told us all their comments were positive, and they did not have any suggestions for improving the service.

Referrals for admission to the hospice ward were made by the hospital staff, the community nurse specialists or GP's. Referrals to the day hospice service were from their community nurse specialists, or their GP. For the day hospice there was a criteria for referral. The person had to be resident in the area and registered with a GP. The person had to agree to the referral, have a diagnosis of a life-limiting illness and be experiencing specific problems relating to the illness. At the start of the service the person and their family would be informed of the fixed date the service would stop. The service had introduced this in response to difficulties experienced in the past where people had been unaware the service was for a fixed time.

People's care and support needs were fully assessed by the doctors and the nurses on admission to the hospice ward. Their details were recorded on the 'cross-care' electronic care records system. Those we looked at were personalised and detailed and provided evidence of the person's likes, dislikes and preferences. For one person we noted there was record about their family structure, their concerns about their partner not coping and their wish to have a snuggly blanket on their bed. For one other person specific information was recorded in their care plan about their about their dietary wishes. Family members were encouraged to bring in specific food items which the catering team then cooked for them. It was evident that people's needs and family wishes very respected and the staff were responsive to people as individuals.

At the beginning of each new shift the nurses and nursing auxiliaries received a handover report. This meant

they were informed about the person's specific care needs at that point in time. People were always involved in making any decisions about the way they were looked after and told about the care and treatment options were open to them. People were given the opportunity to have a say if they wanted things done differently or of they needed additional help in any way.

For those people who were being looked after in the hospice ward their care plans were kept under continual review. Plans could change on a daily basis if their needs changed. The electronic care records meant that any records previously made by the community nurse specialists and the day hospice staff were accessible to the ward staff. The team leader for the day hospice told us they completed a record of each visit the person made to the day hospice, any discussions that had taken place and decisions reached.

The weekly multi-disciplinary team (MDT) meeting was held on the day of our inspection with representatives of all clinical departments of the hospice. External professionals were included in these meetings were relevant and one attended the week we were there. New referrals and any deaths that had occurred were presented to the meeting. The deaths were discussed and there was clear evidence that great emphasis was placed upon the person's preferred place of care and was respected by the hospice staff. New referrals summarised the deteriorating condition of the person and there was consideration and anticipation of family members' anxieties. There was evidence of referrals from the local hospitals and we were reassured that GP involvement was present in the community to support end of life care in people's own homes. Professionals opinions were respected and the outcomes of decisions considered were recorded in the electronic care records, accessible by all hospice disciplines.

People, and their families, were asked to share their views or make comments during their stay on the ward, whilst attending the day hospice or via their community nurse specialist. The registered manager told us feedback was taken seriously and enabled the service to be responsive to their views and opinions. It also enabled the service to make changes based upon how people felt and the service they said they wanted. Examples of where changes had been made included the use of normal, non hospital bed linen and the replacement of white crockery and meal trays. Those bedrooms we did see had coloured soft furnishings, crocheted blankets and bright accessories. In keeping with Weston super Mare's seaside location, the trays and crockery chosen by 'people's voice' depicted beach and seaside scenes.

People and their families told us they knew what to do if they needed to raise a concern. We did not receive any information of concern during our visit to the hospice ward and the day hospice. People were very complimentary about the service, the staff and the way they were looked after. Details regarding the complaints procedure was included in information given to people who stayed on the hospice ward and used the day hospice and those we spoke with confirmed they had received this. The registered manager told us there had been two formal complaints logged in the last year. Both had been logged and responded to in accordance with their complaints procedure. Any issues that were raised in a complaint was used as an opportunity to review practice and to shape the service in the future. It was evident that any learning from complaints was seen as a tool for driving improvements with the staff teams using reflective practice to identify where things could have been done differently.

Good

Is the service well-led?

Our findings

Feedback we received from people and their families about the hospice services supported the opinion that the service was well led and focused completely on meeting peoples' needs well, helping them to live well for as long as possible as well as provide good end of life care services.

The vision of the hospice was to provide every person living within Weston super Mare and the surrounding areas who had a life limiting illness, with the best possible quality of life. Their mission was to provide a high quality specialised palliative care service. They aimed to attend to people's physical, emotional and spiritual needs to enhance their quality of life. They aimed to enable people to die in their preferred place of care, with dignity, and to support families and carers during and after their illness.

It was evident from speaking to people and their families that the hospice achieved this for them. Those staff and volunteers we spoke with shared this vision. Health and social care professionals who emailed us and told us about their experience of the hospice service told us, "Any messages I leave for the specialist nurse is responded to. There is a real 'Can-do' attitude and she always takes time to sort things out", "The service is well organised and when I have needed to admit a patient to the ward this happens smoothly" and "Excellent. The staff are so committed".

The registered manager (director of patient services), was supported by the chief executive officer and a senior management team in delivering a well led service. Following an internal review of the day hospice at the end of 2015 the service had identified the need to have a clinical lead. An occupational therapist had been appointed in July 2016. They provided leadership for the day hospice team, provided therapy input and attended the MDT's and clinical governance meetings.

An 'I Want Great Care' survey was used by the hospice to gather feedback from people and their families who used any of the different hospice services. They were asked if they had been treated with respect and dignity, involved in decisions made about them, whether they were provided with enough information about treatment options and whether they were satisfied with the support they received. They used this to demonstrate that the service was open and focused on the person's experience. The outcome of the last survey was that people/families were extremely likely or likely to recommend the services to family and friends and they 'totally agreed' they had received great care. Feedback was collated and action plans devised where trends were identified, in order to change practice where possible.

To ensure the continued provision of a consistently high quality service, the provider completed an annual clinical audit and produced a quality improvement plan. This meant they were able to monitor the quality of care provided in a systematic way and then create a framework to identify where improvements were needed. Examples of improvements that had already been made as a result of this audit was a more responsive community nurse specialist team, better record keeping, improved team working and improved symptomatic pain control for people in the hospice ward. The action points and plans were discussed at each quarterly clinical governance meeting.

The meeting notes from the previous two clinical governance meetings in October and July 2016 were shared with the inspection team. There was a standard agenda for each of the different services (the community specialist nurse team, day hospice, the ward, family support and complementary therapy services). Examples of the agenda included risk management, incidents and significant events, education, complaints and any other feedback received.

Quarterly performance reports were produced to monitor how the service was doing. Statistics were collated in respect of the number of new admissions to the hospice ward, new referrals to the community nurse specialist teams, bed closure days (due to shortage of medical cover), numbers of people receiving day hospice services and advice line telephone calls received from health and social care professionals. This meant the senior management team were able to keep an eye on whether the service was achieving their objectives.

As a result of this analysis and because of requests from Hospice UK, the service had used the opportunity to review day hospice provision. Instead of providing traditional day hospice services three times a week this was now provided on two days. The third day was now used for drop-in sessions to discuss fatigue, anxiety and breathlessness, or for expressive movement and dance therapy or gentle exercise classes with a complementary therapist, a doctor, community nurse specialist, or an allied health care professional. At the time of our inspection, these arrangements had been in place for four weeks. The aim of this type of service provision was to support people with long term life-limiting conditions to live well for longer and in their own homes.

A number of hospice staff had been allocated lead roles in specific areas. These included safeguarding adults and children, training, the management of medicines, infection control and health and safety. One of the community nurse specialists told us they were the lead nurse for a particular health condition and would provide advice and guidance to their colleagues. Where appropriate staff had received additional training to equip them for their lead role.

The service had a programme of audits to complete to monitor the quality and safety of the service. Audits were completed in respect of infection prevention and control, medicines management, information governance including care documentation, the prevalence of pressure ulcers and pain management for example. The registered manager told us a result of shortfalls identified in infection control audits the kitchen area in the hospice ward had recently been revamped. Following an audit in respect of pain management, the ward staff had introduced a new pain assessment tool which had resulted in improved assessment and documentation of pain. This meant nurses were able to administer better pain management medicines. The service had a number of quality improvement projects in place, were monitoring the outcome of these projects as well as having set audit dates for reviews.

The service kept records of any accidents, incidents and near misses and the follow up action taken. The registered manager and other senior managers were kept fully informed of these events and chased up outcomes if follow up action was not recorded. The prevalence of such events were analysed in order to identify any trends so that further occurrences could be prevented or reduced.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the service and which the service is required by law to tell us about. This meant we were able to monitor how the service managed these events and would be able to take any action where necessary.

The service linked with other local hospice services and both the chief executive officer and the director of

patient services (the registered manager) attended group meetings with their counter-parts in those services. Other hospice staff also attended meetings with other hospices as part of a collaborative approach in hospice care. The aims of these meetings were to share knowledge and good practice, to trial new initiatives and provide peer support. The service was a member of the national Hospice UK association and staff attend conferences and regular meetings with the South West branch. Members of the Weston Hospicecare team attend regular North Somerset and Somerset clinical commissioning group 'end of life' meetings and were a valued source of information in respect of end of life and palliative care.

Weston Hospicecare was one of eight national pathfinder sites chosen by the National Council for Palliative Care and Public Health England to pioneer a public health approach to end of life care. This had involved adopting a community charter with the clinical commissioning groups, the local community partnership and the local authority. The service has engaged with workplaces, people who work in schools, the multi-cultural friendship association and village agents. The hospice had set up an implementation group and amongst other things been able to train and support others and establish supportive networks for individuals.