

St. Rocco's Hospice

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Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

St Rocco's Hospice provides in-patient hospice care, a hospice at home service and a day hospice from one site. The hospice holds clinics, has a family support service, therapy services, a fundraising department and a team of volunteers all based on-site.

The service is a registered charity with a board of trustees. Day to day the service is run by a management team drawn from all departments within the hospice.

There was a registered manager employed for this service. 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. The registered manager was experienced in providing palliative care and had worked at the hospice for a number of years.

People and their families spoke highly of the complementary therapies that were available to both people who used the service and relatives. The hospice provided family support, counselling and bereavement support and had recently appointed a non-denominational chaplain to strengthen their team.

People told us that staff were caring, compassionate and listened to them. People we spoke with who received personal care felt the staff were knowledgeable, skilled and their care and support met their needs.

People's health care needs were met by the in-house medical team. This included consultants, GP's with a special interest in palliative care, an occupational therapy team and a physiotherapy team. We saw the service was developing staff by developing the specialist nurse role and supporting nursing staff to undertake a non-medical prescribing course.

Care plans were personalised to include people's wishes and views. People and relatives told us they were consulted about their care and treatment and that they regularly had the opportunity to speak to medical and nursing staff. Care plans were regularly reviewed in a multi-disciplinary framework. We observed staff caring for patients in a way that respected their individual choices and beliefs.

Staff recruitment processes were followed with the appropriate checks being carried out. There were sufficient staff on duty to meet people's needs although had experienced some shortness of staff recently although this had not impacted detrimentally on the people using the service. The hospice had a bank of staff who they could contact if they needed additional staff. The registered manager told us they were working on a project to look at the skill mix of staff. Staff and volunteers received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care and support.

Staff followed risk assessments and guidance in management plans when providing care and support for people in order to maintain people's safety.

People were protected by the service's approach to safeguarding and whistle blowing. People who used the service told us that they were safe, could raise concerns if they needed to and were listened to by staff. Staff were aware of safeguarding procedures, could describe what they would do if they thought somebody was being mistreated and were aware of who to report safeguarding concerns to.

Staff gave us mixed views about how they felt supported. We explored this with the senior management team who were aware of staff feelings and showed us how they were communicating and engaging with staff over issues they had raised. Staff did tell us they felt optimistic about the outcomes of these issues.

Staff worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff.

People were supported to receive a nutritious diet at the service. Their appetite was assessed through talking to them which led to staff being able to give the person the type and amount of food they would be able to eat. There was a choice of menu on the day we inspected and drinks and snacks were available at any time. The service also provided a café for people, families and staff to enjoy a drink or snack.

The staff undertook the management of medicines safely and in line with people's care plans. The service had health and safety related procedures, including systems for reporting and recording accidents and incidents. The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering the person's care and their environment.

The registered provider had a system in place for responding to people's concerns and complaints.

There were effective systems in place to monitor and improve the quality of the service provided. The service was going through a period of transition with new staff members at senior levels, a project looking at the development of non-qualified staff and new service developments such as the SystemOne electronic care planning system which was just being implemented.

Accidents and incidents were clearly recorded. There was an embedded culture of learning from mistakes and to share action plans for improvement work within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Checks of the building and equipment were completed to make sure it was safe.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. This meant there were systems in place to protect people from the risk of harm and abuse.

On the day of our visit we saw staffing numbers and skills mix were sufficient to provide a good level of care to keep people safe. Robust recruitment procedures were in place to make sure staff were suitable to work with vulnerable adults.

Medicines were safely stored and managed.

Good ●

Is the service effective?

The service was effective.

People's healthcare needs were carefully monitored and discussed with people who used the service and their family members.

Staff told us they had appropriate supervision.

Staff of all levels had access to on-going training to meet the individual and diverse needs of the people they supported. Staff were trained to provide the specialist care people required.

People were assessed to identify risks associated with poor nutrition and hydration and spoke highly about the quality and choice of food

Good ●

Is the service caring?

The service was caring.

People told us that staff were kind and compassionate at all times and treated everyone with dignity and respect.

Good ●

The service provided emotional support to people, their family and friends via a team of dedicated counsellors, nurses and healthcare staff on an on-going basis.

People were supported spiritually. People were encouraged and supported to make decisions about their care and given time to make their own choices; this included their end of life care

Is the service responsive?

Good ●

The service was responsive.

People told us they felt confident to express any concerns or complaints about the service they received.

People and their families were fully involved in assessing their needs and planning how their care should be given.

Staff delivered people's care in a person-centred way, treating them as individuals and encouraging them to make choices about their daily lives.

Is the service well-led?

Good ●

The service was well led.

The management team gave effective leadership and provided a clear strategy for the long term development of the service.

There were clear management structures and lines of accountability. Staff told us the service was well managed, that they were treated with respect and were actively involved in decision-making.

Systems were in place to monitor the quality of the service provided to ensure the service was run in the best interest of people.

Staff did raise some concerns over feeling listened to and we saw that the management team had pro-actively addressed this with the whole staff team.

St Rocco'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.

The registered provider was given 48 hours' notice because we did not wish to impact on the day to day running of the service and wanted to enable nursing staff to be available to speak with us.

The inspection was carried out by one Adult Social Care inspector, one CQC Pharmacy Inspector, a Specialist Advisor in end of life care and an Expert by Experience. The Expert by Experience had experience of caring for someone at the end of their life.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We used this information to inform our inspection.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

At the time of our inspection visit there were five people who used the in-patient service and there were people using the day hospice on a sessional basis.

During the visits we spoke with 14 staff and volunteers, this included the registered manager, a consultant in palliative medicine, senior speciality doctor, human resources officer, two nurse educators, the chef, a family support counsellor, nurses, health care assistants and volunteers.

During the inspection we reviewed a range of records. This included people's electronic care records which

included care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the hospice and a variety of policies and procedures developed and implemented by the registered provider.

Is the service safe?

Our findings

People and their relatives told us they felt safe in the hospice. One patient said that they felt very safe as, "There is always someone in the day room". Another person told us that often several staff members came into their room, to attend to them and clean their room. They said they felt confident that there were always sufficient staff.

Staff displayed a good knowledge of safeguarding adults and children including how to report any concerns they had. Staff knew about various types of abuse and potential warning signs to look out for. Staff said if they had any concerns they would report them straightaway to the safeguarding lead who was also the registered manager.

Staff were aware of the registered provider's whistle blowing procedure. We saw easily accessible information regarding the identified safeguarding lead contact details in the nursing office.

The staff files we looked at showed us that the registered provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. The human resources officer who supported the recruitment process explained the additional measures the service took to check the identity of applicants and their right to practice in terms of current professional registration status for nurses and doctors. This meant staff employed by the service had been checked to see if they were safe to work with people in need of hospice services. People who volunteered within the hospice service were also subject to checks to confirm their identity and that they were safe to work with people.

Through our observations and discussions with people and staff members, we found there were enough staff with the right experience and skills to meet the needs of the people who used the service. We reviewed duty rotas and spoke with the staff team about staffing levels and shift patterns. All of the staff we spoke with during the inspection told us they thought there was sufficient staff on duty that day to meet people's needs. Staff we spoke with said that staffing had improved recently particularly the evening shift; there were now four members of staff on duty each evening. Staff had raised concerns at a recent meeting which was called by the inpatient unit staff to address several concerns they had. All staff we spoke with told us everyone worked well together as a team to pull together to ensure the service was staffed appropriately. We discussed the concerns raised by staff at the recent inpatient meeting with the registered manager and they shared the notes and actions taken by the service in response to the concerns raised. This showed the service listened and responded to issues raised by the staff team.

The service had a good level of medical cover and we spoke with a palliative care consultant who worked with the hospice. There was clear medical cover with regular consultant sessions for the inpatient unit with

structured ward rounds. The inpatient staff knew which doctor was on duty and when, ensuring clinical advice was readily available if needed. We saw there was medical cover each weekday and a shortened ward round on a weekend although there was of hours on call available for nursing staff to utilise. The consultant told us, "The hospice doctors all know where to get support and advice from their senior cover if they need advice on patient care." This showed the service planned and delivered safe medical care for people.

We saw that any calls made out of hours by staff whether a maintenance, care or staffing issue were logged and reviewed by the senior management team. This meant that issues were reviewed and advice and actions given by the on-call lead were recorded so patterns could be identified.

Risks to people's safety were appropriately assessed, managed and reviewed. Risks identified were in a specific coloured folder which contains completed risk assessment paper documents kept in the patient's room ensuring all staff caring for patients were aware of identified individual risks. Records showed that risks were updated and reviewed regularly. People's care plans included risk assessments for swallowing problems, skin and pressure area care, falls, moving and handling, mobility and nutrition and risks specific to their conditions. This helped to make sure that people received the support they needed to live the lives they wanted and to stay safe.

We looked at the way medicines were prescribed, administered and recorded and found that medicines were managed safely. We spoke with the hospice consultant, senior doctor, registered manager, a staff nurse and three patients. One patient told us that their care was, "First class". The patients were all happy to tell us that their medicines were administered on time and in the correct dosage. One patient told us, "I have been involved in the discussions around changing my medications since being admitted."

There were good, detailed policies covering all aspects of the management of medicines, including controlled drugs (medicines subject to tighter controls because they are liable to misuse). Patients were protected from harm because staff were following these policies. Medicines were stored securely and at the right temperature. The room where medicines were kept was clean and tidy.

We watched nurses administer medicines to two patients and saw this was done in a caring and safe way. We looked at four patients' medicine charts and saw that doctors wrote prescriptions clearly and nurses completed administration records. This helped to ensure that the patient received the right medicine in the right way. Medicines were supplied by the local hospital and a specialist pharmacist visited weekly to provide a clinical service.

Controlled drugs (CDs) were handled safely. We checked a sample of four controlled drugs and found no discrepancies between the stock balance and records in the CD register. The registered manager was the hospice's controlled drugs accountable officer. The accountable officer has a legal responsibility to ensure that controlled drugs are properly managed. They attended local intelligence network (LIN) meetings and reported incidents involving controlled drugs in the required way. The LIN is the local forum where different organisations share information to minimise the risk of drug misuse.

Doctors followed national guidelines when prescribing medicines to relieve patients' symptoms. Patients were involved in the choice of treatment and well-informed; for example about the law on driving when taking certain medicines. Doctors discussed best prescribing practise and issues involving medicines at their regular business meetings.

Staff were encouraged to report medicine errors, including those that did not affect patients, so that lessons

could be learned. We saw examples of practice being changed as a result of such incidents to make the use of medicines safer. The Senior Speciality doctor organised audits to check that prescribing was as safe as possible; for example, there had been a recent audit of medicines reconciliation. Medicines reconciliation is the process of ensuring patients continue to receive all the medicines (at the right doses) they were taking before admission, when appropriate. Medicine incidents and audit reports were discussed at meetings of the senior staff responsible for quality and safety at the hospice.

We met with the maintenance staff who oversaw the health and safety checks undertaken at the service. We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the fire alarm, fire extinguishers, nurse call system, emergency lighting and gas and electrical safety. Tests of the fire alarm were completed on a regular basis to make sure it was in safe working order. We saw records that showed water temperatures were taken regularly. We saw that all water temperatures were within safe limits.

We saw that each patient had a personal emergency evacuation plan (PEEP) and we saw that staff on reception had an update sheet which as well as containing important information about patients also had the PEEP status of each person in the event of an emergency. This information was updated daily by the night staff and meant that up-to-date information was held for the emergency services.

We saw that checks in relation to moving and handling equipment under Lifting Operations and Lifting Equipment Regulations (LOLER) had been carried out and people and staff were also protected by a plan to monitor infection control risks. This showed the service had procedures to keep people safe.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. We saw any adverse event was reviewed through the use of colour coded forms for accidents and incidents by the registered manager and escalated through the service's clinical governance processes if risks were identified.

Is the service effective?

Our findings

The hospice employed a range of staff. This included doctors, nurses, healthcare assistants, a team of people who provided family support and counselling, physiotherapy and occupational therapy professionals and complimentary therapists to help to ensure people's holistic needs were met.

All the patients we spoke with felt confident regarding staff competence and knowledge. One patient told us they felt sure that, "Anyone could step into another person's job." Patients and visitors we spoke with said they felt that the staff were able to use all the equipment confidently and skilfully. One patient told us the staff were all, "Majestic at their job" and that although each had a specific role, they "Work as a good team and will do each other's job if necessary".

Staff and volunteers we spoke with told us about the support received to carry out their role. We saw records of group discussions and clinical supervision. Staff told us they regularly spent time with other staff and management during handovers, at the beginning and end of a shift and whenever else needed to talk and provide support to each other. We saw that staff were offered the opportunity to have a one to one clinical supervision session although the uptake from this had not been comprehensive. The registered manager told us; "I wrote to all nurses and healthcare assistants to offer supervision sessions and some staff took it up but not many." We saw records to confirm staff received an annual appraisal which included a review of performance and progress within a 12 month period.

Staff told us they received the training they required to care for people effectively. We spoke with one newly recruited staff member in the day hospice. They told us they had an induction period and e-learning consisting of 19 modules to complete. On commencement of the role they were allowed to spend two weeks just getting to know patients and staff. After several weeks as part of their induction and support, they provided their line manager with a resume of their role as they viewed it. They told us they had been told in their induction training that, "What the patient wants, the patient gets."

Volunteers we met with were clear about their roles. One volunteer told us their role was, "To look after visitors, make tea for people, keep things clean and tidy, check the fridge for out of date food as visitors are allowed to keep food in there for their relatives." They told us their training consisted of a seminar, followed by three separate week's refresher courses regarding hospice policies and procedures.

The hospice had its own practice development centre that not only provided training to staff and volunteers working with the hospice but also provided training to other healthcare professionals. In conversation with the two Clinical Nurse Specialist (CNS) Educators they explained that they had a split role of part educator and part clinical work. They explained that it was a new role which was a developing and evolving. Initially one CNS managed the mandatory training programme and now both CNS were recruited they told us they were focusing on the inpatient staff particularly in developing the healthcare assistant's role. The aim of the CNS educators was also to share knowledge with the community and other healthcare practitioners which would ultimately benefit the delivery of patient care.

We saw that online learning had been implemented for mandatory training skills but some key sessions such as moving and handling, safeguarding, administering medicines and dementia was delivered via face to face sessions. Themes for education for 2016 included bespoke leadership courses, and face to face safeguarding training for all staff and volunteers. External training available had included specific training in palliative care for local nursing homes and G.P.s. This showed the service was keen to work with other stakeholders to improve the knowledge of palliative care in the local area. Other specific induction events were also planned and delivered and we saw that all staff and volunteers received role specific induction that included an introduction into the hospice and service, moving and handling, food hygiene and nutrition, fire and health and safety procedures as well as palliative care, and communication in challenging situations. This showed staff and volunteers received training to understand the role they were to perform in a safe and effective way.

The staff spoken to demonstrated a sound knowledge base in specialist palliative care in-keeping with roles and responsibilities and the service specification. Senior clinical leads were qualified to academic degree level in palliative care and all staff spoken to were well supported with personal and professional development via in-house or externally sourced education.

Nurses were organised regarding revalidation and there was a system in place to support individual staff with a designated confirmer to sign off evidence within the process of revalidation.

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. At the time of our visit, there had been no applications to place a restriction on a person's liberty. We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated a good awareness of the code of practice and confirmed they had received training in these areas. Procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

We saw evidence that mental capacity assessments were conducted and recorded and also evidenced in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. Mental Capacity Act assessment forms were available in paper format and were used to evidence assessment of capacity and decisions taken in patients' best interests.

The patient records reviewed included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. In all cases the decisions were dated and approved by a lead clinician or G.P [when DNACPR was initiated in the community] and on all of these there was a clearly documented reason for the decision recorded on the form with clinical information included. All DNACPR forms included a review having taken place on admission to the hospice.

Discussions about DNACPR with patients and relatives were recorded in sufficient detail within the patient's record. Individual care records indicated that attention was paid to making sure that people were supported to give consent and make decisions about their care and treatment if their conditions changed or deteriorated. We saw that people's treatment wishes were documented in their records. It was clearly recorded what people's end of life preferences and preferred place of care were and these decisions had been reviewed.

Staff we spoke with understood the importance of seeking consent before providing any care or support. Staff confirmed they would respect people's right to refuse. Two patients we spoke with were able to tell us that staff always asked for consent before giving care or treatment. One relative told us, "They even asked [my relative] when they were unconscious; they carried on as though they could hear and that was very professional."

Patients had consent forms in their individual plan of care which clearly listed agreed and signed consent to care and treatment. Consent was also clearly recorded in the patients' electronic notes following any discussion regarding care for example with doctors or nurses. We observed staff getting consent from patients to support and care for the patient.

We were told by all people we spoke with that the food was very good, and that they could ask for anything they want. We observed a patient being asked by a staff member if they were still happy with the choice that they had made for lunch, i.e. pea soup and yogurt, and the patient asked if it was possible to have rice pudding instead. The staff member said in a caring tone of voice, "If you want rice pudding I will get you some." One relative told us their partner had spent some time at the hospice before passing away and that anything they both wanted they could have, and that they had been a chef and thought the food was excellent.

Everyone we spoke with had access to water, and told us that they could have a drink when they wanted, and one patient told us they had a tot of whisky before bed. This showed that people's individual choice was respected.

Food and nutritional needs were met with individualised care and evidence of care planning involving multi-disciplinary team members was evident from care plans we viewed. We met with the catering manager for the service. They told us how after receiving a nutritional assessment carried out by the nursing staff that they also went and spoke with people about what they would like to eat. We saw that all food was freshly prepared and the service worked to ensure that food was fortified with extra calories where possible. We saw the service tried different ways to ensure people were supported to have access to whatever nutritional support they needed.

We saw people's food and fluid intakes were recorded on the electronic record system but staff were aware not to make a huge issue regarding weight loss which often was of concern to family members but which may be actually be part of the end of life process.

The service provided different dining areas for patients, staff and visitors at the hospice which included a comfortable café dining area for people and families and a three course meal for people attending the day hospice services. They had also ensured that special celebrations were supported and had facilitated special celebrations upon request. This showed the service provided caring support to meet the nutritional needs of everyone using the hospice; patients, visitors and carers.

We looked at communication systems within the hospice to ensure the care of people was effective. The

registered manager told us the service was working on improving communication across the hospice as part of their on-going development work. The service had also put out a weekly bulletin that every staff member and volunteer received via email and which gave updates on things happening across the hospice.

There were weekly multi-disciplinary team (MDT) meetings held where a full review of the person's care was undertaken. These meetings helped ensure that people's care was individual and person centred. We saw that the community McMillan nurse team were based at the hospice and district nurses working in the community also attended these meetings as well as the heads of department from within the hospice. This meant that the hospice staff were able to support people both in the community and via the inpatient unit to ensure their needs were met and reviewed with a range of healthcare professionals. We attended the daily morning hand over where the doctors were updated on the patient's current condition by the inpatient unit sister. This report was person centred and included discussion regarding family support needs, and we saw this report time gave the consultant the opportunity to clarify best practice in a specific area.

We listened to the handover from the morning staff to the afternoon/ evening staff. We saw how the nurse in charge firstly established when each staff member was last on duty to ensure all staff were completely up to date with patient care and treatment. The handover was very detailed on all aspects of patient care, physical symptom management, psychological/ emotional / social and spiritual care, any changes to medication regime were discussed and consent and patient and family's understanding was talked through. The nurse in charge also shared information and education regarding the wider aspects of a patient's particular condition. This showed that systems were in place to ensure that patient care was seamless and staff were as up-to-date as possible about people's current condition.

We attended part of the daily ward round where we observed the consultant on duty have a very sensitive conversation with a patient and relative to introduce the individualised end of life care plan; the consultant was outstanding in the way they engaged the patient and family to gently and sensitively deliver this information at such an emotional time.

The hospice was re-developing its day service to provide a more sessional type service so people could have more choice to attend sessions they felt benefitted them. The day programme running three days a week at the hospice gave people a care plan to enable them to participate in a variety of therapeutic activities with qualified staff such as a physiotherapist, nurses and other trained therapists. Sessions include complementary therapies such as massage as well as sessions such as craft, hydrotherapy and exercise. Staff members were also encouraged to access complementary therapies and yoga and there were four staff pamper nights per year where staff members could access sessions.

The environment has been well thought out and designed and was light and airy with good access to communal areas and the garden. The registered manager told us they had added further communal space such as the lounge and dining area in the in-patient unit to promote patient choice and to enable people to mix with other people using the hospice facility. The service also ensured visitors were well catered for and had facilitated a fridge stocked with sandwiches and snacks so people could get some refreshment whilst spending time with patients.

Is the service caring?

Our findings

People gave us only positive feedback about the care they received from the hospice. A patient's relative spoke extremely highly of the staff and experience of care, "We cannot thank all the staff enough, they are wonderful and we feel very supported." People using the hospice expressed to us how much they valued what the service did for them. One person shared with us how it had really made a difference to how they felt both physically and emotionally and told us, "I feel thoroughly pampered".

We were told by patients and visitors that there was no member of staff who did not treat them with kindness and consideration. One patient said, "Staff are friendly and positive, without being too much," and that, "They obviously get on well with each other, they help each other."

People said staff were attentive to their needs and supported their choices. One patient told us that the staff, "Are very considerate" and two relatives told us that they felt very supported and staff talked to them and kept them informed, "Anything you want to know they tell you before they do anything".

A family group of relatives told us that their relative had become suddenly very poorly, very quickly but that, "It is absolutely superb, how everyone is treated." The family had been involved in the care plan, talked to about pain relief and also asked if they wanted a chaplain. They said they felt very supported and had been told about support for them at their relative at the end of their life and beyond.

We saw that the way care was organised focused on the individual and their stories, views and life choices. This information promoted a holistic and person centred approach as staff had the information to support people in a way that met their wishes, beliefs and preferences. Records showed that staff worked with people supporting and giving them information so they were empowered to make their own decisions about their care and treatment. One relative told us that when their partner became very poorly they were told, "In a really lovely way" and that hospice facilitated a wedding ceremony, "With flowers, red carpet, candelabras, a buffet and everything" by the next day.

People were treated with dignity and respect by staff who listened to them. Staff gave us examples of how they provided care in a dignified and respectful way. This included telling people what they were doing, keeping people covered up as much as possible. One staff member said, "We always ask if people are happy for us doing anything with or for them." We were given an example of how staff were also conscious of preserving the dignity of the patient, one patient told us they were supported to use the jacuzzi facility and staff left the room whilst they changed, ensuring their dignity whilst being close by if they were needed. Staff all spoke about person centred care being a priority and individual care was centred on the patient's wishes and choices. Evidence of people being left undisturbed whilst sleeping and care managed around the patients agenda was evident.

The service recognised the significance of family throughout people's involvement with the hospice services. People's family members and friends were able to visit at any time. In addition facilities were available for relatives to stay overnight. Support for family members was available such as being able to access

complementary therapies. We saw people had been able to discuss with staff their spiritual and cultural beliefs and how they wanted these to be met and respected. One patient told us they had counselling which they found, "Very valuable". There was a voluntary chaplaincy service to offer pastoral and spiritual support whatever a person's individual beliefs. The service had just recruited a chaplain and the registered manager told us, "This is a really important role to the hospice." Volunteers and staff from the family support service offered counselling and a support bereavement service that could remain in contact with relatives for as long as they felt it was useful to them.

We saw in care planning records that advanced care planning assessment and end of life care plans were done with people. This allowed people to be clear about their expectations regarding their end of life care and their wishes at this important time. This helped to ensure that people's final wishes could be met. Records indicated that people's wishes were treated with the same respect in death as in life.

The hospice held events within the community to help families and friends remember their loved ones and to help alleviate a family's pain. These included the 'Light up a Life' and annual remembrance ceremonies to offer families the opportunity to come together to reflect upon their loss. There was a non-denominational chapel that contained memory books and we were told that staff and former staff attended the remembrance events to support families to share their memories of their loved ones in the memory books.

We found the hospice environment to be calm and informal and the unit was open to relatives and visitors to visit and stay day and night if they needed to. Places were available for people to use as they wished including for prayer or reflection, café, the reception area, the gardens and a quiet family room for care and privacy after death. A volunteer told us they had known the hospice for a number of years and they were seeing improvements all the time, one of which was the relative's room. This room was very light and airy, has three dining tables with chairs, some soft lounge chairs and a kitchen area which appeared to be fully equipped. Within this kitchen area there was information for both the volunteers and the relatives and a large sign inviting families to use the kitchen, if there was no volunteer on duty e.g. night-time. We could see, and relatives told us, that staff, "are angels" and invested their own time in helping people live full lives, make their own choices, and be part of the local community. We found staff and management to be passionate about and dedicated to their work.

Is the service responsive?

Our findings

People and family members did not have raise any concerns about their care. Staff told us people were given information about the complaints procedure when they first came into the hospice. Information about how to complain was also contained in the information file located in each person's room. All patients we spoke with were aware of how they would complain if necessary although none had anything but praise for the staff. People talked about [name], the registered manager being very caring and compassionate. One patient told us they would tell their relatives and if they felt there was a problem they would speak to the (nursing) sister. We also saw each person using the hospice services received an information pack about the range of services and facilities available such as family support, complementary therapies, physiotherapy and bereavement support amongst others. We saw examples of a well organised hospice within the relative's room, the volunteers had a handover book and a daily sheet was issued with the special requirements of each patient re: drinks, type of vessel they require etc., a sheet identifying the role of the volunteer, and information which may be useful for visitors. We also saw a folder in pristine condition on a table on the ward labelled "Helping you feel at home", and this gave a fully comprehensive set of information regarding being in the hospice.

People told us they could express their views and were involved in making decisions about all aspects of their care. They told us they felt listened to.

All the patients we spoke with told us they were involved in planning their care, and that they were spoken with at a level they could understand. One relative told us that although they were not the next of kin, staff had checked with the patient as to whether they could keep them informed, and once gained this permission they happily keep the relative up to date. This showed the service ensured confidentiality was maintained and that people's consent to share information was sought.

The implementation of the electronic care planning record SystemOne was in progress. SystemOne is a clinical tool to enable one patient, one record model of healthcare. Using SystemOne, clinicians can access a single source of information, detailing a patient's contact with the NHS, so it was currently compatible with the patients hospital and G.P records. Staff told us there was ongoing training at each phase and staff we spoke to were comfortable and confident in its use, fully aware of what stage of implementation they were at and felt supported by the hospice's training programme.

We saw that during the initial assessment process that relevant information was gathered from people and their families. This was so that staff could get to know as much as possible about the person, their needs, preferences and lives and what care and support they would require. There was close working with other professionals to make sure the hospice staff were prepared and able to meet that person's needs.

We saw care plans were individualised to the patient and in line with the five priorities of care, on SystemOne and on the paper documentation. The five priorities of care is a national approach to caring for people in the last few days and hours of life, that focuses on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care wherever that may be. The daily record of care (on

SystemOne) was clear, up to date and gave an accurate account of what was happening to the patient, what the patient and relatives understood and a clear plan of the patient's care. We saw good quality contemporaneous recording ensuring safe, accurate up to date information on the patient's care was available.

Risk assessments and individualised end of life care plans were held in specific patient's folders in the patient's room, the risk assessment documentation was reviewed daily or when needed, and completed and signed by the nursing team.

One patient told us of an example of staff responding to their needs. They told us they had an upset tummy and staff had put a commode into the ensuite bathroom for them to use, this would enable them to take a stool sample, with no inconvenience to the patient. The patient said this meant they weren't inconvenienced in any way.

We saw a specific care plan for caring for people in the last days of life. The 'individual plan of care and support for patients at end of life' document was personalised in a sensitive way with information for relatives about what happens to their loved one at the end of life. We witnessed this care plan being introduced to a patient and their partner by a consultant and it was undertaken in a very clear and extremely sensitive and compassionate manner. We also reviewed one care plan of a recently deceased patient and found after death documentation was clear and precise.

We saw people's cultural and religious needs were captured on SystemOne and one of the nurses we spoke with described the need to explore spirituality further with the person capturing what was most important to them. All staff we spoke with knew how to contact support from community religious or faith leaders as well as how to seek interpreting services if required.

The staff team discussed discharge planning when it was time for the person to go home. This included a discussion on what support the family would need when the person returned home, equipment issues, and liaising with other agencies such as the local authority, the hospice at home service and McMillan nurse teams.

Activities were provided in both the day hospice and inpatient ward. Activities were tailored to the needs of the individuals, and the activity lead told us that nursing staff also joined in with these. Although some people told us they enjoyed craft work, which could later be a keepsake for those at home, or used to raise funds and the patient felt that they were "giving something back", was popular, We also found some patients were not interested as they don't really want to move from the lounge area, often due to their illness, so staff and volunteers may read to individuals or play dominoes or bingo. This was confirmed by one patient who told us they go to the day hospice "to help those at home, give them a rest from worrying about me" and "it gets me out of the house, and I meet people". They also told us that she goes to the therapy unit for reflexology, and, "You can have massages and things".

We attended a weekly multi-disciplinary team meetings were held where a full review of the person's care was undertaken. These involved medics, nurses, therapists, the hospice at home service and community McMillan nurse team. The meeting discussion included a short case history on each individual and explored issues such as treatment options and a discussion about meeting people's holistic needs such as checking all therapy options had been explored as well other individual issues such as spiritual needs. This meeting ensured anyone either receiving inpatient or community support was reviewed by a multi-disciplinary team in a responsive manner. These meetings helped ensure that people's care was individual and person centred.

The hospice at home team of nurses and healthcare assistants were based at the hospice site and work on a short term intervention approach of supporting people at home or to enable them to get home from another place such as a hospital. The team received referrals from district nurses or other healthcare professionals and worked closely with district nurses and G.Ps to support people in their own homes.

The service had a family support team led by social workers. This was available if a person needed practical support or advice such as legal advice and wills. They could make referrals to the local authority social work teams if necessary. The family support service told us about other services available which included bereavement support that provided support to families after death. They told us how counselling was available to people who used the service and their relatives. This meant that families were supported by the hospice and its service right through the journey of supporting someone with a life limiting illness and through the grieving process by trained and professional staff.

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

St Rocco's hospice had a number of different ways in which it assessed and monitored the quality of service it delivered. We looked at performance reports, audits, the organisation's quality accounts, risk management/governance systems and questionnaires carried out by people, families and staff.

Feedback collected from relatives was very positive and this had been recorded by the service. The themes running through the letters, cards and general feedback given to the hospice included the dedication of staff, and the competence of staff and the compassion and sensitivity shown to people and their families. Our observations supported that staff across all areas within the service were motivated and committed to the continuous development of a high quality service to people and their families within and outside the hospice in the community. All staff we spoke to demonstrated a positive culture and they were all enthusiastic to work at the hospice.

People using the service, their relatives and staff said that the immediate in-patient managers were approachable and supportive and they could speak to them whenever they wanted to. Patients could be involved in a user involvement group, which we saw had met regularly throughout 2016. We saw the group had discussed a "post it" quick and easy feedback system which had been used successfully in the day hospice and was going to be implemented in the inpatient unit. This showed the hospice looked as ways it could support feedback from people using its service.

There was a clear management and governance structure at the hospice. The staff we spoke with were aware of the roles of the management team and told us they were approachable and we saw they had a regular presence within the hospice. There was a sense in speaking with senior clinical staff that they had autonomy in practice with structure and support to allow that to happen in a safe way. We met with the registered manager and Chief Executive for the hospice. They explained the documents provided to us by the hospice showed how trends and themes of concern were monitored and acted upon by the clinical governance group, sub groups and senior management team.

In conversations with the inpatient staff we found that there was some inconsistency of responses to staff feeling supported and valued by the management team, some staff did, some didn't. Some staff felt very supported, valued, listened to and had opportunities to develop, some didn't. Some staff felt some members of the management team were more approachable than others to discuss their concerns. The staff explained that the inpatient unit had recently experienced a very busy time with complex patients which had led to the staff calling an emergency meeting with the management team.

There was a level of uncertainty amongst the staff since having the emergency meeting and the follow up meetings to discuss their concerns and formulate a plan. The staff were reassured by the response from the management team to hold these meetings. Some staff felt it was a time of 'starting afresh' and 'wait and see'

if things improve. Other staff felt that the staffing had improved and that there was now a programme in progress to develop the learning opportunities for the healthcare assistants which was an issue raised.

We discussed this feedback and the outcome of the emergency meeting with the management team at the hospice. They were open and aware of the issues and showed us their action plan to the concerns raised by the staff team and measures they were taking to address recruitment and a communication plan with clear actions and outcomes and an evaluation. This showed the service was responsive to concerns and that it listened and acted upon staff concerns.

All staff we spoke with were committed to providing a high quality service for the patients they cared for. This mixture of feelings has not in any way negatively impacted on the high level of patient care at the hospice. One nurse told us they had worked in the inpatient unit prior to working in the day hospice and that the atmosphere "is wonderful, that is why I do it."

The hospice had a robust risk management approach. The system was found to be comprehensive allowing staff in each area areas to report clinical and non-clinical incidents. Accidents and incidents were reviewed and graded. A report was then produced with recommendations and an action plan drawn up. This was then passed down to areas for implementing a "lessons learnt" approach.

We saw the service was positively planning toward change which included having a clear one year and five year strategy to explore issues such as the increasing the presence and awareness of the hospice in the local community and ensuring the service was at the forefront clinical delivery, access to services, involvement and education in end of life care.

Regular team meetings were held where staff were kept up to date with developments and could have discussions about the running of the service. We saw minutes of the meetings where staff had discussed their roles, recruitment and health and safety. Using a benchmarking survey toolkit from Hospice UK, a whole scale survey of staff across the clinical and non-clinical areas of the hospice service had been undertaken in June and July 2016. The hospice then undertook a, "You said, we did" response to the survey showing the hospice had actioned feedback from the staff team with clear measures. For example, feedback was around improving IT access. The service responded by making laptops available for non-office based staff, staff were enabled to log on remotely and staff could book ad-hoc training with the IT department. These messages were shared through a weekly news bulletin and this showed the service was willing to listen and respond to staff feedback.

We saw the service as part of their contractual arrangements supplied the Clinical Commissioning Group (CCG) with a quarterly Service Quality Performance Report in which they gave information regarding their achievement against Performance Indicators and Local Quality Requirements set by the CCG. There were also sections to report on incidents; safeguarding compliance and patient experience feedback (patients provided excellent feedback in relation to the level of care and their experience via various methods). This showed us the service had reviewed its own performance.

We saw the service was keen to engage with its local community. There was a community project called "rocON!" facilitated by the hospice that worked with schools and young people about death and dying. Young people had visited the day hospice and met with patients, joined in sessions and used equipment. We were told that RocON! had a marked impact on the psychological and emotional care of patients, as well aiming to improve access to care and enabled the hospice to engage with more potential service users.

Another scheme called Rocco's On Your Doorstep had established a volunteers befriending service where

volunteers were matched to people and meant that people living in the community were supported to have a chat with a befriender, be accompanied to appointments and volunteers could do errands or go shopping for the person. This meant people who may be lonely were supported for as long as they needed by a regular "friend".