

## St. Gemma's Hospice

# St Gemma's Hospice - Leeds

### Inspection report

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Date of inspection visit:

13 July 2016

19 July 2016

Date of publication:

03 October 2016

### Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

# Summary of findings

## Overall summary

We inspected St Gemmas Hospice on 13 July 2016 and then returned on 19 July 2016 to provide feedback to the registered provider. The first day was unannounced which meant that the staff and registered provider did not know we would be visiting. The second day was made by appointment. At the last inspection in November 2013 the service was meeting the regulations we looked at.

St Gemma's Hospice (in patient unit) provides specialist palliative and end of life care to a maximum number of 32 people. The service also supports around 200 people in the community. At the time of our inspection visit there were 26 people who used the in patient service.

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

People told us there were enough staff to meet their needs and keep them safe. Staff had the extensive knowledge, information and support to ensure people were kept safe from abuse. Staff told us they would report any concerns to the nurse in charge or the registered manager. There was a 'no blame' culture with staff encouraged to report any clinical incidents or accidents. These were fully investigated and used as a learning tool to drive improvements in the delivery of care and safeguard people from harm.

Staff understood people's individual needs and the support they and their family members required. Staff were passionate about their roles and placed people at the heart of their work. We saw that care was provided with the utmost kindness, respect and compassion. People who used the service and relatives spoke very highly about the care and service they received. People said their right to privacy was fully protected within the hospice. Families of people told us the end of life care their relatives had received was excellent. People had their wishes documented in their care plans and there was clear evidence that these wishes had been carried out. One member of staff told us, "One gentleman wanted to die in Scotland this was in his care plan. We had to make so many calls to find somewhere who could continue his care, but we did it. A nurse flew up to Scotland with him to ensure he was settled in the hospice and we were proud to know he got his last wish." The hospice provided excellent family support, counselling and bereavement support within and outside the hospice.

Meals were produced specifically for each individual to their own taste. People could have meals when they wished and could request anything they wanted to eat. People's cultural and religious needs were taken into account when preparing any meals. Staff told us meals were so important to people that they tailored them to what people wanted. Comments included: "The menus are extensive and there are no set meal times, you eat when you want to." "The food is superb, you can have whatever you choose and at whatever time you feel like eating." Nutritional assessments were undertaken to identify risks associated with eating and drinking. Referrals were made to the appropriate professionals.

People received care from a multi-disciplinary staff team who were qualified to a high standard and supported and trained to meet their individual needs. There was a very proactive approach to the personal development of staff and the acquiring of new skills and qualifications. A system of competency based assessments ensured staff could demonstrate the required knowledge and skills to meet people's needs effectively. Staff received supervision and support.

A well-established pharmacy team provided good clinical services to ensure people's medicines were managed safely. The team regularly attended clinical meetings to discuss people's individual pain management requirements and ensure good clinical practice was followed. One relative told us, "They really understand non-verbal cues about pain; they saw when he wasn't quite right even when we didn't notice. They'd change his medication until they were sure he was comfortable."

There was a holistic approach to people's care with the physical, psychological, social and spiritual needs of each person given equal importance, together with the needs of those closest to them. Staff respected people's cultural and spiritual needs and people told us they received the religious and spiritual support they wanted and needed from a multi-faith chaplaincy team.

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

Checks of the building and equipment were completed to make sure it was safe. The service had a comprehensive maintenance file which included any outstanding actions and completion dates throughout.

There were very few complaints and concerns raised. The provider had a positive and open approach to using complaints and concerns to improve the quality of the service. Each complaint was assessed to establish the lessons learned and where necessary, appropriate action taken to improve the service provision for everyone using the services at the hospice.

The management structure showed clear lines of responsibility and authority for decision making and leadership in the operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards.

Staff worked closely and in partnership with external health and social care professionals and other national organisations to improve the service within the hospice and health provision in the local community and nationally.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

People were kept safe as there were sufficient staff to meet people's assessed needs.

Staff managed people's medicines safely and effectively, and were particularly concerned with ensuring effective pain relief was managed.

Staff knew how to keep people safe from abuse. They could identify the signs of abuse and knew what procedures to follow if they thought someone was being abused.

Good 

### Is the service effective?

The service was extremely effective.

Staff were highly skilled in their roles and knew the individual needs of the people they supported very well.

People and their families told us how the food was tailored to their needs, and could eat and drink at any time throughout the day or night.

The registered manager and all staff understood the principles of the Mental Capacity Act (MCA) 2005 and how to apply these in practice. This was evident from the mental capacity assessments carried out in the hospice.

Outstanding 

### Is the service caring?

The service was very caring.

People and their families told us the care they received was excellent. They praised staff and told us they were always treated with the upmost respect and dignity at all times.

People and their families told us about staff who always went the extra mile in supporting their loved ones with their end of life wishes.

Outstanding 

People's views around end of life care was clearly recorded, respected and carried out as people requested.

### **Is the service responsive?**

The service was extremely responsive.

People were encouraged to express their views and shape their support to reflect their own individuality. This included devising their own advanced care plans which recorded end of life choices so that care was responsive to their needs.

Feedback was sought in many different ways from people and their families to improve and monitor the quality of care.

The provider had a holistic positive and open approach to using complaints and concerns to improve the quality of the service.

**Outstanding** 

### **Is the service well-led?**

The service was very well-led.

There was a clear management structure in place strong leadership and senior staff allocated in lead roles. The management team provided a safe, high quality and extremely caring service which promoted high standards throughout all work practices.

The provider worked alongside other healthcare professionals, national organisations and charities to make improvements to health provision for people in the local area.

Auditing procedures and different quality groups provided a framework for ensuring on-going proposals for improvements were considered and carried out within the hospice.

**Outstanding** 

# St Gemma's Hospice - Leeds

## **Detailed findings**

### Background to this inspection

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

This inspection took place on 13 and 19 July 2016. The first day was unannounced. The inspection team on day one consisted of two adult social care inspectors, a specialist advisor with a background in nursing, a specialist pharmacist inspector and an expert by experience with a background in care of older and younger adults. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection one adult social care inspector returned to the service to provide feedback to the registered manager and chief executive.

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

We reviewed all the information we held about the hospice, including previous inspection reports and statutory notifications. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted health and social care professionals who were familiar with the service. Their comments can be read in the main body of the report.

At the time of our inspection there were 26 people using the In-Patient Unit. The hospice also supported around 200 people in the community. During our visit we spoke with six people who used the service, nine relatives, seven members of staff, the cook, the lead pharmacist, spiritual care manager, chief executive and the registered manager. We spent some time looking at documents and records related to people's care and

the management of the service. We looked at four care records and 15 medication records. We spoke with 15 people and five relatives of the people in the community on the telephone after the inspection.

## Is the service safe?

### Our findings

All the people we spoke with told us they felt very safe receiving care at the hospice. People's comments included, "I feel safe here because everything is to hand; doctors, nurses and whatever I need is here." "It takes so much strain off of the family and my wife, being cared for in here." "I definitely feel safe here. I have lost my mobility and at home and would try and get up myself but in here, I don't feel bad about asking staff to help me." "I absolutely want for nothing. I feel very safe here; I have no concerns what so ever because if I want anything I press my buzzer and they are here within minutes".

We spoke to relatives of people who used the hospice and some of their comments included, "She feels safe and happy here." "I can now sleep at night because I know he is in safe hands now." "I have been given a 24 hour number where I can phone if we have any problems."

The building had secure access which was gained only by a security coded lock or the receptionist where visitors were identified and the purpose of their visit was established before entry was allowed. All visitors were required to wear a visitors badge and, prior to access to the main area, were requested to use the available alcohol hand wash. This process was delivered in a friendly manner by the reception staff and it was explained why this was essential, to minimise the risk of infection. The entire building was exceptionally clean and tidy yet maintained a homely and friendly atmosphere.

People and their visitors told us they thought there were sufficient staff on duty throughout the day and night. They told us staff were visible and they did not have to wait for a response if they pressed their call bells. We asked people for their comments which included, "I never have to wait long if I need a nurse, and staff are constantly popping into my room to check on me." "The response times to call bells is very good, I can't fault the care I am receiving." During the day, we observed staff who were always visible on the wards and saw them constantly going into rooms to check on people. Whilst we were sitting in the reception area of the inpatient unit we saw evidence of quick responses to call bells. Two call bells had been activated and we noted that one was answered in 30 seconds and the other within one minute.

We spoke to staff about safeguarding people and one staff member told us "Safeguarding is about understanding the risk of abuse. It is part of my role to protect people. I wouldn't say anything there and then as you can misinterpret a situation, but I would go to the nurse in charge or to my mentor. The nurse in charge would investigate." All staff knew what safeguarding was. They were aware where people may be at risk and understood their responsibility to report any concerns. Staff were confident senior management would act appropriately on any concerns they raised.

The provider followed a thorough recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people being cared for across hospice services. This included carrying out a Disclosure and Barring Service (DBS) check and obtaining appropriate references.

The provider information return (PIR) sent to us before the inspection stated the hospice had a procedure for assessing and managing risk and they encouraged an open reporting culture through the incident

reporting procedures. We observed where there were risks to people's safety associated with their medical conditions, staff had assessed the risk. Risk management plans were in place so that staff understood how to keep people safe. These plans were reviewed regularly and any changes were shared with all staff during the staff handover meeting between shifts. One member of staff told us, "The handover is used to pass on information about risks and changes in people's needs." This ensured staff had up to date information about the individual risks associated with people's healthcare needs. Where risk assessments had identified specific equipment was required to keep people safe, we saw this was provided.

We spoke to staff who could describe what they would do in relation to any incident or accident. One staff member told us, "Any incident is reported to the nurse in charge and incident forms are filled in. We inform the onsite doctor who writes a statement and we discuss anything that needs to be done. All the incident forms are checked and up to date on the ward every day and then go to management." Another staff member told us, "Patient safety has been added to the mandatory training, we make sure all staff know what happens to the information and why it is needed." All the staff we spoke with could describe in detail how the incident reporting processes worked. The matron told us she looked at incident reports to try to identify trends at ward level and as an opportunity to learn about ward and care management.

A well-established pharmacy team provided good clinical services to ensure people's medicines were handled safely. A dedicated specialist palliative care pharmacist was located at the service. They regularly attended clinical meetings to discuss people's individual pain management requirements, discuss with people about their medicines and ensure good clinical practice was followed. All advice and any discussions about medicines were recorded directly into people's medical care notes. The pharmacy technician dedicated two hours per week to order and check in medicines on arrival and return.

All medicines were stored securely. Daily temperature records confirmed that medicines were stored within the recommended temperature ranges to ensure their safety and effectiveness. The storage and recording of controlled drug medicines which require extra security was managed safely.

In the PIR the provider told us, 'There is an open culture of incident reporting focussing on lessons learned, supported by policies'.

The hospice was very responsive to learn from any errors in relation to medication. One example of this learning included a change of system in documenting omissions and delayed doses by introducing an omissions record sheet to the drug card, following the results from a doctor audit on omissions and delayed doses. This sheet was designed to give further details why doses had not been administered and reduce the number of omissions recorded. Medication errors were reported via a drug incident/near miss reporting form where the pharmacists reviewed the severity of the errors and conducted root cause analysis if required. Any medication errors were discussed at a pharmacy group meeting which had participation from senior medics and nurses.

In the PIR the provider told us, 'Hospice premises and equipment are maintained to a high standard with a comprehensive maintenance programme'.

We looked at a range of certificates and maintenance records that showed the provider ensured the premises were kept safe. For example fire-fighting equipment and systems, electrical systems and gas installations were regularly checked up to date and kept in good working order. Regular fire drills were held using volunteers to act as patients and visitors to give staff good experience of evacuating the building. We saw there was sound planning for fire evacuation, PEEPS (personal emergency evacuation plans) in place with clear delegation of responsibilities to fire marshals.

## Is the service effective?

### Our findings

All the people and relatives we spoke with told us about the extremely high levels of individualised care provided by caring, knowledgeable staff. Comments from people included, "I cannot fault the care I am receiving. Everyone explains things in a patient manner and they are happy to explain it again and again." "I cannot fault it here, the staff are completely lovely and make sure that your every need is taken care of." People's relatives told us, "Mum's medication is often changed daily and whilst she was at home we had problems to get the right balance. Gemma's is able to do this which makes a huge difference."

In the PIR the provider told us, 'All staff undertake induction; the programme is regularly reviewed and updated. Competencies have been developed with Skills for Health. A comprehensive annual training programme is delivered; all clinical staff receive communication skills training. All staff receive training on the use of equipment'.

Excellent robust and specialist training was given to all staff at the hospice which was tailored to their individual professional needs. We spoke to the consultant nurse who explained the training they had recently completed on nurse prescribing, and how this was used on a daily basis in the nurse led unit. In addition to this the consultant nurse had presented at conferences both at the hospice and externally, on how the skills and knowledge from the course had been implemented in practice and benefited people by the nurses on shift having the extensive knowledge around all aspects of medication. We were told by the registered manager all senior nurses had specialist clinical skills in palliative care. The consultant nurse attended a learning group for specialist nurses and doctors in palliative and end of life care in Yorkshire which was held at the hospice. A senior member of ward staff said, "We have visiting professionals come in to run training sessions – if something happens that we don't know much about we get someone in to talk to us. For example we had a specialist come to the ward to talk about motor neurone disease when we had a patient with this condition. The coroner has been to talk about what they do, and we have had a senior nurse deliver a session on skin care. We respond to people's needs."

We spoke to staff around training. Staff told us they had access to an effective rolling programme of refresher training which included, safeguarding, mental capacity, infection control, health and safety and they said they could ask for any additional training needed or would like to do. Some comments included, "There are lots of opportunities for training. Alongside mandatory training there is the academic unit on site, and staff can apply for training there as well if there is anything they are interested in." "We try to learn from each other – if anyone has a particular area of professional interest, for example in dementia, they can run training sessions to share that knowledge with the team through the special interest groups. This is a rolling programme. The focus on mouth care has come from this; we have created a display on the ward to help explain to relatives what we are doing."

The hospice was developing new and innovative ways of ensuring staff with the correct knowledge and skills were recruited as clinical nurse specialists (CNS). We spoke to the nurses who discussed the challenges of not being able to recruit CNS to the vacant posts. The hospice had produced a training and development pack for general trained staff nurses. The staff nurses were recruited to the development role and the

training gave them the skills and knowledge to then be able to take up a CNS post. Staff worked closely and in partnership with external health and social care professionals to improve the service within the hospice and health provision in the local community and nationally.

Staff told us about the induction they had to complete before commencing work. One staff member in a new apprentice post, told us "I had a good induction. I had a general hospice induction and learnt who does what and then had my mandatory training including safe handling and movement. Then I spent a year being supernumerary on the wards. I had two mentors who supported me and helped me learn, we still have a good relationship. The induction went at my pace; it was tailored to my learning. There was always time to go through things with my mentors, and I could ask for any extra training as I went."

On the first day of the inspection, the hospice was holding a celebration of its practice in the form of a conference that a proportion of staff attended from the in-patient unit (IPU), community multi-disciplinary team (MDT) and volunteers attended. There were 80 staff in total. Each presenter told of the achievements of people and staff and what benefits had been made to the people who used the service, along with the challenges and future aspirations of funding. This meant everyone was involved in the plans for moving the hospice forward.

We spoke to staff about the ways they were supported and how this helped them be effective in their roles. Staff told us supervisions were held regularly, alongside reflective learning sessions which were responsive to events on the ward such as the death of a person they had been caring for. In addition staff received an annual appraisal. All staff said they felt they received sufficient, effective support and could approach members of management at any time if they felt they needed additional one to one meetings. A staff member said, "We have reflective meetings. We can discuss any issues, talk about the person who has died and how we might have been affected by it. We talk about what has gone well and anything we could have done better. We feel like such a strong team, we really support each other." A senior member of ward staff said, "I am supervisor for a small group of employees. People can ask for extra meetings if they want them, that's no problem. When we are in group supervision everyone gets chance to talk, and I try to direct some questions to the quieter ones to help bring them into the conversation. I have a regular supervision with someone from outside the organisation every six weeks. It is really helpful to get off the ward and speak to someone neutral like that." We saw evidence of these on the day of inspection.

The rights of people who were unable to make important decisions about their health or wellbeing were protected. The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty so that they can 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). Staff had received training in MCA and DoLS and had an understanding of how the legislation impacted on their practice. The registered manager explained, "Where there are any issues (around a person's capacity) the medical team would do an assessment and our social work team would be involved throughout the whole process as well."

Four care plans we looked at contained capacity assessments which were clearly documented. Consent to treatment was also clearly documented. People's own words were used throughout the care plans; discussion with the person about individual care could be seen throughout. The hospice had check lists in place for consent which included prompts for advanced directives, power of attorney (health and finances) advanced decisions, MCA and DoLS. Although people had capacity, staff had clearly discussed with people

that that may not be possible towards the end of their life, due to fatigue and their fluctuating conscious state. These discussions were documented in their care plan. People's care preferences, level of symptom control they would want, who was to be with them were all discussed and documented. Staff informed us of how important it was to gain the information from the person and ensure it was updated on each admission. Staff told us they always assumed people had capacity but had a clear process to follow if this was not the case. Staff told us MCA was an on going subject across all discussions from supervisions to meetings. One member of staff told us, "We are all aware of the importance of continuously assessing capacity as this can change from one day to the next. We saw evidence throughout the care plans where this had been completed in relation to a person's fluctuating capacity."

People told us they enjoyed the food provided at the hospice. Comments included: "The menus are extensive and there are no set meal times, you eat when you want to." "The food is superb, you can have whatever you choose and at whatever time you feel like eating." "If you want to eat, it is marvellous and staff will go out of their way to find something I will eat." We observed this on the first day of inspection when a person had chosen something to eat which was not on the menu. The member of staff went straight to the shop to purchase it. Relatives of people told us, "Staff noticed that he had not ordered his tea so the cook came to him personally and asked him what he would like." "The bistro is extremely good and well-priced which is important to us as we visit daily. It is good quality food and they will cook to order."

We spoke to the chef who told us the hospice had set daily menus with a four weekly rotation. The chef told us they regularly sought advice from the dietician in relation to people's diets. We saw sample menus and found these to have a good selection of choices available, including vegetarian options. In addition to this, each person had a file available that explained a huge variety of additional meals that were available to order. The information and choices were also presented in pictorial format. The chef told us the menus were chosen following feedback from people. The hospice used a local supplier who would sometimes donate kosher ingredients if needed but kosher meals were always available to ensure the needs and beliefs of people were always met. The chef said "I get to know the people and at times I go to see them to talk about their particular likes so that I can make them meals that they will eat. We have no set meal times, people will choose when they want to eat." This was evidenced throughout both days of the inspection where people were eating meals at different times throughout the day. One member of staff said, "People can have what they want or can manage. We respect and promote different cultural needs, for example halal foods, and we get to know people's likes and dislikes mainly by talking to them and their families." Another staff member said, "One person's family wanted to be very involved with their food, but their cultural approach was to give lots and lots of food; that was good care to them. We knew the person had lost most of their appetite. I spent 40 minutes talking to the person and their family and discussing the person's comfort. It was about us understanding their cultural needs and finding the common ground."

People had access to other healthcare professionals such as physiotherapist, occupational therapist and dietician who were all internal members of staff. We saw reviews of care completed by diabetic specialist nurses had taken place

The hospice had champions within the service which were nurses with specialist interests. These nurses researched their topic i.e. mouth care, tissue viability, falls, nutrition. They then gathered best evidence practice and discussed this with other hospices, hospitals and specialist groups of staff with the same interests. The champions then devised a plan of care and/or assessment tool for the staff to use. This meant the hospice shared good and innovating practice with other organisations to ensure best practice.

## Is the service caring?

### Our findings

Without exception, everyone we spoke with felt that the care given was of the highest of standard and that there was no room for improvement. People's comments included, "I feel the staff here are absolutely brilliant. They always introduce themselves and are always coming in and asking me if I am ok, they are very personable people right from the cleaners to the doctors." "They look after the family too. The doctors always make time for the family." "Staff are so friendly and are genuinely caring people. It comes natural rather than just being a job." And "I now feel fully supported in making decisions about my care." "Staff always pull the curtains around my bed. You can't fault the way they make you feel". "Staff are very friendly and very kind. It is not like being in hospital; it is like we are all friends. They are constantly reassuring me that I have to ask for help whenever I need it." "I couldn't have wished to have been brought to anywhere that is as wonderful as this. They have so much time for me, you would think I was the only one here – they make you feel like that."

We spoke to relatives who told us, "All of the family feel that the staff here provide excellent care. They are genuine people and fully explain everything to us." "Staff moved mountains for us and I feel like I have known them forever." "The experience of care is very different from a hospital i.e. The attitude to pain relief is not a task; here it is very much the central point of care." "Staff give us a very bespoke, individualised and personal approach to care."

In the PIR the provider told us, 'We have taken forward the '#hellomynameis campaign' led by Dr Kate Granger'. We saw on each notice board during the inspection 'Hello, my name is' with photographs and an explanation of what each uniform colour signified.' This meant people were aware of who was supporting them at that time.

Everyone we spoke with told us the nurses and doctors explained things to them in a way they understood and they explained step by step to ensure that both people and their relatives could make informed decisions with regards to their care and treatments. Comments included, "I am fully involved in every treatment change. They explain it to my husband in a way that he understands. I have always been asked about my feelings and have given my permission before treatments have commenced." "I am always asked by staff to tell them if they can do anything more for me. I have been asked to give verbal feedback constantly." "This is how amazing they are – I really wanted a bath so staff came up with a plan to protect my dressings so that I can now have one every day, nothing is ever a bother to them. Bathing me every day is now in my care plan, I feel wonderful being able to do this it makes such a difference to how you feel." "We have always been told that there is always someone we can talk to if we feel we want to". And "Yes I am (involved in care planning and treatments), everything is discussed with me and I am willing to try whatever the doctors think is best, I agree to try anything. I know that they would listen to any concerns or opinions I have and discuss them with me."

In the PIR the provider told us, 'During holistic assessments we listen, find out what matters to people and gain information on their understanding of their condition and care plans'.

Advanced care planning had been implemented in all the care plans we looked at. We saw in one care plan where the person had stated their preferred place of death. Do not attempt Cardiopulmonary Resuscitation (DNACPR) documentation was completed correctly and discussion with person had been recorded. We saw clear care planning goals were in the persons own words for example, 'I want to die here' at St Gemma's. Who is important to you? 'I do not have any family'. Funeral arrangements had been put in place on an earlier admission and risk assessments had been completed. Excellent mouth care assessment documentation was in place with clear pictures with all risk factors and up to date evidence. Referrals were made to complementary therapy for dry mouth and it was documented that this had taken place with what the benefits were to the person. We saw risk assessments on the same document as the care plan. All risk assessments were completed weekly and the care plan updated according to the person's condition at that time. This meant the assessments for people were always up to date and current to ensure the best and most appropriate care was in place.

People's wishes for their final days were respected. One person we spoke with told us of their end of life wish. Their husband was in hospital after a traumatic accident leaving him extremely ill. Their last wish was to see them. The staff were able to arrange for the hospital doctor and nurse to bring the husband across to spend an hour with them before he died. Another person told us they were transferred from an acute hospital approaching the end of their life, with no contact details for family. The hospice was able to track family down within a few hours, the person told us they had been in the Royal Airforce (RAF) and was always smart, and enjoyed classical music. The family spent time with them and were able to shave and cut their hair. The relatives purchased some new clothes for the person and played them classical music. The person and family told us this had a huge impact on their life, this meant they could spend precious time together catching up on each other's lives. This meant their wishes were respected and carried out with the upmost care jointly by family and staff.

People who used the service were offered excellent psychological and practical support by staff. A father told us of how he was able to make memories with his two year old son when the hospice staff arranged for a reindeer to come in for photos and special Christmas memories.

Staff were passionate about the importance of respecting end of life wishes for people and their families. One member of staff said, "We pride ourselves on making last wishes happen. We ask about people's goals in the care planning, but you pick up on things too whilst you're chatting to them." Another staff member told us, "One gentleman wanted to die in Scotland this was in his care plan. We had to make so many calls to find somewhere who could continue his care, but we did it. A nurse flew up to Scotland with him to ensure he was settled in the hospice and we were proud to know he got his last wish." Another staff member told us, One lady had wanted to meet Frank Sinatra – We arranged an impersonator to come and give a performance on the ward and persuaded him to forgo his fee. The look on her face was priceless, the room was full of people and their families listening and singing along." Family involvement was encouraged by staff and one family were able to have a champagne lunch with their relative on the balcony at the hospice.

People were given choice and involved in decisions about their care and treatment. "They have explained the reasons why to me but I am going to ask the doctor next time I see him because my panic pill really does help me." Everyone we spoke with told us the nurses and doctors explained things to them in a way they understood and that they explained step by step to ensure that both people and family could make informed decisions with regards to their care and treatments.

Staff were respectful of people's cultural and spiritual needs. People told us they received the religious and spiritual support they needed. One person's family were supported to prepare the body of their loved one in accordance with the traditions of their culture. The hospice had a spiritual care manager, part time Chaplain

and six volunteers to support the spiritual team. The spiritual care manager told us, "We have had many weddings here before. One person talked to me and asked about getting married in the hospice as they became really poorly. We arranged everything for them, we got in touch with the registrar in Leeds and they were married that day. This meant a huge amount to not only the person but their whole family. We made a dvd of wedding pictures for them to keep. It was a wonderful yet emotional day." One person told us, "I am not religious but I do like to go into the chapel to just think. You need that time on your own sometimes which is really nice. Means I can come to terms with what is happening and have my own space to think."

Bereavement support in the form of a counselling service was made available to people and their families to provide emotional and practical support to those who required it. One person told us, "I have been using this service for a few months now; this has made a great difference to me. The people are wonderful, thoughtful and actively listen to me. I could not have got through this without their support." The bereavement team held team meetings four times a year, which discussed volunteers and their training policies. We saw evidence of bereavement packs which were given to families which gave support and told of monthly Bereavement Support Meetings which were held on the second Friday of every month. There was also support given to families on a one to one basis. Which meant families had access to and could receive the support they needed.

## Is the service responsive?

### Our findings

People we spoke with told us their care and support was excellent and staff responded to their individual needs. One person told us, "I cannot fault the care I have received in any way, believe me if I had to rate it between 1 and 10 this would be 11." Another person told us, "They always involve me in decision making and ask my consent before doing anything." Another person said, "The doctors have spoken to me and I have requested that a DNACPR is put in place. They have explained to me that everyone involved in my care is aware of this." Relatives we spoke with told us, "My [Name of person] is a very independent man and his privacy and dignity are important to him. The nursing staff at Gemma's ensured that this is respected at all times and only male carers assist him with personal care" Another relative told us, "Staff have been very attentive and [Name of person] has a lot of nerve pain. He came in an absolute mess and a lot of attention has been given around pain relief as well as the side effects of the drugs." And "Gemma's has provided a full range of equipment and adaptations for [Name of person], such as chairs, a bed and even a variety of different pillows (people had a choice of firmness of pillows, these were used to support effective pain relief for each person). There is also a phone in his room so that we can speak to him at any time". Another relative told us, "They provide a really holistic approach and have a range of complementary therapies such as reflexology and reiki."

People had access to social activities based around each individual needs. The hospice had arranged a Frank Sinatra impersonator to come and give a performance on the ward. Staff told us the room was full of people and their families listening and singing along. Family involvement is actively encouraged within the hospice to enable people to be stimulated through different types of activities including, singing, and music and relaxation therapy.

In the PIR the provider told us, 'Information on services and how to access them is available on the Hospice and Leeds Palliative Care websites with clear eligibility criteria based on patient and family needs'.

People were referred to the service by either their district nurses GPs or hospitals, and were offered an appointment to visit the hospice. Information packs were sent out prior to admission. At the time of our visit people were looking round the hospice. The registered manager told us, "We try to put people at ease and we encourage family members to come and ask questions also."

The hospice was highly proactive in planning individual care and support. We saw person centred care planning underpinned the work the staff carried out. Advanced care plans we looked at were holistic, considering all elements of the person's care including their physical, social, emotional and spiritual needs. They illustrated that people chose where and when to receive care and their needs, wishes and preferences were fully considered throughout. We saw in all the care plans we looked at they contained evidence of regular and detailed reviews supported by people and their families.

Excellent examples of care around pain and distress which was assessed on a holistic level was evident. This was documented outlining interventions using medicines, distraction, positioning and talking. These were

all evidenced and the choice of intervention had been assessed when three hourly checks of the person were carried out. Each time medicine was given its effect was monitored, and recorded.

We found an example, where one person's care plan for pain took in account their hearing and sight impairment. We spoke to a relative who told us, "They were the first people to react to his dizziness. Here they narrowed it down to three causes and tried different medicines. He really appreciated that they tried so hard to help." Another relative told us, "They really understand non-verbal cues about pain; they saw when he wasn't quite right even when we didn't notice. They'd change his medication until they were sure he was comfortable."

The service provided a rapid response to meet people's needs. They had a very effective 24 hour on-call which had been well constructed and worked well for families and staff. This was key as we were informed by the nurses that things could change very quickly and dramatically, be that the person's condition or within the family. We also saw 'floating staff' were included on the staff rotas to be able to respond to emergency or crisis care. Staff spoke about this in a positive way and expressed being able to respond at short notice to the wishes of a family as satisfying. One staff member had been called in due to the fact of one person's health rapidly declined. This person was able to have one to one support.

Staff had a clear understanding of differing values and beliefs. End of life care was tailored to meet the needs of diverse cultures and religions, such as responding to requests for weekend death certification and registration to facilitate a Muslim burial. The hospice was constantly looking to adapt and include all people's religious and cultural needs, such as responding promptly to a family's request for halal food to be made available. The hospice employed the services of interpreters if necessary to ensure that the service could respond to people's communication needs.

The hospice had a clear structure of care in place. St Gemma's had applied for a grant from The Health Foundation Innovating for Improvement and had started a pilot. The pilot was to develop and implement nurse led beds for the end of life patients within a hospice in-patient unit. The application for this grant stated no other hospice had nurse led beds for end of life care at that time, there were similar nurse led beds for rehabilitation only. The consultant nurse at the hospice had 15 official enquiries from other hospices interested in this innovative work at the time of our inspection. The objectives of the hospice project team was to enable people to die in the place of their choosing, improve the quality of end of life care received by patients and their families, reduce in hospital deaths, maximise the use of the hospice beds, reduce hospice waiting times, and develop nursing skills and knowledge. This initiative, if approved would also set outcome measures using the outcomes assess and complexity collaborative (OACC) which is validated in a palliative care setting. The hospice formally reported back to the Health Foundation with their progress. The midway report stated they were expecting to meet their objectives This was a small scale pilot, demonstrating a reduction of Hospital death is complex as there are a number of variables. The project measured the number of hospital bed days saved. To date the admission of the non-cancer patients has saved 57 hospital beds days, and allowed hospice to be a choice for patients and families for end of life care.

Policies and protocols for care were in place and followed for people in their care plans. This meant the service was leading the way in hospice care in the Leeds area.

In the PIR the provider told us, 'Information on making complaints was readily available to people who used the service, They were supported to make a complaint if they wished to do so. Each complaint was investigated by an officer appointed by the Chief Executive. Where appropriate and particularly for clinical complaints a meeting would be held with the complainant/s face to face.'

We saw there was a clear and comprehensive system that enabled and encouraged people and their families to make a complaint should they feel it was needed. People had access to staff for any concerns/complaints to be closely examined and acted upon. People and families we spoke with said they had nothing but praise, and expressed no complaints about the service, but they knew the procedure to follow should they wish to raise a concern. We spoke to some families who told us they had confidence their concerns would be acted upon immediately.

Families views were gathered regularly using surveys, focus groups and informally during admissions and visits. Feedback from people and their families were published in the hospice magazines. An internet facility was developed to include a praises and grumbles section and people and family's views had been used to shape the development of the service, such as in the new garden of remembrance area. Compliments from the survey dated in 2015 included, 'From the moment [name of person] came in there was a meeting with the doctor and he was given honest replies'. And 'All the pressure has been taken off [name of person] regarding medication etc. [Relative] feels so comfortable at the hospice' and '[Name of person] is deaf and the communication from the moment she arrived has been excellent'.

## Is the service well-led?

### Our findings

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

The hospice was very well led and managed with a clear focus on responding to the needs of the people and their families not only by the senior management, there was a sense of shared responsibility throughout the whole team. We saw strong leadership throughout the inspection, highlighted in key points such as meetings and conference sessions we observed.

We spoke to people and their relatives who told us, "Matron is great, very approachable and hands on. She gave me her card and contact details and told me to use it anytime." Another person told us, "Every one of the staff here go that extra mile, I am forever grateful to each one of them." Everyone we spoke to told us that all staff were approachable and visible to them at all times.

We spoke to staff who all told us they felt all the staff team was approachable and supported each other. Comments included, "We are very open as a team. Communication is excellent." "The Heads of Department meet regularly with the leadership team, and we are very empowered to make changes we see we need. We can discuss these informally with the directors, but the registered manager likes action plans and rationales. If we introduce something new we get time to tweak it, make sure it works. We have very clear formal lines of communication." "The sisters and matrons are all very supportive, you can talk to them on a friend level and they are good managers. They take what you say on board. They listen." "We are all on first name terms, right up to the directors. We have the same level of informality with them. They are really supportive."

There was a 'no blame' culture with staff who were encouraged to report any clinical incidents or near misses. These were fully investigated and used as a learning tool to drive improvements in the delivery of care and to safeguard people from harm. Where investigations identified an issue which resulted in a change of practice, the relevant policies and procedures were revised. The changes were communicated to staff in writing through emails, and verbally at monthly team meetings and through staff handover meetings.

The hospice provided extensive opportunities for people, families and staff to shape the service through meetings, drop in sessions, coffee mornings and focus groups. Suggestion boxes were in place around the hospice and people and staff told us they felt comfortable to raise ideas. Families told us they felt valued and listened to, and improvements had been made to the hospice from their suggestions, for example in relation to the food in the hospice. One person suggested that the hospice source halal meat, this was done.. Families told us they found the website and newsletters informative and felt they were included and involved in the running of St Gemma's.

We looked at many thank you cards sent in from people and their families and the comments on these showed the high level of gratitude felt by all. Some of the comments taken from these cards included: 'It was like being in a big bubble at St Gemma's, so loving and caring'. 'You helped him be free from pain, you made him laugh and you respected his dignity'. 'We are eternally grateful for the amazing care and support given

to [Name of person] over the past 10 days. Staff always had time to speak to [Name of person] as an individual'. 'The mental stimulus such as the visit from the pat dog and the amazing Leeds Rhinos will be remembered forever'.

In the PIR the provider told us, 'The Hospice has adopted 'Good Governance: a Code for the Voluntary and Community Sector' which is used to measure governance standards and inform improvements. We have a three year strategy supported by annual business and financial plans. We have a clear framework of reporting lines and accountability including a scheme of delegation of decision making and risk management framework'.

Clinical governance meetings minutes we looked at evidenced feedback of audits on a regular basis. The inpatient unit (IPU) audit plan recorded the frequency for each audit. These ranged from monthly nutrition, hand hygiene and mouth care audits to annual infection prevention and control audits. Quality assurance visits by trustees were unannounced every six months. We were shown the June 2016 report by the registered manager which was also reported back to the clinical governance meeting.

We saw governance arrangements in place in identifying and addressing developments needed for the hospice. The minutes from the board of trustees meeting in March 2016 highlighted the need for more robust data that was more valid and reliable on measuring outcomes. Four of the six OACC (outcome assessment and Complexity Collaboration) were in use in the hospice. The final two, IPOS and Zarit Burden as phase of illness and views on care were already in place at the time of the inspection. Other clinical groups such as the clinical leadership group, falls group and intravenous therapy considered operational issues in greater detail, which discussed best practice and training. These were all discussed at the weekly Multidisciplinary Team (MDT) meetings.

Training for staff was organised and run by the hospice for a post graduate certificate in palliative care as well as GP access modules. We were told by one of the consultants following three critical incidences in local care for palliative care /end of life care, the hospice held training events for GPs. The clinical commissioning group (CCG) funded the training and collected data from the GP practices, to assess its effects. The hospice adapted the number of training days to suit the feedback from the GPs. Follow up sessions were in place for GPs to bring case studies forward to the hospice.

We looked at the partnership with the University of Leeds Academic Unit and St Gemma's. . Professor Mike Bennett is the head of the Academic unit and Professor of Palliative Medicine St. Gemma's. He is one of four consultants at St Gemma's. Professor Bennett co-authored the British Medical Association Medical Book of the Year 2015, which gave advice on advanced pain management techniques for cancer pains. The Yorkshire Palliative Medicine Regional Learning Group holds four half day meetings within the hospice. The meetings include presentations on recent developments in palliative medicine, case presentations, and the outcomes of clinical audit and research projects. This was evidenced throughout the inspection of how this had been implemented at the hospice through examples of care around pain and distress which was assessed on a holistic level in people's care plans. This was documented outlining interventions using medicines, distraction, positioning and talking. This meant the hospice was part of the on going innovative research within hospice care.