

St. Giles Hospice

St Giles Hospice - Whittington

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

This inspection took place on the 28 September, 5 and 7 October 2016.

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

St Giles Hospice is an independent registered charity that provides specialist medical, nursing care and treatment, health diagnosis and screening; associated with specialist palliative and end of life care for people with life limiting, progressive and advanced disease or illness. The service includes a 27 bedded inpatient unit with an on-site advice and referral centre, a day hospice with on-site lymphoedema clinic and outreach service; a hospice at home service, which also supports people who may choose, to die at home. A range of other care and support services are offered for people and their families, which include bereavement and counselling, spiritual care, occupational, physio and alternative therapies, community engagement support and a transport service.

At the time of our inspection there were approximately 1380 people using the service, including 21 people accommodated on the inpatient unit at St Giles Hospice.

People felt safe and in control of their care and treatment. People's care, treatment and medicines were consistently accounted for and safely managed. Risks to people's safety associated with their health condition, environment or care equipment were fully accounted for. Staff understood and followed people's care plans, which showed the care actions required to mitigate any identified risks to people's safety from this.

People were protected from harm or abuse. People felt safe and both they and staff were confident and knew how to raise any concerns about people's care and safety. Staffing and emergency planning measures helped to ensure that people received safe care. Equipment, environmental maintenance and cleanliness, was consistently maintained. This helped ensure people's safety in care.

People and their families were highly satisfied and complimentary of the individualised care, treatment and support provided; and felt this made a positive difference to their health and emotional wellbeing. People's care and treatment was consistently delivered in a way that met with their needs and wishes and often exceeded their expectations. Staff and volunteers worked as a cohesive team in consultation with external health professionals when required; to optimise people's care and treatment options and their health and comfort. Plans to establish revised outcome measures for people's clinical care and treatment from recent national guidance, aimed to further this.

The provider's arrangements for staff training, development and support were comprehensive, well-

resourced and service specific. This enabled effective clinical leadership, staff expertise and knowledge concerned with people's palliative and end of life care and treatment.

Staff understood the importance of ensuring people received good nutrition and hydration; and the related support requirements at people's life end stage of care. People accommodated on the inpatient unit were provided with quality and choice of food and drinks at times to suit them.

Staff understood and followed the Mental Capacity Act 2005 to obtain people's consent or appropriate authorisation for their care. Manager's checked the related assessment and decision making process to ensure this was being properly followed. This enabled people's rights in care and helped to protect them from receiving end of life care that did not meet with their needs, wishes or best interests.

People received care from kind, caring and compassionate staff and volunteers who treated them with respect and were highly motivated to provide good quality care. Staff understood the importance of establishing good relationships with people and their families and took time to ensure people's dignity, rights and involvement in their care. Policy and related staff practice aimed to ensure people received sensitive and dignified care following death. People and their families were treated as equal partners in their care, which was regularly reviewed with them. A range of care awards and good practice initiatives, demonstrated a caring organisation.

People, their families and members of the wider community were informed and supported to understand and access relevant care, treatment and support options available to them. Twenty four hour timely advice, support and appropriate care referral helped to ensure this when required. People's relatives and staff had access to bereavement counselling and emotional support following a person's death for as long as they needed it. This helped to ensure that staff, people using the service, those that mattered to them and the wider community received the information and support they needed.

Staff were attentive to and mindful of the detail of people's lives, how their illness affected them and what was important for their care and treatment. Timely pain relief, symptom control and emotional support were well assured and central to people's care provision. When people received life end stage care, they received this in private, with their families as they wished.

Staff understood and followed people's decisions, wishes and preferences for their care and treatment. Related record keeping and information sharing systems helped to ensure this. Measures for continuous service improvement promoted people's timely assessment, referral and involvement in decisions about their care and treatment. Strategic planning meant the provider engaged closely with the local community to build links, services and support networks to help shape, inform and support palliative and end of life care.

The provider had robust systems to report, review and learn from complaints and adverse feedback. People and their families were routinely consulted about their care experiences and knew how to raise any related concerns or complaints. Feedback obtained from this was used to inform and make service improvements when required.

People, their families, staff, volunteers and key stakeholders were confident the service was well managed and run. All said they would recommend the service to friends and family. Staff and volunteers described an open, positive culture where they were proud to work, valued and felt they made a real difference to people's care. All were consulted and involved in way that helped to inform people's care and treatment provision, service operation and improvement.

Senior leadership was visible, strong and supportive. Defined management and clinical governance arrangements ensured clear lines of authority, communication and decision making for the management of the hospice service and people's care and treatment. Staff and volunteers understood their roles and responsibilities for people's care, treatment and support. They were confident and knew how to report any related concerns or observed changes to people's health, care or safety needs.

The provider operated comprehensive systems to regularly check the quality and safety of people's care and treatment, which they regularly reviewed against relevant recognised national guidance concerned with this. The service management and reporting culture helped to ensure open, critical care review and learning from any serious care incidents. The provider had notified us of any important events that occurred at the service when required. This meant the hospice board and managers knew about and took responsibility for things that happened in the service, to safeguard people from harm.

Service planning took account of local population demands, financial viability and work force planning considerations. Partnership working and links with key external organisations, educational providers and care authorities; helped to support and inform people's care and treatment provision, staff and service development and joined up care. Cross sector working, sharing of good practice, together with relevant local and national service development initiatives, were consistently sought and followed. This helped to inform and ensure the quality and shape of people's care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

People felt safe, in control of their care and treatment and they were protected from the risk of harm or abuse. People's medicines and their care, treatment and related equipment were consistently accounted for and safely managed. Staffing, environmental and emergency planning measures helped to ensure this. People's safety in care was regularly checked, assured and optimised.

Is the service effective?

Good ●

People received holistic care, treatment and nutrition. This was consistently assessed, planned and delivered in a way that helped to optimise people's care, health and comfort. Plans to introduce revised outcome measures for people's clinical care and treatment aimed to further inform and enhance people's care experience. Staff understood and followed the Mental Capacity Act 2005 to obtain people's consent or appropriate authorisation for their care and treatment. Staff training, development and support arrangements were comprehensive, well-resourced; role and service specific. This enabled effective clinical leadership, staff expertise and knowledge concerned with people's end of life care and treatment.

Is the service caring?

Good ●

People received care from staff who were respectful, compassionate, kind and caring. Staff understood and followed the provider's aims and values for people's care, which helped to ensure their dignity and rights. People and their families were routinely consulted and treated as equal partners in their care. Both they and the wider community were informed and supported to access timely care, treatment and related support for as long as they needed it. Staff understood how people's illness affected their lives and followed what was important to them for their care and treatment. Related record keeping and information systems helped to ensure this and people's confidentiality in care.

Is the service responsive?

Good ●

People were protected from receiving care or treatment that did

not meet with their known wishes. People received timely, informative and individualised care and treatment from staff who knew them well. Staff consistently understood and followed people's decisions and preferences for their care and treatment. Record keeping and information sharing systems helped to ensure this. People and their families were routinely consulted about their care experiences and knew how to raise any concerns or make a complaint about this. People's views and comprehensive community engagement helped to shape, inform and improve the hospice care service.

Is the service well-led?

People, staff and all key stakeholders were confident the service was well managed and would recommend to friends and family. Staff and volunteers were valued, proud to work at the service and understood their roles and responsibilities for people's care. Visible, strong and supportive senior leadership; consistent management and governance arrangements helped to ensure the quality, safety and financial viability of people's care. Relevant external partnerships and working links helped to influence cross sector care provision; inform and ensure the quality and shape of the hospice service.

Good ●

St Giles Hospice - Whittington

Detailed findings

Background to this inspection

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

The inspection was unannounced on 28 September 2016, with additional visits on the 5 and 7 October 2016. The inspection team consisted of one inspector, a member of the CQC medicines team, a specialist advisor and expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor held significant experience of working within the field of palliative and end of life care.

Before this 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 sent out survey questionnaires to 17 people who used the service, 19 relatives, 34 medical and nursing staff, five care staff and six external community professionals. Respectively, we received completed returns from three, one, 11, nil and one. We also contacted local stakeholders, such as local care commissioners and looked at all of the key information we held about the service. This included written notifications about changes, events or incidents that providers are required by law to tell us about.

At our inspection we spoke with eight people who received care and 12 relatives. This included the relatives of some people who received care in their own homes, either from the community nurse specialist or the hospice at home care staff. We also observed how staff interacted and supported people in communal areas of hospice.

We spoke with a range of 27 staff from the hospice care team across most of the services provided by the hospice. This included nursing, medical, pharmacist, therapy, care staff and volunteers, catering and

support staff. This also included the registered manager, who is the responsible individual for the provider and some staff with clinical specialist, management or service development lead roles.

We looked at five people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. For example, checks of the quality and safety of people's care, minutes of meetings, staff and care surveys, service planning and strategy and complaints records.

Is the service safe?

Our findings

People and their relatives told us they felt safe when staff provided care. They said that staff took time to make sure that people were safely supported. All confirmed they had no concerns about the safety in care provided by the hospice. One person said, "I feel completely safe; staff are brilliant; they know what they are doing." Another person's relative told us, "Staff always take the time to listen and explain options, they always make us feel safe and reassured." The provider's records of feedback received from people and their relatives from April to June 2016 showed that people felt safe and secure when they received care from staff at the service. Survey returns we received from people and their relatives also showed this.

During our inspection we observed that staff supported people safely when they provided care. For example, when they supported people to move or to take their medicines. People and relatives told us that staff consulted with them about known risks to people's safety from their health conditions and environment and how these could be managed. Many commented that this helped them to feel safe and in control of their care. Staff we spoke with understood people's safety needs and related care requirements, which were recorded in their written care plans.

People's care records showed that risks to their safety from their health conditions, environment and care equipment, were assessed, monitored and reviewed with them or their representatives before they received care. This was done in a way that met with recognised national guidance. For example, in relation to known risks associated with certain medical treatments; risks from falls, infection and skin sores or from care equipment such as urinary catheters. Staff we spoke with understood people's safety needs and related care requirements. This showed that people were safely supported in a way that helped them to feel safe and in control of their care.

The provider's arrangements to identify; monitor and act on care and service level risks were comprehensive, routinely followed and regularly reviewed. For example, this included known risks associated with people's clinical care and treatment, staffing arrangements, the hospice environment and equipment used for people's care. Clinical incidents, accidents and safeguarding concerns were routinely monitored, recorded and analysed. This helped to determine any root cause; whether they were avoidable and action plans to mitigate further risk when required. Related discussions with staff along with staff meetings, patient safety and training records showed that findings and any improvements needed were routinely shared with management, relevant staff groups and hospice board members. Staff said this was done in a highly positive way that helped to promote their reflection, learning and where required debriefing and critical incident review. This helped to ensure people's safe care and treatment.

Throughout our inspection we saw the hospice environment was clean and well maintained with no related, observable hazards to people's safety. Survey returns we received from people, their relatives and staff showed they felt the hospice environment was well maintained, kept clean and hygienic. They also showed that staff did all they could to ensure good infection control. For example by using anti-bacterial hand gels, and protective clothing such as gloves and aprons when required, which we observed during our inspection. External health and social care professionals we surveyed told us they felt staff followed good hygiene and

infection control practices.

Records showed that required servicing and maintenance of equipment used for people's care was regularly checked and kept up to date for safe use. Where there was potential for medical emergencies to occur in relation to people's health conditions, there were clear procedures to inform staff how to respond, which staff understood. This included, if life preserving equipment and procedures needed to be used or followed. This showed the provider's arrangements to manage care and service risks were comprehensive and helped to ensure people's safety and protection.

People, relatives and staff were confident to raise any concerns they may have about people's safety in care. All surveyed felt people were protected from harm or abuse when they received care. Procedures were in place to enable staff, people and visitors to the service; to report any concerns they may have about people or children's safety. The provider's written procedures showed clear lines of accountability and reporting for safeguarding adults and children who are vulnerable, which staff understood. Staff and volunteers were provided with guidance and training, which included multi-agency roles and arrangements for safeguarding adults and children. The provider's safeguarding adults' staff training provision was under review to follow new national guidance for health care staff roles and competencies. This helped to ensure that people and children who came into contact with the service were safeguarded when required against harm or abuse.

Staff and volunteers described safe recruitment procedures were followed, which helped to make sure they were suitable to provide people's care and support. Related records we looked at reflected this.

People, relatives and staff said that staffing arrangements were sufficient to meet people's care needs. All of the people we spoke with confirmed they received timely care and support from the right staff at the time needed or agreed. At the inpatient unit, we observed that staff were visible and to hand when people needed them. Most people and relatives we surveyed in relation to people's care at home said staff arrived on time and stayed for the agreed duration of the care call. Managers told us that staffing arrangements were closely monitored and acted on when required to ensure people's care. For example, in the event of staff absence from work. Contingency plans were in place in the event of staff sickness and absence and for unexpected events and unforeseen emergencies, such as adverse weather conditions. All of the staff we surveyed told us there was a lone worker policy in place which helped to keep them safe. This showed staff were safely recruited and deployed.

Medicines were consistently managed by staff in a way that was safe. The provider employed a lead pharmacist, who undertook to ensure the safe and efficient use of medicines used for people's treatment, known as medicines optimisation. This included looking at any reported medicine incidents. A second pharmacist provided support checking prescription charts for safety. Policies for the safe management, optimisation and prescribing of medicines in palliative care were available and kept up to date. Nurse competencies in medicine management were checked to ensure their understanding of the safe handling, preparation, administration and recording of medicines.

Arrangements were in place for recording medicines prescribed for and given to people. Overall prescription charts were clear and fully completed which showed people were getting their medicines when they needed them. We were shown how medicines prepared in a syringe driver for one person's pain relief were checked and recorded by two nurses. This helped to ensure the correct amount of medicine was being given to the person. A syringe driver helps control symptoms by delivering a steady flow of liquid medication through a continuous injection under the skin. A specific pain management chart had been developed by the service. This was used to assess people's level of pain in order to determine what pain relief was required. When people wished to self-administer their own medicines independently they were supported to do this and

potential risks to their safety from this were assessed with them.

We found an open culture of reporting any medicine incidents such as recording errors, which were documented and investigated. Medicine incidents were also reviewed at the provider's Medicine Management Forum meeting and then also at the quarterly Clinical Governance Committee to ensure positive outcomes from the incidents. For example, following incidents of clinical staff failing to record patients' correct medicines on admission; an improved checking system was introduced. We were shown how two nurses check and sign that all medicine information is recorded accurately. This meant lessons were learnt with new systems for medicines safety implemented.

Medicines, including oxygen and controlled drugs, were correctly stored so as to protect people using the service and to ensure that the medicines would be effective when used. Controlled drugs (CD) are a group of medicines which are subject to strict legislative controls due to their potential for abuse and harm. We found that safe arrangements were in place for the storage, recording and administration of CD. An Accountable Officer (AO) for CD had responsibility for ensuring safe storage and recording of CD. The AO also attended the regional CD Local Intelligence Network meeting to share good practice across the region.

Is the service effective?

Our findings

People and their relatives were highly satisfied with their care and treatment across the services provided. We received many positive comments and high level praise from them about this. One person told us about the care they received at the hospice inpatient unit. They said, "My health is fragile, but I am absolutely cared for by all staff grades; the care is wonderful here." Another person told us, "I am getting lots of help here with my pain and symptoms; it's such a relief; they are helping me sort out what I will need at home. The relative of a person who received care at home from the hospice community nurse specialist said, "We couldn't have wished for better care."

Two people told us about their care and treatment, which they received from staff in the lymphoedema outpatient clinic at the day hospice, They told us, "They are miracle workers; they continually review my care with me to make sure I get the most effective up to date treatment;" and "Information, treatment, care and advice here is second to none; I wouldn't be walking if it wasn't for this service." Lymphoedema is a chronic health condition that affects the body tissues, causing swelling often in the arms or legs.

The provider's findings from their recent survey of people's and relatives views across the hospice services showed they were satisfied with the care and treatment provided. People and their relatives were particularly pleased with pain and symptom control and the range of care, treatment and support offered to people; which was often described as 'good' or 'excellent.' Survey returns we received from external professionals concerned with the service reflected this. They also said that staff at the service worked in collaboration with them to help to ensure the best care outcomes for people. All respondents surveyed about the care from the hospice at home team said the care and support they received had made a positive difference, much better than expected. All said they would recommend the hospice care to friends and family.

Twenty four hour medical and nursing support was provided at the hospice inpatient unit. This included people's medical care via a 9am to 5pm medical presence and on call medical support out of those working hours. People were able to access a range of health professionals relevant to their care requirements. For example, therapy staff, including physio and occupational and complementary therapists. Emotional, spiritual and personal care and support was provided for people and their carers'. This included aftercare following a person's death and a chaplaincy service.

Recent figures collated by the provider, showed their hospice at home and clinical nurse specialist team supported 98% of people who received care from them and who expressed a preference to do so, to remain at home at the end of their lives. This had increased from the previous year and was above the national and local government expectations.

People were fully involved and informed in their care and treatment. We observed one of the weekly MD team meetings held, which showed staff were knowledgeable about people's health conditions, their related care, treatment needs and choices. This and related records showed that people's care and treatment was agreed with them; regularly discussed, reviewed and accurately recorded for staff to follow.

People and their relatives confirmed their care and treatment was regularly discussed and agreed with them. All we spoke with said they received the information they needed to help them to understand the hospice service, their health condition; care and treatment options. Results from the provider's recent survey questionnaires with people about their care, showed they felt fully involved in making decisions about their care as they wished. Many rated quality and usefulness of written and verbal information provided as either 'good' or 'excellent.'

People told us that staff were competent when they provided their care and treatment and always completed their agreed care. One person said "I find all of the staff to be highly skilled; they know what they are doing." All grades of staff and volunteers we spoke with and those we surveyed told us they received the training, support and development opportunities they needed for their role and responsibilities. This included relevant clinical skills training and competency checks and performance appraisals. It also included access to regular peer and individual bespoke supervision when required. This helped to ensure individual and team reflective practice and learning. Staff who provided people's care via the provider's hospice at home service received mainly peer supervision. Individual supervision was dependent on staff arranging this with their line manager or a specialist supervisor, rather than routinely planned for staff. We discussed this with management, who advised this was under review, with monitoring of staff uptake to ensure they received regular one to one supervision.

We received many positive comments from staff about their training and support. One nurse said, "Training and development opportunities are really good here; routinely offered, supported and encouraged." A large onsite, well-resourced learning and development centre helped to facilitate staff learning and education. All new staff and volunteers were required to complete a comprehensive training programme relevant to their role before they started providing care. This included working alongside more experienced staff, of a relevant grade where appropriate. People and relatives we surveyed believed staff had the skills and knowledge required to provide people's care.

Staff and volunteers were supported to retain and develop their own service specific learning for their role. This included through regular refresher training, new or further learning to degree level. All nurses and care staff worked to a 'passport', for key training and competency relevant to their role. The passport set out clear continual development pathway for staff to follow from appointment. This included core training, education plans and optional studies, linked to and reviewed via staffs' individual annual reviews of their performance and appraisals. Checks of staffs' professional registration were made when required to confirm their status to practice. For example, to provide people's nursing or medical care.

Staff leads were established for all key areas of clinical care. For example, nutrition, infection control and tissue viability. Staff were actively encouraged to share their learning and where relevant, teach and support each other. The care certificate was introduced for new health care support staff and mapped across existing staff to ensure they fulfilled the learning principles from this. The care certificate identifies a set of care standards and introductory skills that non-regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care.

Peer learning and development was well promoted through a range of staff learning forums that were regularly held. For example, journal club for review of research and practice concerned with end of life and palliative care, staff case presentations and critical appraisal. Clinical staff were encouraged and supported to undertake research and development to help inform, influence and improve people's care where required. For example, in relation to nutrition and end of life care. The provider planned to introduce a number of measures aimed to further improve and enhance people's care experience. This included a new

nationally recognised method designed to support hospices and other palliative care providers across the UK in implementing outcome measures into clinical practice. This helped to ensure that people received care based on nationally recognised and best practice standards and initiatives from staff with the right knowledge and skills.

Everyone we spoke with in the hospice inpatient unit expressed their satisfaction with the quality, choice and availability of food provided. Examples of their comments included, "Really delicious food, great variety and choice;" "I can choose healthy options - I'm eating better and my appetite has improved;" and "Tasty, home style cooked food to suit."

Staff promoted the importance of good nutrition and hydration for people they cared for. They supported people to eat and drink foods they enjoyed and to maintain a balanced diet where possible. Many people who used the service had a reduced appetite or difficulty eating and drinking. All people we spoke with said that their food was freshly prepared in portion sizes and consistencies to suit their wishes and needs. Aids and adaptations, such as specialist plates and cups, were available to help people eat and drink independently when required. Records showed people's nutritional status was monitored. Where concerns were identified with people's nutrition, relevant health care professionals were consulted and staff followed their advice and instructions where required.

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 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 is in their best interests and legally authorised under the MCA.

Staff received training in the MCA and they understood and followed the MCA principles. Staff told us that all of the people receiving care usually had the capacity to make decisions about their care and treatment. They also told us that some people's capacity to do this on a day to day basis could sometimes fluctuate because of their health condition. Staff were able to describe how they sought people's consent by offering information and choices to support their decision making. For example, by discussing people's care and treatment options with them and obtaining their written agreement to this, which related records showed. They were also able to tell us about how they decided and gave care in people's best interests when required, which related records also showed.

During our inspection we observed that staff gave relevant explanations and sought people's agreement when required before they provided care. For example, when people needed support to make decisions about their medicines such as pain relief or what to eat and drink. Managers checked the assessment and decision making process to ensure this was properly followed.

People's consent was obtained for other matters relating to their care and treatment, such as information sharing or photography for treatment purposes. Discussions held with people and care plans we looked at showed this. This also included any important advance decisions they had made about their care and treatment, such as in the event of any worsening of their health condition or for their preferred priorities for their care. These are known as advance care plans. This meant that people were protected from receiving end of life care that did not meet their needs, wishes or best interests.

Is the service caring?

Our findings

People and their relatives spoke highly of the caring, compassionate nature of staff who provided their care. They described good relationships with staff who they felt treated them with respect and consistently strove to ensure their dignity, privacy, involvement and independence in care. All confirmed that staff took time with them to understand people's care and daily living needs and preferences. One person said, "From the cleaners to the medical consultant – they are so caring, and helpful." Another person told us, "All of the staff; they are friendly but professional and treat you with utmost respect and courtesy; nothing is too much trouble." All of the survey returns we received from people and their relatives reflected these views.

Throughout our inspection we observed that staff treated people with the utmost care and respect. They took time to ensure people's privacy, dignity and involvement in their care. For example, when they supported people with personal care, they made sure that curtains and doors were closed, that people's clothing was properly adjusted or that their personal items, drinks, meals and call bells were accessible to them. We also saw that staff took time with people to explain what they were going to do before they provided care and checked that people were happy and comfortable before, during and after. Arrangements were in place following a person's death, to ensure that their body would be cared for in a sensitive and dignified way by staff; which staff understood. The provider's related policy guidance, together with staff training and instruction helped to ensure this.

Returns from the provider's recent care surveys with people and their relatives showed that staff treated them as individuals and respected their privacy and dignity. They also showed people and relatives felt they had regular opportunity to discuss and agree their own support needs with staff. This showed that people had positive relationships with caring, compassionate staff; who treated them with respect and ensured their dignity and rights in care.

People and their relatives were informed, involved and supported to make decisions about their care. One person said, "The doctor and nurses explain things; they give you the facts and help you to understand what's important to you." Another person told us, "There's lots of information to help; talking things through and written information to help you think about things." A relative told us, "Staff are brilliant – they explain everything in simple easy to understand terms; It's a very good experience here, we can now make decisions about end of life care; it all feels more comfortable now."

People's care records showed that their preferred priorities for their care were discussed, agreed and regularly reviewed with them. They also showed how people were informed and supported to make decisions about their care and treatment. Training and procedures were provided for staff to follow about handling confidential personal information relating to people's care, which staff understood and followed.

A comprehensive range of service information and related care advice and literature was provided. This helped people to understand and navigate their related care, treatment and support options, both within and outside the service. The provider's on site advice and referral centre was pivotal to this. It provided twenty four hour, timely advice, support and appropriate care referrals for people and relatives when

required. People and their family members could access a range of support services across the hospice and community setting to suit their needs and preferences. For example, art and complementary therapies, individual and family bereavement counselling and support. People and their families had access to a chaplain for spiritual and bereavement care and support. Assessment and agreement of people's emotional and spiritual needs and those of their carers; were shown in people's care records. This showed that people were appropriately informed and supported in their care.

People and relatives we spoke with particularly valued the emotional support they received from hospice staff and the timely pain relief and symptom control people received. One person said, "Caring is above and beyond, they almost anticipate when you need support; they are wonderful." We spoke with another person about their pain relief management. They told us they were fully informed and involved in any decisions about their treatment and said, "I am asked how much pain I am in and it is certainly better managed here; The staff are so kind to everyone; They are angels." One person's relative told us, "They looked after us both; they make me feel it's okay to ask for help; it's such a relief."

Comments received from people and relatives showed they felt staff paid attention to the detail of their lives, how their illness affected them and matters that were important to them. One person said, "The really care about you're not just a condition here." The relative of one person who received hospice at home care said, "You only have to mention a worry – they go out of their way to help; I've never come across such care."

People's families were supported to visit the hospice at times to suit them and also the person receiving care. Dedicated facilities were provided for people's visitors, which included a lounge rest area, access to meals and drinks and a private area for people's families. When people received life end stage care, they received this in private. Their families were supported to stay overnight either in an overnight stay room or by use of 'put up' beds. One person told us, "My wife can visit and stay overnight now; there's a pull out comfy bed plus a family area with bedroom lounge and kitchen."

People using the service, those that mattered to them and the wider community received the emotional, spiritual and bereavement support they needed. St Giles hospice provided a comprehensive counselling and bereavement support service. This was provided to adults and their families, children, younger adults and also staff where required. A number of methods were used to deliver this from a range of professional and qualified staff. For example, counselling and support for people's children who had been bereaved due to a sudden or traumatic death of a close family member. Nurses and care staff employed at the service received varying levels of bereavement training up to advanced level where relevant to their role; to support people's care in this way. During our inspection we saw that relatives were supported to attend the hospice for bereavement support after the person's death. This helped to ensure that people using the service and those that mattered to them received the emotional, spiritual and bereavement support the needed.

The hospice service was subject to a range of awards and good practice initiatives, which demonstrated a caring organisation. For example, collaboration with a partner hospice, charitable trust to set up a community support centre to promote people's wellbeing in later and end of life. This enabled people to access care and advice closer to home with support from local volunteers and care professionals. St Giles Hospice, Whittington also won Bereavement Project of the Year in 2015 through the National Council for Palliative Care National awards for their Bereavement Help Points. These are drop in sessions, that continue to run across the wider community in places such as supermarkets; offering people advice and support on coping with bereavement and loss.

Is the service responsive?

Our findings

People consistently told us they were involved in decision making about their care, treatment and support needs. One person said, "They talk through my care with me all the time; they wheel the computer to my bedside to go through things with me; yes, I can say that I am fully involved." Another person's relative told us, "We have talked as a family and my wife wants to try care at home; the hospice community team are looking at if our home can be set up suitably." Community health care professionals told us that staff acted on and followed any advice for people's care in a timely manner. They also said staff worked well them to share any relevant information about people's care. For example, when people's care needs changed.

People's care records showed how their care and treatment options were discussed with them and their related choices and preference were followed. Staff told us they had up to date information about people's care and treatment needs, choices and following any agreed changes to this. The provider's electronic care plan record keeping system supported this across the hospice services. People's care was discussed; agreed and recorded with them at the place they received care. For example, the inpatient unit or at home via the hospice at home service. This helped to ensure that people's known care and treatment decisions were agreed with them, followed and acted on in a timely manner by staff.

One person told us about an advance decision they had made about their care and treatment. This is a decision a person can make in the present to refuse a specific type of treatment at some time in the future. The person told described the 'sensitive, honest and informative support' they received from medical and nursing staff. This helped them to consider their health condition and related care and treatment options. They said, "It helped me feel so much better; I don't have to worry so much; I know I'll get the care I want."

People's care records we looked at showed where possible, staff took time to check if people had made an advance decision before they provided care and treatment. We found there was a delay in staff confirming this information from one person's care record we looked at. We discussed this with management and staff, who took the action required to address this and also to help prevent this from happening in the future. This meant that people were protected from receiving care and treatment that did not meet with their known wishes.

In May 2016 the provider launched their Advice and Referral Centre (ARC). We found a mix of trained call handlers, specialist staff and supportive care volunteers provided advice and support on a range of matters, either directly related to or concerned with palliative and end of life care, life limiting illness, sudden death, loss or bereavement. The service was developed from an existing referral centre launched in 2014; to provide and improve people's timely assessment, care and treatment referral. Advice, support or signposting to other services was also provided for people, their families and external health professionals when required. Whilst most admissions to the inpatient unit were planned, arrangements were established for people's referral, medical and nursing assessments out of normal working hours when required. For example, if people's needs changed quickly.

A relative told us how the hospice team were supporting their family member to go home for their care. They

said, "It's brilliant; they can transfer all the care to our home; we couldn't ask for better. Another relative told us, "We have talked as a family and my wife wants to try and live at home; the community team are looking how this can be set up for us."

Active discharge planning from the inpatient unit, helped to support people's end of life care. This supported people who chose to go home, or to go home after a period of rehabilitation and symptom control; to be discharged in a considered, timely manner. People, relatives and staff said this was done in a way, which enabled people to receive the care and support they needed after their discharge home. For example, medicines and equipment needs, environmental adjustments and financial considerations were explored with people. One of the hospice community nurse specialists told us as a trained prescriber for specified medicines; this could enable people's quick access to the medicines for their symptom management when required. Anticipatory medicines were subject to people's assessed needs and could be administered out of hours by the district nurse if required, to help prevent the person being unnecessarily admitted to hospital. Anticipatory medicines can be provided in advance, which are to be given when a person's condition worsens; to help alleviate their discomfort or distress. This helped to ensure people received the right care at the right time. .

The provider's arrangements helped to ensure that people were engaged, supported and informed in a way they understood and was helpful to them. One person receiving care on the inpatient unit was unable to move because of their health condition. They were provided with an environmental control device to assist their independence. This is a form of electronic assistive technology, which enables people with significant disabilities to independently access equipment in their environment, such as home or hospital. For example, to enable them to open bedroom curtains or switch room lights on themselves. People and their families were informed about the hospice service and matters relating to death, dying, bereavement and loss through a range of service literature and information. Key service information could be provided in alternative formats to suit people's needs. For example, language, type or picture format.

Comprehensive arrangements via dedicated staff helped to inform and support the local and wider community through direct engagement with them. For example, by providing education and bereavement support to local schools, colleges, employers and community groups. The provider also worked in partnership with external care agencies such as CRUSE and Age UK to set up 'drop in' centres providing advice and support in relation to dying matters. This showed the provider took a key role in the local community to build links, services and support networks.

Service strategy and improvement planning sought and took account of local and national health population demands for end of life and palliative care. Review and development of the hospice community services was a key objective for 2016-17; to consider how the service could be shaped to be as flexible, efficient and effective as possible. For example, to support the increasing number of people who wish, to die at home. As part of this review, the provider was conducting a survey with local GPs to help better understand and determine their expectations and perceptions of the service. Recent service initiatives included a pilot project underway on the in-patient unit - for two continuing health care funded beds for people life limiting illness nearing the end of their life; but without complex specialist palliative care needs.

People and their relatives knew how to raise any comments, concerns or make a complaint about the service if they needed to. All knew how to contact the service out of normal office working hours if they needed to. People we spoke with told us they had not found any cause for complaint, but felt any concerns they may have would be listened to and acted on. The provider told us they had received 11 complaints during the previous 12 months. For example, improvements to discharge planning and co-ordination and equipment used for people's care. Records showed how these were investigated and responded to. They

also showed how learning from complaints, together with any changes or improvements needed were shared with board, senior management, staff and volunteers to help ensure they were consistently understood and followed. Recent examples of improvements made from this included, improvements to discharge planning and co-ordination and equipment used for people's care.

The provider's published Quality Account for 2015-16 included how they managed and responded to complaints received about their care provision. This included a related assurance statement from local health care commissioners and showed that St Giles hospice had robust systems to report, review and learn from complaints and adverse feedback. A Quality Account is a report about the quality of services by a health care provider. The reports are published annually by each provider, including the NHS and independent sector, and are available to the public.

Is the service well-led?

Our findings

People, staff and key stakeholders were actively consulted with and involved to inform service operation and development. All we spoke with or surveyed told us management were accessible, approachable and took their views into account to help agree care and service provision. They also said they knew who and how to contact manager's if they needed to. We received many positive comments from people and their relatives about this. For example, "I can say with certainty - the place is very well managed and well organised;" "There is an open door policy;" "There are good working relationships and understanding, which makes for good care." All said they would recommend the service to family and friends.

Staff we spoke with described an open, positive and supportive culture where they were proud to work and felt they made real difference to people's care. We received many positive comments from them in relation to this and the management of the service. Examples of staff comments included, "Senior managers, trustees and our lead medical and nursing consultants – they are busy, but visible, always contactable and approachable;" and "Manager's, lead clinicians – they are all visible and supportive;" and "I love my job; I'm well supported to learn, develop and give the best possible care to people and their families." .

The service was well managed and led. Defined management and clinical governance arrangements provided clear lines of authority, responsibility and communication for decision making about the management, operation and direction of the hospice service and for people's care and treatment. Staff understood their roles and responsibilities for people's care. They told us they were regularly consulted and informed about related decisions, changes or improvements needed. This was consistently ensured via a raft of governance, business, clinical, generic and role specific team meetings and briefings, which circulated meeting minutes showed. The senior management team and chief executive medical director provided regular drop in and information sessions for volunteers and staff, who told us that they received regular supervision and formal appraisal of their work. Findings from the most recent independent staff survey show that most staff understood what the hospice wants to achieve as an organisation, comparing similar to other hospices surveyed.

The provider operated consistent and comprehensive systems to check the quality and safety of people's care. For example, there were clear systems for monitoring, managing and responding to any serious incidents relating to people's care and treatment through to hospice board level. This included reporting procedures, which staff understood; such as in the event of any medicines error, equipment failure or serious injury to any person receiving care. Records showed that all incidents were analysed and relevant findings communicated to staff, including any changes or improvements needed to people's care as a result. The provider had notified us of any important events that occurred at the service when required. This helped to ensure the quality and safety of people's care.

Staff consistently told us that learning from any incidents and complaints, was critical to help ensure people received safe, good quality care. They spoke positively about the way this was managed and described a culture of shared learning through anonymised reporting, with timescales for action and learning. For example, through additional training when required. A senior manager told us, "It's important that we

ensure critical care review, reflection and learning; to check how we communicate and promote this in a non-threatening way; it's about staff ownership, not blame." We found the provider had recently formalised their procedure for post incident 'critical care reviews.' This was to ensure staffs' formal support and reflection when required and share any wider emerging learning themes from this with all staff where relevant. This meant that the hospice board and managers knew about and took responsibility for things that happened in the service, to safeguard people from harm.

The service worked in partnership with key organisations, including the local authority, safeguarding teams, and clinical commissioning groups, to support care provision, service development and joined-up care. Links were established with the local general hospitals, universities, and relevant national organisations to support and inform palliative and end of life care; staff training and development. The provider also worked closely and consulted with external community professionals, who told us that hospice management strove to continuously improve the quality and people's care and support.

Senior leadership was visible, strong and supportive. The registered manager understood their responsibilities for people's care and their related legal obligations concerned with their registration. All staff we spoke with described a caring and dynamic organisation that continuously sought to improve people's experience of their care and treatment. The hospice is an organisation member of Hospice UK and the National Council for Palliative Care, which enabled cross sector support, sharing of good practice and service development initiatives. For example, measures were being introduced to review the quality and efficiency of end of life care from a national government initiative seeking to improve this.

The provider had either made or planned a number of service improvements, influenced by feedback from people, stakeholders and national initiatives concerned with end of life and palliative care. This included a review of community services against service demand; to continue to enable people who preferred to remain at home at the end of their lives. Comparative figures showed the provider had enabled more people to do so than the average percentage expected by national and local authorities during the period 2015-16. The provider's arrangements for staff moving and handling training and their safeguarding policy were under review to ensure they continued to match growing service demand and changes in national guidance. The provider was also seeking to review the quality and efficiency of their end of life care via a new national collaborative measure of assessment; known as the Outcome Assessment and Complexity Collaborative (OACC). This showed the provider consistently sought to develop and improve their service when required.

Senior staff were well supported to engage in relevant roles outside the service, to support and inform people's care. This included research development work and through membership of lead groups or councils concerned with end of life and palliative care. For example, the deputy chief executive officer was chair of a regional executive clinical leads group for hospice and palliative care. The director of clinical services was a member of the National Nurse Consultants in Palliative Care Group and also held membership at commissioning and local hospital steering groups concerned with end of life and palliative care. Other staff held positions of chair or memberships at a range of national or regional recognised groups concerned with people's care and treatment. For example, bereavement or lymphoedema care and treatment. This helped ensure nationally recognised practice was followed concerned with people's end of life and palliative care.

We looked at the provider's records relating to their forward strategy and business plan due to be formalised in the Autumn of 2016. This showed key service opportunities, challenges and operational considerations were taken into account, which reflected known directives and challenges for delivering specialist palliative and end of life care. For example, meeting the diverse, changing care needs and related population health demands. It included focus on people living with dementia who may require hospice care and workforce

planning requirements. The strategy was inclusive to external stakeholder voice. It linked to the hospice's fund raising and voluntary income strategies, which was important to ensure that it would be realistic and financially viable.

The hospice quality account report was published annually and provided information to the public, commissioners and other interested parties about the quality of the healthcare services provided by the hospice. We looked at the hospice published quality account for 2015-16. This assured that a high quality of care was being provided by the hospice service, which reflected the positive feedback we received from people, staff and external stakeholders at our inspection.