

Sue Ryder

# Sue Ryder - Nettlebed Hospice

## Inspection report

Joyce Grove  
Nettlebed  
Henley On Thames  
Oxfordshire  
RG9 5DF

Tel: 01491641384  
Website: [www.suerydercare.org](http://www.suerydercare.org)

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## Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

# Summary of findings

## Overall summary

This inspection took place on 2 and 7 February 2017 and was unannounced.

Sue Ryder Nettlebed Hospice provides palliative and end of life care, advice and clinical support to people with progressive, life limiting illnesses and their families. They provide holistic care including counselling and bereavement support for people and their relatives. There are 12 inpatient beds to support people with complex needs associated with their conditions. People access the hospice to support symptom control and pain management. People are supported with end of life care in the inpatient unit if this is their choice. The hospice supports people in their own homes through their community service and day hospice. On the day of our inspection there were 11 people using the inpatient service.

The hospice has a multi-professional team consisting of medical and nursing staff, social worker, spiritual care lead, family support workers and therapists. The hospice is also supported by volunteers.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On the day of our inspection the registered manager was not available.

Sue Ryder Nettlebed Hospice is an outstanding service. Its aim is to ensure people are supported with palliative and end of life care that meets the needs of each unique individual in a genuinely compassionate and caring way. The hospice understands that recognising the needs of relatives is vital and does this in a supportive and inclusive manner.

Throughout the inspection there was a calm and reassuring atmosphere. Staff spoke with people and relatives in a respectful manner and intuitively recognised people's moods and anxieties. All staff were welcoming and caring. Staff spoke with great passion about the work of the hospice and were clearly proud to be part of it.

People and their relatives were overwhelmingly positive about the medical care, support and guidance the staff team at Sue Ryder Nettlebed Hospice provided.

Without exception people and relatives spoke in an extremely positive manner about the caring nature of staff across the whole staff team. People and relatives were confident in the expertise of the staff and saw them as experts in their knowledge relating to palliative and end of life care.

Staff had access to training and development opportunities that ensured they had the skills and knowledge to support the complex needs of people using the services provided by the hospice. The emotional impact of working in a hospice environment was recognised and staff were offered a range of support to enable them to manage any potential impact. This included one to one support and the opportunity to reflect in a

group environment. Staff were positive about the training and support they received.

People and their relatives told us support was individualised. Care was designed and developed with the individual to ensure their needs were met in the way they chose. The hospice went to great lengths to ensure people were able to receive their end of life care in the place of their choice. People and relatives gave examples of staff going the 'extra-mile' to ensure people could achieve their preferred place of death.

People were provided with information and advice to ensure they were able to make informed decisions. Where people were assessed as lacking capacity in relation to a specific decision their rights were protected in line with the Mental Capacity Act (MCA) 2005.

Staff across all disciplines worked cohesively to ensure people's needs and wishes were met. People moved seamlessly between the services provided at the hospice and multi-disciplinary team meetings ensured people's needs were understood by all teams supporting them.

Bereavement support was individualised for each family member and was provided with empathy and compassion. Relatives spoke of the enormous difference the support had made to them. Relatives were able to access the support for as long as they needed it and many became involved as volunteers or as part of the service user group.

Everyone we spoke with was overwhelmingly positive about the management of the service. Their commitment was seen by all as the driving force behind the outstanding care provided to people and their relatives at Sue Ryder Nettlebed. There was extreme confidence in the management team which was seen as the reason for the outstanding achievements the hospice made for each individual.

The management team were committed to improving palliative and end of life care both locally and nationally. They encouraged staff to participate in local and national forums to share good practice and to inform developments in practice. Staff at every level were positive about the support they received and were extremely confident they were valued and listened to.

Governance of the service was excellent and quality assurance systems were in place that ensured continual monitoring of the service to identify ways to develop and improve the care people received.

## 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 supported by staff who had a clear understanding of their responsibilities to identify and report any concerns relating to abuse of vulnerable people.

There were sufficient staff at every level to meet the needs of the people accessing the inpatient unit, day hospice and community support service.

Risks to people were identified through risk assessments. Where risks were identified management plans were in place to ensure risks were managed in a way the people wanted.

Medicines were managed safely. People were supported with their medicines by staff who were appropriately trained and competent to do so.

Good 

### Is the service effective?

The service was effective.

Staff had access to training and personal development to ensure they had the appropriate skills and knowledge to support people with professionalism and compassion at the end of their life.

Staff received excellent support. Staff benefitted from regular supervisions in relation to their clinical practice. Staff had various methods of spiritual and emotional support to ensure the impact of working in a hospice environment was recognised and managed.

People were supported in line with the Mental Capacity Act 2005 (MCA). Staff promoted people's wishes and there was a strong emphasis on ensuring people's best interests were at the centre of all decisions.

People's health needs were closely monitored and appropriate medical expertise was sought to ensure people experienced peaceful and pain free end of life care.

Good 

### Is the service caring?

The service was very caring.

Without exception the feedback from people and their relatives about the caring nature of all staff was exceedingly positive.

Staff showed exceptional empathy for people and their relatives. There were many examples of staff taking exceptional action to ensure people were supported to achieve their end of life wishes.

People and their relatives had access to emotional support and counselling which helped them to manage their fears and come to terms with their situation.

People were completely involved in every element of their care and were in control of how their needs were met. People were given information, guidance and advice to enable them to make informed decisions.

Outstanding 

### Is the service responsive?

The service was very responsive.

People received support from a service that was flexible and responded to changing needs in a timely and effective manner.

Feedback from people and their relatives about the responsiveness of the service and the impact it had was overwhelmingly positive.

People were supported to develop and maintain relationships to reduce the risk of social isolation. People were encouraged to take part in activities and access alternative therapies to help them manage any anxiety caused by their condition.

Outstanding 

### Is the service well-led?

The service was very well led.

The service was managed by an outstanding management team who provided leadership that ensured people were at the centre of all the service did.

There was an extremely strong culture of openness and honesty that ensured people, relatives and staff felt valued and listened to.

Outstanding 

The service developed relationships with other organisations to inform and support services in palliative and end of life care both locally and nationally.

There were extremely effective auditing systems in place to ensure the quality of the service was constantly monitored and actions taken to drive continuous improvement.

# Sue Ryder - Nettlebed Hospice

## **Detailed findings**

### Background to this inspection

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

This inspection took place on 2 and 7 February 2017 and was unannounced.

The inspection was carried out by two inspectors, a pharmacy inspector and a specialist advisor in palliative care.

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 also reviewed notifications of significant events that affect the health and safety of people who used the service.

We spoke with eight people who used the service, ten relatives and one health professional. We also spoke with the hospice director, the registered manager from another location, the service improvement manager, the finance officer, the social worker, one family support officer, one medical practitioner, a ward manager, five nurses, two nursing assistants, a physiotherapist, the spiritual care lead, a befriender, a volunteer, a fundraising officer, the domestic supervisor, the cook and an engagement champion. We looked at seven people's care files, three staff files and other records relating to the management of the service.

## Is the service safe?

### Our findings

Without exception people felt safe using the service. One person told us, "I feel very safe. I am delighted I got in here". Relatives were equally confident that people were safe. Comments included: "I think it's comfortable and safe. You feel [person] is going to be fine, to be cared for"; "They are rigorous about things like security. For example, the doors being shut after hours"; "Yes it is very safe, very reassuring" and "They [people] were in extremely safe hands".

Staff had completed training in relation to safeguarding vulnerable people. There were regular training updates to ensure staff maintained their skills and knowledge in this area. Staff had a comprehensive knowledge of their responsibilities to report concerns and who to report them to. Staff were confident concerns would be taken seriously and timely action taken to resolve any issues. One member of staff told us, "I would tell a senior member of staff and if nothing happened I would definitely report higher or go outside of the organisation if I needed to. I would go to social services".

There was a qualified social worker employed by the service. Where issues relating to potential abuse were identified, the social worker liaised with the local safeguarding authority. The social worker told us the importance of working closely with people to ensure they had the outcome they wanted and were supported to feel safe.

There were safeguarding policies and procedures in place. All concerns were investigated and immediate action taken to protect people from harm. Issues raised in relation to the care people were receiving were thoroughly investigated and learning taken to reduce the risk of reoccurrence. For example, where people developed pressure sores a detailed root cause analysis was conducted to ensure all appropriate action had been taken and identify where improvements could be made.

There were sufficient staff to meet people's needs. One person told us, "There are always lots of staff and all are very helpful". A relative told us, "Anybody will help you at any time". We saw that any requests for support both in the inpatient unit (IPU) and day hospice were responded to immediately and staff were always available to spend time talking with people or relatives. People had access to call bells and when activated they were answered promptly.

When people or relatives accessing community services required support they told us staff were always available. One person said, "I can pick up the phone at any time and they will always be there and they will always help me".

The hospice had up to date policies and procedures in place to ensure medicines were managed safely. A community pharmacy checked levels of stock medicines, prepared orders and delivered to the hospice twice a week. Stock lists and quantities of medicines were reviewed to ensure medicines were available to people when they needed them. There was a process in place for removing expired medicines to ensure they were not used.



In-house doctors prescribed medicines for people admitted to the hospice. A clinical pharmacist, from a local Hospital, visited the hospice twice a week and checked that the prescribing was safe.

Peoples' own medicines and stock medicines, including emergency medicines and oxygen were stored appropriately. Medicines requiring refrigeration were monitored and temperatures recorded were within range. Unwanted medicines were disposed of in line with waste regulations. Medicine safety alerts (alerts that are issued nationally regarding faulty products) were sent to relevant staff and records demonstrated that appropriate action had been taken.

Nurses checked people's own medicines on admission to the hospice to ensure they were safe and appropriate for use; these were stored in secure medicines trollies. People did not usually administer their own medicines. There were no lockable facilities in people's rooms to enable people to keep their medicines and self-administer them. However, the nurse said people could ask the nurses to fetch their medicines if they wanted to take their medicines themselves.

We saw that all nurses working at the hospice had their competency assessed to ensure they administered medicines safely. A nurse, who was newly employed by the hospice, had received a comprehensive induction, including supervision by a senior nurse and assessment of her skills.

We observed medicines being administered in a caring manner; nurses talked to people about their medicines and asked about their pain. Medicines administered were documented appropriately.

Nurses had access to current guidelines on medicines safety and specialist decisions about using unlicensed medicines were made by multi-disciplinary teams, including consultants and pharmacists.

Medicines errors and near misses (errors that are identified before the medicine reaches the patient) were reported and investigated. Any issues identified in relation to staff practice were addressed. Staff were supported to complete additional medicines training and their competence was assessed prior to them administering medicines unsupervised.

Staff carried out medicines audits and results were discussed at team meetings. Meetings were attended by the clinical pharmacist and we saw evidence that meetings were also used as training opportunities. For example, a mental health pharmacist was invited to talk about managing depression, anxiety and insomnia.

People's care records included risk assessments and where risks were identified there were plans in place to manage the risks. Assessments included risks associated with moving and handling, falls, pressure damage, nutrition and pain. Management plans included details enabling staff to support the person to manage the risk. For example, one person was at risk of developing pressure sores. The care plan identified the person required pressure relieving equipment and to be encouraged to be repositioned. Risk assessments were reviewed regularly to ensure management plans reflected the person's needs and how they would be met. For example, one person had a falls risk assessment which was reviewed daily as their condition was deteriorating.

There were effective systems in place to manage infection control. For example, there was antibacterial hand gel at various points in the building for staff and visitors to use. Visitors were encouraged to use the hand gel in reception when they entered the building. Staff told us about the procedures they followed to prevent and manage potential outbreaks of infection. We saw that protective equipment, such as aprons and gloves, were readily available and utilised by staff and volunteers. Bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices. The building was clean and

had a pleasant odour. One member of the domestic team told us, "Every Monday morning we get together with my manager and we choose a different area to inspect and try to find any possible improvements (relating to infection control)".

The service followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people. These checks were also completed for all volunteers supporting the service.

## Is the service effective?

### Our findings

People were extremely complimentary about the skills of staff supporting them. One person told us, "Staff seem very qualified for their role. Doctors and nurses are great and well organised". Relatives were reassured by the skills of staff supporting people. Relatives comments included: "They always know what to do to make [person] comfortable" and "Staff are very knowledgeable, especially the nursing staff".

Staff were complimentary about the support they received. Staff comments included; "They (management) are always supportive. They have a very positive approach" and "I have excellent support".

Staff showed excellent skills and knowledge when supporting people. We observed staff talking knowledgeably with people about their condition. Staff were able to make informed suggestions about symptom management and gave clear explanations in relation to treatment plans. Without exception staff were able to answer people's questions in a reassuring and confident manner. One person told us, "They (staff) have such expertise. If they don't know the answer they will always find out".

All staff had regular supervision, which they valued and told us they were always encouraged to raise any issues or concerns. Where staff required clinical supervision in relation to their specific profession this was provided by professionals outside of the service. For example, there was only one social worker in the service who told us they had supervision with their line manager but that peer supervision had been arranged with a social worker from another service. Clinical supervision is an activity that brings practitioners together to reflect upon their practice and identify areas for development.

At every level there was a clear understanding of the emotional impact working in a hospice environment may have on staff. One member of staff said, "Management acknowledge the work is emotionally difficult and will always offer help and support". Staff were extremely positive about the pastoral support they received. One member of staff told us, "There is always someone to talk to. The spiritual care lead is always available and I have had a few impromptu one to ones with him". All staff spoke positively about the spiritual care lead and how supportive staff found the conversations they had with him. Staff told us the spiritual care lead had an open door policy and would hold individual and group meetings with staff to help them reflect and resolve issues.

The hospice used the nationally recognised practice of 'Schwartz' rounds. Shwartz rounds enable staff to come together in a supportive environment and reflect on the emotional impact of working in the hospice. Staff were encouraged to share experiences and support each other. Staff were positive about the support the sessions provided and valued the time spent with each other discussing the impact of their work.

The management team supported learning to improve the quality of service and the experience of people. Morbidity and mortality meetings were held to reflect on cases where there were areas of learning to promote quality improvement. There were also focused journal club education sessions that promoted learning around specific conditions or events to enable staff learning and development. For example, the service had supported a person with a learning disability with end of life care. Staff had recognised the

importance of gaining the person's trust and the different skills staff had gained from working with the person and their family. As a result a journal club education session had been arranged to enable staff to reflect on the experience of working with the person. The session supported the development of staff knowledge to ensure people with a learning disability received high quality palliative and end of life care.

The management team were proactive in supporting staff to identify development opportunities. One member of staff told us, "I regularly have a one to one with [registered manager], she has asked me where I want to go in relation to my career and the service and is responsive to suggestions".

Staff were extremely positive about the training and development opportunities they were given. Staff comments included: "I've had lots of training opportunities to develop a career pathway and currently applying for secondment to do my nurse training".

Training was delivered by a variety of methods, including e-learning, classroom based activities and input from external trainers. All training was based on current best practice. A training matrix identified the training staff and volunteers had completed. A wide range of training was on offer and included fire safety awareness, equality and diversity, moving and handling, and infection control. There was specific clinical practice training available which included medicines, male catheterisation and prevention of pressure ulcers. In addition, all qualified nurses were supported to undertake a degree module in palliative care and nursing assistants were supported to undertake a foundation degree in order to progress their career options for a full degree in nursing.

The service supported staff through Nursing and Midwifery Council (NMC) revalidation process. The revalidation is the process that allows nurses to maintain their registration with the NMC and demonstrates their continued ability to practise safely and effectively.

Staff completed an induction that was relevant to their role. The induction training for health care assistants was linked to the Care Certificate. The Care Certificate is a set of 15 standards that gives everyone the confidence that workers have the same induction and learn the same set of skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The hospice contributed to sharing best practice with other health and social care providers. Collaboration had been undertaken with local universities which specialised in health, social and community care qualifications. A specialist training course in pressure ulcer care had been provided by one of the lecturers from the university to all the health care staff at the hospice. Staff from local care homes and domiciliary care agencies had been invited to share the training. The training had proved to be particularly successful and well received. We were provided with records of positive feedback from staff regarding the training course. One member of staff wrote, "The whole session promoted positive conversation that will filter down to the ward and how best to prevent and manage pressure ulcers". Another member of staff wrote, "I learned the best use of dressings for the different types of wounds we see and the way we can best heal them". This meant that people using the service and those in the wider care homes and community settings were supported by staff who were able to recognise and effectively manage pressure ulcers.

People were positive about the food they received. One person told us "I think the food is excellent. It's cooked very well, the portions are just perfect. You can have what you like. If it's not on the menu they will prepare it for you". A relative who had sampled the food said, "The food is excellent and always looks very pretty and appetising".

The chef was passionate about providing food that people enjoyed. The chef told us, "I have prepared the

menu to accommodate the needs of people. I'm here for the patients. I know that they may want to eat something that is not on the menu and we are prepared to do this".

Patients were supported to eat and drink in a way that met their individual needs and preferences. On the day of the inspection, people were asked what they would like to eat and drink. People had meals in the privacy of their rooms if this is what they asked for. Staff went out of their way to ensure people had access to food they enjoyed. For example, one person had requested berries to eat. The nurse immediately requested these from the kitchen staff and they arrived on the ward in a short time.

We saw staff updating the chef with people's choices and they discussed alternative ideas for the nutrition of people who lacked appetite. Staff made suggestions to help people decide what they might like if they did not want what was on the menu.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had a clear understanding of MCA and how to use the MCA in practice to ensure people's rights were protected. Staff had completed training in MCA and knew where to go for advice and guidance. One member of staff told us, "I always assume someone has capacity. If I was unsure I would go to a senior member of staff to discuss. There can be cognitive issues for people and their capacity can change. It's about getting to know people well and ensure we are always acting in their best interests if they have not appointed a lasting power of attorney".

Staff were given on going support and guidance to improve their knowledge in relation to MCA. For example, notes of a team meeting showed there had been a discussion around people declining to be repositioned which increased the risk of pressure damage. The discussion had enabled staff to consider the person's wishes and how to ensure they understood the risks related to their decision.

There was a social worker on the team who was able to support people, relatives and staff in relation to any concerns relating to a person's capacity. The social worker was a qualified best interests assessor and supported people in a way that ensured their identity was maintained. Staff were positive about the impact having a social worker on the team had on ensuring people were supported in line with MCA. One member of staff told us, "Having [social worker] on the team has been fantastic. He challenges us when we are making decisions; pulls us back and reminds us who we are there to support. Family dynamics can be complex and [social worker] is good at reminding us we must put the best interest of patients first".

People's care records included clear instructions regarding people's resuscitation status and there was evidence to show this had been discussed with people and relatives. Where people had made advanced decisions in relation to their care and treatment this was documented. The social worker supported people to make advanced decisions where this was requested.

Records showed that people's decisions around the level of consciousness they wished to maintain during their end of life care had been discussed and were clearly documented.

People's health needs were met by a range of health professionals during their stay in the inpatient unit and

when being supported in the day hospice and at home. Professionals included: specialist palliative care consultants, palliative care doctors, GP's, occupational therapists, physiotherapists, complementary therapists and community nurse specialists. There were excellent methods of communication between the various health professionals to ensure people received seamless care when accessing the various services provided. A local GP who supported people accessing the service told us, "Over the years we have developed a very strong relationship. The referral process is good, they will do everything they can to admit people. There is good communication particularly around discharge information".

## Is the service caring?

### Our findings

There was a unique caring ethos throughout the service. People and their relatives described their feelings about the service as: "It radiates care and tranquillity" and "It is a haven of peace and kindness".

People and their families developed meaningful relationships with staff at every level. Without exception staff were found to be caring and considerate. People's comments included: "I'm absolutely amazed about the level of how we are looked after. I didn't imagine the service like that may exist"; "Staff are fantastic. I wouldn't have managed without them" and "It is absolutely brilliant support. They have changed my life and they have such a brilliant attitude".

It was clear that the kindness shown to families was hugely helpful and appreciated. Relatives comments included: "It's been absolutely amazing. Everyone has been professional and caring. They are offering us different types of counselling"; "We stay awake with night staff. They always remember your name, offer you refreshments and explain things. The patient is the most important person to them. They explained everything to [person] so he receives the real version of what is happening" and "It's the palliative care at Sue Ryder, the actual caring for each person. You see it. Not just with [person] you see it. You see it with nurses, doctors, with everyone. They know everything and they listen. It's not just the patient, the person with the cancer or the terminal diagnosis. It's the person closest to them as well that they take such care of".

Staff were highly motivated and inspirational in their willingness to provide care that was kind and compassionate. Staff spoke with passion and commitment when speaking about the people they supported. Staff comments included: "The staff here are all so caring. It's the people and their relatives that are important to us all"; "Patients and their families are at the forefront of everybody's mind and everything we do" and "We are about empowering people and supporting relatives"; "We provide excellent care. All of the staff feel passionate about what they do".

We found many examples where staff had taken exceptional steps to ensure people's wishes were met, showing compassion and empathy for people as individuals. For example, one person had been distressed when they had to leave their pet tortoise at home. A member of staff who kept pet tortoises offered to 'adopt' the person's tortoise and brought it in regularly to the inpatient unit to visit the person. Another person had wished to get married in the hospice. The staff had arranged the event and the spiritual lead carried out the service.

A person in the in-patient unit had requested to go home to meet their solicitor and put their affairs in order. The staff across the hospice worked cohesively to ensure the person's wish was fulfilled. For example, additional staff were trained and insured to take the person home on the hospice mini bus. An occupational therapist made a visit to the person's home to ensure everything was in place to make the person comfortable and a nurse from the inpatient unit visited to ensure medical supplies and equipment were available and in working order. Through the commitment of staff the person was able to fulfil their wish to meet their solicitor in the privacy of their own home.

Staff went out of their way to ensure people felt comfortable and supported in the environment. We heard from staff how they had supported one person who had experienced substance misuse. The person was initially reluctant to engage with staff and made a comment on the "intrusive nature of care". Staff took time to build a relationship with the person ensuring all the support was led by the person. As the relationship with staff developed the person began to disclose some of the problems they were experiencing. This resulted in staff supporting the person in a way that promoted their independence and enabled them to fulfil their preferences. As a result of the support the person's health improved and they were discharged home with support from the community team and a referral for the day hospice. The person was readmitted some time later as they had chosen Sue Ryder Nettlebed Hospice as their preferred place to die. Staff told us the person had experienced a positive and safe environment which had enabled them to explore their health and social needs and maintain control over their life. .

During the inspection we spent time in the day hospice. There was a cheerful atmosphere with people, staff and volunteers chatting and laughing together. People had clearly built relationships with each other and with staff. One person told us, "It's amazing. Staff remember how you have been from the week before and always ask how we're doing". Staff were extremely intuitive of people's needs. We saw staff approach people and take them into a private place to talk if they needed one to one support. It was clear people were comfortable and confident with staff asking them openly about issues relating to their conditions. Staff responded openly to people's questions and concerns whilst ensuring they respected people's privacy and confidential information.

The hospice provided a comprehensive and flexible support and bereavement service which ensured the individual needs of people and their families were met. People were able to access support from a family support team and a spiritual care lead. People were supported to work through relationship issues, grief and loss and supported to adopt coping strategies. One family support worker told us, "We offer one to one counselling for relatives and family members; for those struggling to come to terms with their diagnosis".

Relatives were extremely positive about the support they received both during a person's illness and after their death. Comments from relatives included: "My [another relative] has found it very useful (counselling). She was able to talk freely which is important. The spiritual counsellor was also really good, allowing [person] to express his concerns" and "I had counselling and it helped me massively".

The family support team were proactive in ensuring bereaved relatives were aware of the support they could access following a person's death. Letters were sent to bereaved families a few weeks after death to offer them support, either in the hospice or in their homes. Relatives were able to continue accessing bereavement and emotional support for as long as they needed it after a person's death. One bereaved relative told us they were always made to feel welcome at the hospice and could speak with the spiritual care lead at anytime if they felt they needed on going support.

The spiritual care lead provided spiritual, emotional and religious support to people, families and staff, regardless of their beliefs, culture or community. Support was offered on the inpatient unit, day hospice and community settings. People were encouraged to talk about their worries and explore ways of coming to terms with their anxieties and fears. One person living in the community had been extremely anxious about their condition and their family relationships. The spiritual care lead and social worker made many visits to the person in their home to help them understand, manage and resolve their anxiety. The spiritual care lead had facilitated a meeting with the person's family at the hospice to encourage the family to talk about their issues and to find a resolution. All the family attended and there were positive outcomes for the person and the family. Despite the person moving out of the area the spiritual care lead kept in regular contact with the person to enable them to be supported by someone they had learnt to trust and seek support to manage



their anxieties.

The support services worked alongside relatives, supporting them and the people accessing the service. Relatives were supported to discuss their concerns about people's on going care needs and to reflect on the impact the caring role had on them. The relative of a person who had been admitted to a care home told us, "They were always there for me and still call me and check up on me. We are now arranging for them to visit me and they have gone to visit my [person in the home]".

The service recognised the importance of remembering those who had died and held an annual remembrance event known as 'Light of Love'. It was clear relatives found this event therapeutic and enjoyed being involved in the planning and implementation of the event.

Staff were skilled in supporting people to understand their conditions and their ongoing options in relation to their medical and care needs. People felt able to have difficult conversations with the staff who assisted them to make plans and decisions relating to their end of life care. One person told us how staff had supported them to complete a 'Do not resuscitate' form. The person said, "They talked me through what I want to do and they handled it very well". People were supported to complete advance care plans which detailed the person's preferred place of death and their wishes following death.

## Is the service responsive?

### Our findings

People and their relatives told us the hospice had a huge impact on their lives from the moment they had contact with the service. One person attending a well-being session in the day hospice told us, "I was in a very dark place when I first came here. They [staff] gave me one to one sessions until I felt able to cope. Now I look forward to coming here because it's me time and I don't have to worry about anyone else".

Relatives comments included: "On our first visit to Sue Ryder we just pinched ourselves to say is this for real? You couldn't buy this; you cannot buy this care that they give. You can't put a price on it"; "Just amazing, you can't put it into words. I wouldn't be coping as well as I am now if they hadn't been there for me, it was just so wonderful"; "It was as though [person] had come home and was amongst friends" and "The moment [person] arrived they became calm, it was like coming home".

People's care was planned with them to meet their health, social, emotional and spiritual needs. Staff from all disciplines worked together to ensure people's needs were met holistically. Multidisciplinary meetings were held weekly and were attended by staff from the inpatient unit, community service and day hospice. Staff attending included: medical and nursing staff, family support staff, social worker and the spiritual care lead. Each person's needs and wishes were discussed to enable staff to develop a care plan that reflected what the person wanted to happen and how staff would help the person achieve this. Care plans detailed how people's needs were met and showed they were reviewed daily or more often if a person's condition changed.

There was exceptional multidisciplinary working that enabled people to access help and support from across the disciplines within the service. For example, a relative described how they contacted the hospice in desperation on Christmas morning. Their relative had been discharged from hospital on Christmas Eve and the relative did not know what to do with the person's medicines. Although not known to the service the hospice staff offered to arrange a visit from a community nurse. The relative declined the visit but accepted help from the hospice staff to contact the hospital regarding the person's medication. The hospice staff contacted the hospital and arranged for the correct medication to be delivered. The medication was delivered on Boxing Day and the person was visited by a Clinical Nurse Specialist from the hospice who supported the relative to understand and feel confident to administer the medicines. The relative was encouraged to call the hospice at any time if they were unsure or concerned. The relative said, "You can't get hold of a hospital ward at 6am. You can dial 999 but you know, who wants to rush [person] into a hospital. I just wanted [person] cared for. I mean that is the word – care. Sue Ryder helped. At least I can ring Sue Ryder 24hrs and it's calming. They've got medical knowledge and they care. It's that care word, palliative care. People are frightened of it but it's not frightening. They care for patients; they know what they're going through".

People and their relatives spoke highly of accessibility to any service at any time of day and night. For example, one person was being supported by the community team who were liaising with the inpatient unit to arrange a future admission. Over a weekend the person experienced a fall. The person's relative called the hospice in a distraught state explaining the emergency services were going to take the person to the acute

hospital. Hospice staff spoke with the medical staff on call who agreed to come into the hospice and arrange for an admission to the inpatient unit. The hospice staff then arranged for the emergency service to bring the person to the hospice, where they were able to be supported in an appropriate environment.

Another relative told us how hospice staff had supported them when they had a crisis at home. The person's condition had deteriorated suddenly. The relative contacted the hospice who immediately arranged for one of the community staff to visit. The hospice had immediately arranged for some additional equipment and support as the relative wanted to be able to continue caring for the person at home. Following the crisis it became clear the person needed specialised care. The social worker supported the family to look at care homes and arranged for the admission. The relative told us, "Sue Ryder organised the hospital bed in a crisis, organised the ambulance to take [person] to the nursing home. They organised it all they were absolutely fantastic. They liaised with everyone on my behalf". The relative told us the social worker was still supporting them with "form filling". The social worker had also been to visit the person in the nursing home to ensure they were settling in to their new environment.

The hospice had a befriending service. Befrienders were recruited on a voluntary basis to help people to live the fullest life possible by offering emotional and practical support. The befriending coordinator told us how they 'matched' people together to ensure people got the very best out of the service. For example, one person wanted to create memories for their grandchildren as they were worried they would be forgotten after their death. The befriender visited the person, building a relationship that enabled the befriender to support the person to complete the mementoes for their grandchildren that were so important to them. Another person was diagnosed with a neurological condition that affected their ability to read. The befriending coordinator identified a befriender with a clear, pleasant voice to visit the person and read to them. As the relationship developed the befriender began to record the person's memories for them. This provided meaningful social interaction for the person and reduced their feeling of social isolation.

People were treated as individuals whatever their condition and regardless of race, gender, sexuality or any other aspect of their lives. The hospice ensured everyone accessing the service was treated equally and were responsive to people's diverse needs. For example, a person with a learning disability was admitted to the inpatient service. The person was extremely frightened on admission. The person declined to be examined and was reluctant to let staff support them in anyway. This included declining pain relief. Slowly, with the help of a relative, nursing and medical staff worked to gain the person's trust learning how to approach them, what foods and activities the person preferred and taking time to gain their confidence. The service ensured the person was supported by staff they had got to know and trust. The person received individualised care that enabled the person to have high quality end of life care.

The day hospice ran three days a week and included a well-being morning and a long term conditions programme. The well-being session enabled people to access alternative therapies and activities. During our inspection people enjoyed a yoga session. One person told us, "The yoga is wonderful". Another person told us how they had been encouraged to do some artwork. The person said, "I do it at home and it helps me to lose myself. It's a real achievement and something positive. I want to get better at it. It's all thanks to Sue Ryder". People were positive about the impact of attending the weekly well-being sessions; they valued the expertise and kindness of the staff and the support and relationships they had built with other people attending the day hospice. People told us how the sessions met both their social needs and provided emotional support. Comments included: "We do a bit of everything; chair based exercise, yoga, reflexology, chatting with the others. It makes me feel normal"; "It's brilliant. They (staff) ring me if I don't come in to check I'm alright" and "We've built a community".

Staff went to great lengths to ensure people were supported to maintain relationships that were important

to them. Staff recognised the uniqueness of family relationships and the complex dynamics that these relationships could present. For example, staff told us how they had supported a person's visits from a relative who was homeless. The hospice staff had arranged for the relative to erect their tent in the hospice grounds to enable them to be close to the person and visit often. The relative had not wanted to make use of the family accommodation in the hospice so staff had supported an alternative arrangement that satisfied the relative and reassured the person in the hospice that their relative was safe.

The hospice had supported a married couple to stay on the inpatient unit when one of the couple was nearing the end of their life. This person had been the informal carer for their partner and it was the couple's wish to be together. Following the person's death hospice staff supported the family and remaining partner to make difficult decisions about their on going care provision.

There was accommodation for relatives to enable them to stay close to people. The accommodation had been designed to create a calm, relaxing atmosphere that helped relatives to spend some time away from the ward in a comfortable environment. One relative told us, "They have terrific family accommodation. I have stayed a couple of nights and they could not have been more helpful. Offering me food and showing concern for me to make sure I was comfortable".

People and their relatives knew how to raise concerns and were confident that any concerns would be taken seriously and resolved promptly. Comments included: "I was given the leaflets (complaint information) when I was admitted but I've had no need" and "If I didn't like something they would change it for me". There were clear complaints procedures and these were displayed in the service. There were few complaints received by the service but all complaints were taken seriously, investigated and responded to in line with the policy. All complaints were taken to the monthly quality improvement group who reviewed actions taken and any learning to improve the quality of the service. For example, one person had complained about the noise from the floors on the ward. All staff were advised to wear soft soled shoes to minimise the noise and the quality improvement group were looking at alternative floor coverings to address the issue of noise.

## Is the service well-led?

### Our findings

The hospice promoted an open and caring culture that valued the uniqueness of people. Everyone involved in the delivery of the service was committed to ensuring people and their relatives were at the centre of everything the service did.

There was a clear management structure that drove the person-centred culture ensuring people and relatives experienced high quality care and support when people were receiving palliative and end of life care. Relatives who were involved with the service and the staff spoke of the commitment and passion of the management team that had resulted in continual improvement of the service.

People and their relatives were overwhelmingly positive about the management of the hospice and in particular the hospice director and the registered manager. Comments included: "Their (registered manager and hospice director) determination not to be thwarted by difficulties is immense. They have constant determination to improve absolutely everything in every way"; "Nothing is left unturned. [Registered manager] attention to detail is phenomenal" and "Despite financial constraints they (management team) are still driving forward. I have immense admiration for [registered manager] and [hospice director], their conscientiousness is immeasurable. They are kind and caring to everyone; patients, staff and the user group. Their standards are exemplary and they are imaginative"

Staff at every level were exceptionally positive about the hospice management team and the inclusiveness promoted with staff across the disciplines. Comments included: "The whole structure runs smoothly. I'm quite happy with what I am doing and the support I receive from the manager"; "I am very supported by [registered manager]. We have a shared passion for developing the long term condition programme"; "The service is managed enthusiastically and proactively"; "I am extremely well supported. Communication is very good. [Registered manager] and [hospice director] are very approachable, they would listen and act. There is definitely an ethos of openness"; "There is a very open culture. We are well respected, valued and listened to. I feel my feedback is really well received"; "What's really struck me is the team is very warm and reflective. I have been made very welcome and everyone is very open and receptive to shared ideas" and "It was a very, very good move for me. [Registered manager] is particularly open to ideas and suggestions. I definitely feel listened to".

There was an established service user group whose members were involved in every aspect of the development of the service. The service user group were responsible for the development of the family accommodation at the Hospice. The registered manager had supported the group to put forward a financial bid for funding to develop the accommodation. The registered manager had supported the group to look for innovative ways to achieve a supportive and welcoming environment for relatives within the constraints of the budget. For example' the group had been supported to use the hospice links with the community to involve local people on a voluntary basis to design and decorate the accommodation. Relatives who used the accommodation were positive about the difference being able to stay in the accommodation had on the additional time they could spend with people and the ability to have a space to go to when they needed to be alone.

A member of the service user group attended the quality and improvement group (QIG) meetings. One member told us how welcome they were made to feel at the QIG and that the registered manager always took time to explain issues to them and involve them. They described the meetings as "open and honest" where issues were discussed openly and without blame; with an emphasis on solving problems and improving the service. The service user group member told us their presence at the QIG meetings enabled them to 'provide a patient perspective on care, effectiveness and safety'. They felt the QIG was open to challenge and listened and acted on ideas made. The QIG had improved the communication with people accessing the service as the service user group member had raised concerns about people's understanding of the hospice service. The service ensured that people understood the role of the hospice which prevented anxiety and misunderstanding when they accessed the hospice services.

The service used feedback from people, relatives and staff to inform improvement and development. For example; a new call bell system had been installed. One nurse told us how staff had provided feedback that the call bell units could not be attached to people's beds and continually slipped out of people's reach. The management team took the concerns seriously and found a device that enabled the units to be attached to bed linen. Although this appeared to be a small issue the management team recognised the impact on people's anxiety if they were unable to summon support when they needed it.

The hospice was committed to continuously improving services and looked for innovative and imaginative ways to do so. For example, the service had introduced a long term condition programme. The programme was aimed at providing information, guidance and support to people who had been diagnosed with long term conditions in order for them to have better understanding and plan for the future. After the completion of the first programme people were asked to feedback about their experience, this feedback was used to develop and improve the programme. For example, the structure of the sessions was changed to enable people more time to discuss their concerns. Additional information relating to coping strategies and alternative therapies had been added. One person told us, "They took my feedback on board and I am discussing with them the development of a session for younger sufferers". People were positive about the impact of the programme. One person told us of the positive impact a massage had on their pain management after staff had encouraged them to try a massage and had arranged for it to take place at the hospice.

Professionals supporting people with long term conditions were extremely complimentary about the impact the long term condition programme was having for people. One health care professional stated, "To know that you are actively encouraging some of these patients to come to day care is wonderful and so good both for them and their carers".

The service worked in a collaborative way with many support groups. For example, a representative from a group supporting people with Progressive-supranuclear-palsy (PSP) had approached the hospice to ask if they could use the hospice as a meeting place. The hospice had responded and suggested working together to ensure the hospice was not used merely as a meeting venue, but to help engage group members in other suitable activities so that they could benefit from the hospice services as a whole.

The registered manager and hospice director were committed to sharing good practice and learning from national developments in order to drive improvement in palliative and end of life care across the sector. There were many examples of the hospice accessing development opportunities for staff within the service and encouraging membership of both local and national forums. For example, the development and implementation of the long term condition programme had been shared with a professional forum for Hospices by the registered manager to encourage other hospices to develop their support for people with long term conditions.

The registered manager supported the development of the compassionate employers programme by NCPC which is a measure of organisational commitment to support employees facing end of life and those bereaved. The registered manager presented the programme to a large national retail company who then invested in the initiative. The registered manager used their clinical experience gained from carers and the reaction of their employers to dying and bereavement to promote the initiative which resulted in better understanding.

One of the medical consultants in the service took a specialist lead in End of Life care for the Thames Valley Strategic clinical network. This promoted good practice and service innovation across the region. The specialist lead role involved sharing national work at a regional level. The medical consultant had also been supported to maintain their role as Trustee of National Council of Palliative Care and Dying matters. The management team recognised that this role had a value and benefit to end of life care for people accessing the services provided by Sue Ryder Nettlebed and to those outside of the services provided by Sue Ryder.

The hospice director was passionate about the service and developing the care provided for people at the end of their life. The hospice director was involved in several projects to drive improvement and development in palliative and end of life care in the county. This included membership of an End of Life Care Reference Group, this was a group for local end of life care providers led by the local Clinical Commissioning Group. The director was actively involved in the development of a palliative advice line for the county to provide a coordination service supporting people and their relatives in relation to end of life care. The director told us that the service was planned to be based at Sue Ryder Nettlebed and would provide a 24 hour 7 day a week service that would improve the support available to people and their relatives. People and relatives would benefit from advice and guidance from staff with specialist knowledge of palliative and end of life care.

The hospice director was also involved in the development of closer working relationships with local health trusts and ambulance services to provide better access to and understanding of hospice services. For example, the director was working with a local NHS trust who were developing an end of life domiciliary care service to enable people to remain in their own homes. The director told us the plan was for staff from the NHS trust to integrate into Sue Ryder Nettlebed in-patient unit and clinical nurse specialist teams to ensure their clinical skills were kept up to date. This meant that additional people would be able to be supported by skilled staff in their own homes and avoid admissions to acute hospitals.

Health professionals were complimentary about the management of the hospice. One health professional told us, "They are supportive of developing relationships with the community and of sharing information, explaining what they do to the community". The health professional was the lead for the local Gold Standards Framework group and was complimentary about the involvement of the hospice staff in attending the group and their willingness to share their expertise. The health professional told us, "They are excellent; there is always at least one member of the team that attend the meetings".

There were a large group of volunteers actively involved in the daily running of the hospice. They played an important role in a variety of ways which included: spending time with people in the inpatient service; supporting people accessing the day services; providing a friendly welcome on the reception desk; fulfilling some administrative duties and arranging fund raising events. We spoke to relatives who had been supported by the service when a loved one received care and support at the end of their life. Many were still involved with the service and had become volunteers and fund raisers as a result of their experience. One person told us, "It is such a wonderful service. I just want to give something back. I still go in and I know I'm welcome".

The hospice was proactive in involving the community. Many local shops supported the hospice with fund raising and local people volunteered in various ways. In order to promote the work of the hospice and to improve understanding of palliative and end of life care the service was organising an open day. The open day was being called "Matters of Life and Death. There was a planned programme of talks and workshops to share information which included information about legal matters, benefits of exercise and healthy living and religious and spiritual needs. A number of other services were planning information stalls and included information about living with dementia and bereavement counselling.

There were extremely effective systems in place to monitor and improve the service. This included a series of detailed audits covering records associated with; medicines, care records and pressure ulcers. Where issues were identified steps were taken to address the issues and drive improvement to reduce the risk of reoccurrence. For example, an issue related to the documentation and treatment of pressure ulcers had resulted in nursing staff being supported through one to one supervisions to reflect on their practice and identify what they felt they needed to improve. As a result nursing staff had attended a tissue viability study day. The ward manager told us the system of identifying issues had been positive. The ward manager told us, "It has created a culture of openness and it is gratifying that everything is reported". The ward manager talked about the importance of staff taking time to reflect on their practice and told us, "Reflections can be so candid and beautiful".

There were systems in place to monitor all accidents and incidents to look for trends and patterns. All incidents were recorded on the service Datix system and were discussed at QIG meetings. Where there was learning to be shared with staff this was included in the weekly staff newsletter. We saw copies of the newsletter which detailed learning from Datix and audits including; use of bedrails, recording in inpatients notes and documentation of consent being gained from patients.