

Marie Curie

Marie Curie Hospice West Midlands

Inspection report

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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?

Good



Is the service well-led?

Outstanding



Overall summary

This inspection took place on 1 and 2 July 2015. Due to the sensitivity of the care provided within the hospice, the provider was given 24 hours' notice of our visit. This was so people who used the service could be told of our visit and asked if they would be happy to talk with us.

Marie Curie Hospice West Midlands is a registered charity for the delivery of care and treatment for people across the West Midlands who are affected by life-limiting conditions. Care and support is provided to people by a

range of health and social care professionals and volunteers. This is provided through a 24 bed in-patient unit, a day unit and support in people's own homes. At the time of our inspection there were 19 people receiving care in the in-patient unit.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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

People received care from a multi-disciplinary staff team who were qualified, supported and trained to meet their needs. There was a very proactive approach to the personal development of staff and the acquiring of new skills and qualifications. A system of competency based assessments ensured staff could demonstrate the required knowledge and skills to meet people's needs effectively. Staff received supervision and support and there were also reflective practice sessions where they could discuss any issues associated with their work. Volunteers received training to assist them in their role in giving practical and emotional support to people and their friends and family.

A well-established pharmacy team provided good clinical services to ensure people's medicines were managed safely. The team regularly attended clinical meetings to discuss people's individual pain management requirements and ensure good clinical practice was followed.

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

People, friends and relatives were consistently very positive about the caring and compassionate attitude of the staff. They told us they were completely satisfied with their care. They spoke of excellent relationships with staff who understood their needs and preferences and who

devoted time to them. Staff were very motivated and demonstrated a commitment to providing the best quality end of life care in a compassionate way. People's wishes for their final days were respected.

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

Relatives told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member. Bereavement support was available to people and their families and friends. This provided emotional and practical support to those who required it. A specialist team provided bereavement support to the children and young families of people receiving palliative care.

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

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

Staff worked closely and in partnership with external health and social care professionals and other national organisations to improve the service within the hospice and health provision in the local community and nationally. Staff were encouraged and supported to undertake research and act as education facilitators to share best practice and ensure the best possible outcomes for people with life-limiting conditions and those closest to them.

The provider continually assessed the needs of people who used the service and the care and support they required. For example, the hospice was working to

Summary of findings

develop the service it provided to people living with dementia. The provider had a forward plan which involved raising the awareness of what a hospice can provide to people with life limiting conditions, apart from end of life care.

Summary of findings

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 told us they felt safe receiving care at the hospice. Staffing levels and skill mix provided a good level of care to keep people safe. People told us staff had time to spend with them. Plans were in place to manage any risks associated with people's medical conditions. A dedicated specialist palliative care pharmacist led a team who ensured people's medicines were handled safely.

Good



Is the service effective?

The service was effective.

People received support from a staff team who were trained to meet their needs. Training was well co-ordinated and monitored to ensure staff knowledge was kept up to date and skills maintained. Staff were aware of the mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This meant there were safeguards in place for people who may be unable to make decisions about their care. People were involved in making decisions about their treatment and care needs and received support to manage their pain.

Good



Is the service caring?

The service was caring.

People and their relatives spoke consistently about the caring and compassionate attitude of staff. Staff demonstrated a commitment to providing the best quality of care and people told us staff took time to understand their preferences and needs. Staff supported the emotional wellbeing of people and their relatives and end of life care was provided with sensitivity. Staff were respectful of people's cultural and spiritual needs. The provider supported staff to manage their emotional wellbeing.

Outstanding



Is the service responsive?

The service was responsive.

The provider had a holistic approach so they could respond to the physical, psychological, social and spiritual needs of each person and those closest to them. Staff were responsive to changes in people's physical health so they could have the support and equipment they needed to ensure their wellbeing. The provider had a positive approach to using complaints and concerns to improve the quality of the service.

Good



Is the service well-led?

The service was well-led.

There was a clear management structure in place with senior staff allocated lead roles. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards. The provider worked with other healthcare professionals, national organisations and charities to make improvements to health provision in the local area.

Outstanding



Marie Curie Hospice West Midlands

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 1 and 2 July 2015. The provider was given 24 hours' notice of our visit. This was so people who used the service could be told of our visit and asked if they would be happy to talk to us.

The inspection team consisted of three adult social care inspectors, a pharmacy inspector, a specialist advisor with experience of palliative and end of life care (palliative care is specialised medical care focusing on providing people with relief from the symptoms and stress of a serious illness) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service.

Before our inspection visit we asked the provider to complete a Provider Information Return (PIR). The PIR 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 found the information in the PIR was an accurate assessment of how the service operated. The provider also sent us a list of

people who used the service, their relatives, community professionals and care staff. We sent questionnaires to a selection of those people to find out what they thought of the service provided.

We reviewed other information we held about the service. We looked at information received from relatives and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with local health authority commissioners responsible for contracting and monitoring people's care at the hospice.

At our inspection we spoke to a range of people about the service. They included 13 people (either in the in-patient unit or in the day therapy unit) and 10 visiting family members. We spoke with the registered manager, the lead nurse for community palliative care, specialist palliative care pharmacist, the day services manager, six nurses (including a community nurse specialist) and four health care assistants. We also spoke with two bereavement counsellors, two members of the therapy team, the principal social worker, practice educator, a member of the chaplaincy team, the facilities manager, two members of the facilities team and three volunteers.

We reviewed three people's care plans to see how their support was planned and delivered. We looked at a selection of medication records to check medicines were managed safely. We spent time observing staff interacting with people and their relatives. We reviewed management records of the checks made to assure people received a quality service.

Is the service safe?

Our findings

All the people we spoke with told us they felt very safe receiving care at the hospice. All family visitors agreed. One relative said, “I am completely assured my father is in a very safe environment. The doctors are on the ball, the staff know what they are doing, the place is spotlessly clean. What more could he want?” One person who was unable to talk because of their condition told us in writing that this was the ideal place for them because it was unsafe for them to be cared for at home. A family member confirmed this and said, “[Person] is right you know; this is the perfect place.” One hundred percent of people and their relatives who responded to our questionnaire told us they felt safe with the staff providing their care and support.

Staff and volunteers were provided with guidance and training so they understood their role in keeping people safe from abuse. Staff had a good understanding of the type of concern they should report and how to report it. A volunteer told us, “We have been told what to do. Report it to one of the nurses. Basically, not to keep it to ourselves, but not to spread it around.” Staff knew to contact the hospice social work team if they had any concerns that people were not safe. Staff had the necessary knowledge, information and support to ensure people were kept safe from abuse.

People and their visitors told us they thought there were sufficient staff on duty throughout the day and night. They told us staff were visible and they did not have to wait for a response if they pressed their call bells. We asked one person if staff came quickly when they needed them and they responded, “It wasn’t many seconds, the nurses were passing all the time and they would wave or put their head through the door and ask if I was okay.” People consistently told us staff had time to spend with them and make sure their individual needs were met. One relative told us, “I had a conversation with the nurse this morning and there was no looking at her watch. She took her time.” Another relative said, “The doctor has sat here and explained it all. He spent two or three hours with me yesterday sorting [person] out.”

The registered manager told us that staffing arrangements were based on an assessment of people’s needs and would

be increased if a need was identified. For example, if people were at high risk of falling, staffing levels could be increased so people had a more intensive level of support to keep them safe.

Staff told us there had been some pressures on staff because there had been a number of staff vacancies. One member of staff told us, “We have had some pretty horrible shifts but it has got better lately. We had a lot of people leave and we were using a lot of agency. We have had some really good new starters so it has got better lately.” We discussed this with the registered manager who confirmed there had been a high use of agency staff, but this had reduced as staff vacancies were filled. One staff member told us “We have time to sit and talk and they say it’s so nice that you’ve got the time.” We spoke with a member of the nursing team who provided care in the community. They told us their caseload was approximately 30 people which was “about right”.

The provider followed a thorough recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people who lived in the home. This included carrying out a Disclosure and Barring Service (DBS) check and obtaining appropriate references. Staff we spoke with confirmed they were not able to start work until all the required checks had been completed and associated documentation received. Volunteers and student nurses on placement at the hospice also had checks carried out to ensure they were safe to work with people.

Where there were risks to people’s safety associated with their medical conditions, staff assessed the risk and management plans were in place so that staff understood how to keep people safe. These plans were reviewed regularly and any changes were shared with staff during the staff handover meeting between shifts. One member of staff told us, “The handover is used to pass on risks and changes in people’s needs. If something happens after handover, the nurse will let you know or inform you.” This ensured staff had up to date information about the individual risks associated with people’s healthcare needs. Where assessment had identified specific equipment was required to keep them safe, we saw this was available.

We were told that some people could be at increased risks of falling because of their medication and their illness. A ‘falls group’ had been established to look at individual falls and what equipment or action could be taken to reduce

Is the service safe?

the risk of further falls. The provider had also introduced a leaflet for people and their families setting out simple steps they could take to reduce the risk of falling whilst maintaining their independence. The manager explained, “We want to encourage people to keep their independence.” People we spoke with told us risks were managed, but their freedom was supported and respected. One person told us, “In no way do I feel restricted in here. I can get up, wander about, go to the café. Even at night, in the middle of the night, I can wander about, make myself a drink in the kitchen area. If it wasn’t for the fact I’m dying, it’s like being on holiday.” One person was supported to go on a short family visit home and said, “I like there is no restriction of movement. It sort of normalises things.”

The provider had a system in place for learning from adverse incidents and monitoring safety. During our visit we joined the weekly incident review meeting which was chaired and led by the registered manager and attended by other members of the management team who had responsibility for the oversight of incidents, risk and investigations. Each reported incident was

discussed in detail and agreement reached on whether an incident could be closed or further investigation was required. For example, there had been a couple of occasions where syringe drivers (used to deliver controlled doses of medicines) had leaked. This had been investigated fully and resulted in a specific batch of machines being taken out of use and returned to the manufacturer. This ensured people’s safety was not compromised.

The provider received alerts about patient safety in respect of medical products, equipment and medicines and circulated these to all staff. The alerts were managed by the registered manager who ensured the medical and nursing team were aware of these and took any necessary action. All alerts were filed on the computer system in an organised way.

There was a system of checks and audits to ensure the environment and equipment was kept in good order to maintain people’s safety. A maintenance request log listed all the repairs and concerns about the building and any equipment in it and staff told us repairs were acted on in a timely manner. Risks at service level were assessed and managed. For example we saw a fire risk assessment in

January 2015 had identified some areas where improvements were required. Documentation evidenced that the appropriate action had been taken and signed off as completed.

A well-established pharmacy team provided good clinical services to ensure people’s medicines were handled safely. A dedicated specialist palliative care pharmacist was located at the service. They regularly attended clinical meetings to discuss people’s individual pain management requirements, discuss with people about their medicines and ensure good clinical practice was followed. A clinical pharmacist also visited daily from the Heart of England Foundation Trust Hospital to provide daily clinical pharmacy support to the units. The pharmacy team were actively involved in all aspects of people’s individual medicine requirements. Any concerns or advice about medicines were discussed with the prescribing doctor or with the nursing staff. All advice and any discussions about medicines were recorded directly into people’s medical care notes.

People’s own medicines were stored securely in locked cupboards in their bedroom. This meant that medicines were managed on an individual basis rather than part of a medicine round. Nursing staff had the keys for the cupboards which allowed immediate access to people’s medicines. Arrangements were not in place to enable people to look after and self-administer their own medicines if they were able to. The specialist palliative care pharmacist told us they would like to develop this service so people or their relatives had more individual choice and control when taking their medicines.

Other medicines were stored securely. Daily temperature records were available which recorded the temperatures for the medicine refrigerator and the medicine room temperature. These confirmed that medicines were stored within the recommended temperature ranges to ensure their safety and effectiveness. The storage and recording of controlled drug medicines which require extra security was in accordance with safe practice.

We found an open culture of reporting medicine incidents with arrangements in place to ensure they were documented and investigated. A Medication Safety Officer role was undertaken by the Specialist Palliative Care Pharmacist. Weekly meetings on medicine incidents were discussed with clinical management and nursing staff to ensure lessons were learnt. There was good evidence of

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shared learning across the service. A regular newsletter called the 'Clinical Update Bulletin' or 'CUB' was widely circulated which detailed any medicine incidents including learning points. Nursing staff told us that it was a helpful reminder with good opportunities to read and learn. For example, we looked at the CUB newsletter for June 2015.

This reminded nursing staff to 'take care when preparing controlled drugs' and followed a recent medicine incident. The pharmacy team also undertook monitoring of any changes to ensure safe practice continued. The learning from these incidents helped to improve medicines safety and therefore people's safety.

Is the service effective?

Our findings

People and visitors told us the staff were skilled and competent to meet people's needs. This was confirmed by all the people and relatives who responded to our questionnaire. One person told us, "Everybody seems to know what they are doing, from the cleaner, cook, ward clerk, nurses and doctors – everybody." A visitor said, "It must take some dedication and skill to work here because it seems they have an abundance of both."

People received care from a multi-disciplinary staff team who were qualified, supported and trained to meet their needs. Twenty four hour medical and nursing support was provided within the hospice in-patient unit. Each person had a named palliative care consultant with doctors aligned to them to ensure continuity of care. The medical team undertook a daily patient round, were available during the day and provided on call medical support at night. The holistic multi-disciplinary approach meant people had access to specialist palliative care nurses, physiotherapists, occupational therapists and psychologists. There was also a range of complementary therapies available such as aromatherapy, remedial massage and reflexology.

Training was well co-ordinated by a practice educator and set against a training policy which informed staff at all levels what training was needed for their role. There was a very proactive approach to the personal development of staff and the acquiring of new skills and qualifications. Staff had protected time for training and clinical staff received five study days a year in addition to the mandatory training they completed. Each staff member had an individual development plan based on their previous training, experience and knowledge. A matrix tracked the training required and identified when it was due. This ensured staff training and knowledge was kept up to date and their skills maintained.

Nursing staff told us they received all the training they needed to keep their clinical skills up to date and to follow best practice. One of the nurses told us, "[Practice educator] is approachable. We see her and training can be arranged." One of the non-clinical staff told us, "I am very impressed and proud of the clinical care. All the nurses strive to maintain very high standards." If a person was admitted to the hospice and needed a particular medical device which staff were not familiar with, the manufacturer

was contacted for detailed information. Staff were then trained and assessed to ensure they used it effectively. All staff completed a medical device sheet so it was clear which devices they had been assessed as competent to use. All the nursing and medical staff who responded to our questionnaire confirmed the training provided supported their practice.

To ensure staff were competent and could demonstrate the required knowledge and skills, staff completed a process of self-assessment and observation before a final assessment of competence by a senior took place. Competence continued to be assessed through regular clinical supervision and observation of practice.

Poor, unsafe or out of date practice was challenged. The practice educator talked to the member of staff concerned and addressed any identified learning needs. This linked into the staff member's development plan and could trigger additional training and assessment of competence. Where an issue of poor practice identified a learning need on a wider level, action was taken. For example, there had been an instance when information had not been communicated well between clinical staff. All clinical staff had subsequently attended training in a communication tool to ensure relevant and essential information was always shared appropriately. Where changes were made as a result of poor practice, a note was added to the 'Clinical Update Bulletin' that all staff received.

Staff attended a bereavement awareness course that gave them the skills to deal with issues around end of life care and death. This included an awareness of how these issues could affect them on a personal level. The course facilitator explained, "We have education so staff understand how loss and grief is going to affect you. Let's skill you up so you have confidence in having conversations." Staff we spoke with told us the training helped them deal with 'difficult' conversations.

Volunteers also received training to assist them in their role in giving practical and emotional support to people and their friends and family. We were told, "Some are qualified counsellors but the majority are ordinary people who feel they want to do this role. Everyone goes through 60 hours training which talks about their losses and how it has affected them. A lot of it is about self-awareness around loss, the theory around bereavement and loss, and active listening skills. The course is open to anyone in the hospice."

Is the service effective?

Staff had an in-depth induction when they started working at the hospice which included working alongside a more experienced member of staff. Staff told us the induction gave them the confidence to carry out their responsibilities effectively. We spoke with a member of nursing staff who was going through their induction period. They told us, “Everybody has been so nice and supportive. Nothing has been too much if I ask anybody. I have done three weeks shadowing. It is really good. It gives you time to step back and get used to your environment. It helps get your confidence being in a new team. I have had to get clinical supervision and observations as part of the induction. You have to get so many competencies.” A healthcare assistant told us, “I tagged along with staff who had been here for a while who showed me the ropes and routine so I felt confident enough to carry on and do things on my own. It was not a fixed period, it was until I felt confident in what I was doing.”

Staff received supervision and support and there were also reflective practice sessions where they could discuss any issues about how they had managed a situation. For example, a recent reflective session had discussed a person whose symptoms had been difficult to control. Staff also had annual appraisals where their performance was discussed and confirmed this information fed into their personal development and training plans. One member of staff told us they found their appraisal positive and explained, “This is how I am attending my extra courses now.”

The rights of people who were unable to make important decisions about their health or wellbeing were protected. The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards to ensure that decisions are made in people’s best interests when they are unable to make their own decisions about their care or when their freedom is restricted. Staff had received training in these areas and had an understanding of how the legislation impacted on their practice. The registered manager explained, “Where there are any issues (around a person’s capacity) the medical team would do an assessment and our social work team would be involved as well.”

The principal social worker was the lead for the MCA and DoLS within the hospice. They had produced a DoLS flowchart which guided relevant staff on when and how to

make a referral for authorisation to the local authority when a person’s liberty had been restricted. Where restrictions had been identified, the appropriate applications had been submitted. The social worker told us they had developed a good working relationship with the DoLS lead at the local authority and discussed any complicated cases to ensure they were always working within the legislation.

People told us they enjoyed the food provided at the hospice. Comments included: “The food is brilliant.” “Plenty of choice.” “The food is fantastic and you get a good choice.” We saw the menu changed daily and contained a variety of nutritious meals including hot and cold meals and vegetarian options. The menu was flexible so people could choose to have their main meal at lunch time or in the evening and there were facilities to provide meals to people who wanted to eat at any other time of the day or during the night. Family and friends could eat with people in their bedrooms.

When people were admitted to the hospice, a nutrition sheet was completed which included any special needs, diets or allergies. These were completed with the support of the person, their relatives and nursing staff. Food was prepared in portion sizes and consistencies to meet people’s individual needs. This ensured that both people’s nutritional requirements and their preferences were met. Where people required a specialist diet, for example because of a stomach condition, these were discussed with the nursing team. If there were any concerns about a person’s dietary intake, they could be referred to a dietician for further support. Physiotherapists assessed people who had problems eating independently to identify whether aids and adaptations such as specialist cutlery and cups would help them in maintaining their independence. The catering team were able to meet any cultural preferences. One visitor told us the kitchen staff had gone out of their way to provide Asian inspired food.

People and their relatives told us they felt comfortable to discuss their health needs with staff who took time to explain the healthcare and treatment options available to them. One family member told us, “Even as things change from day to day, I am thoroughly involved with what is going on. They go out of their way to listen and inform. They don’t sugar coat it but they do it in a nice gentle way.”

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Another person told us, “The doctors and nurses must look at my notes before they come in because I don’t have to repeat and repeat the same thing. I mean they check out and all that but they are not noseey or tiresome.”

People were encouraged to be actively involved in their pain management. Pain levels were assessed and documented three times a day. The registered manager explained, “One of the main reasons people come to a hospice is pain management. We are proactive and ask

how their pain is and they are reviewed by a doctor every day.” Where people could not verbalise their pain, staff used visual prompts such as facial expressions to ensure people remained comfortable and pain free. One patient told us, “If you have got pain, you only have to tell them and they will sort it out.” A relative told us, “As soon as [person] came here they identified the pain and dealt with it straightaway and she hasn’t been in pain.”



Is the service caring?

Our findings

People, friends and relatives were consistently positive in what they told us about the very caring and compassionate attitude of the staff. They told us they were completely satisfied with their care. Comments from in-patients and those supported in their own homes included: "What can I say? Absolutely brilliant! You can't fault any of them." "I cannot fault any of the staff here. Wonderful." One hundred percent of people and relatives who responded to our questionnaire confirmed that staff were caring and kind.

Many of the people told us they had been very fearful of entering a hospice environment, but had found it a very positive experience because of the compassionate, enabling care they received from staff. One person who received support at home and attended the day unit told us, "I was frightened to come, but it says it all because now I look forward to coming. I thought it was because there was nothing else they could do, but it wasn't. It was to get me going." A relative told us, "It's beautiful. I have been fighting not to bring [person], but I should have brought him before."

Everyone we spoke with emphasised that both clinical and non-clinical staff made them feel they mattered and took time to understand things from their point of view. A typical comment was, "They have always been kind, caring and ever so helpful." People spoke of good relationships with staff who understood their needs and preferences and devoted time to them. This was because staff understood the importance of focusing on the person and seeing beyond their illness. One member of staff told us, "We see the person first, and yes you have a diagnosis." We spoke with one person attending the day centre who also received support at home. They told us, "I really enjoy it. I think it is peaceful, friendly and all the staff are so willing to be helpful. They are very accommodating and understanding. You are always greeted with a big smile. They take a great deal of care of you as though you were the only visitor. They make you feel tremendously welcome and wanted. When you leave, you always leave feeling happy, content and joyful."

Staff were motivated and demonstrated a commitment to providing the best quality end of life care in a compassionate way. For example, during the day we observed one person on the in-patient unit was distressed and disorientated and crying out. One of the healthcare

assistants answered their calls and went and sat down by the side of their bed. They spoke softly and reassuringly to explain where the person was, "You are not lost darling, you are in the Marie Curie Hospice in Solihull." They held out their hand to the person and said, "Let me give you my hand. Would that make you feel a bit safer. It's okay, it is absolutely fine. Can you feel the lovely fresh air from the garden." They sat with the person for a while gently talking with them about the photographs by the side of their bed and giving physical and emotional reassurance. They did not leave until the person was relaxed and calm.

Staff were creative in overcoming obstacles to achieve the best possible outcomes for people. One person's hearing loss was having a big impact on their psychological wellbeing. The person did not want to go to hospital for specialist treatment in the 'Ear, Nose and Throat' unit because they thought they would never return to the hospice. It was arranged for a member of staff to go to hospital with the person as it gave them reassurance they were to return to their room at the hospice.

People and their families were central to the delivery of treatment and they were supported to express their views and make decisions about their care. One person said, "They are always knocking on my door to see how I am." A relative explained to us, "The doctors and nurses, they put you at ease – doctors are always on first name terms. Quite informal, but very professional. They are always happy to talk to you." Another visitor said, "They are always coming in and asking if he needs help, asking about his welfare." People told us staff dealt with requests without delay.

People's wishes for their final days were respected. Information about people's personal preferences were part of the handover process between shifts and ensured that people received end of life care that met their wishes.

Staff understood the importance of people being able to communicate to them and to their loved ones. They worked innovatively to ensure people whose communication had been compromised by their illness could still have meaningful conversations and their voice heard. Staff told us they received a lot of training around communication and explained, "If they [people] can't speak, we have communication charts, we have them from the occupational therapy and physio department. People suffering with motor neurone disease, maybe they can still wink or nod. We go for training where we provide them with short questions like would you like a tea." One member of



Is the service caring?

therapy team explained further, “We had one patient recently whose speech deteriorated and they did not want to be locked in (unable to communicate and make their wishes known). We did a communication board specifically for them, then got a speech therapist to make sure there were no gaps (in the words needed on the board). We did all that before they lost their speech because they knew it was going to happen and they did not want to get to the stage when they would be locked in.”

Relatives told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member. One relative told us, “They’ll even notice when I’m down. They’ll sit me down and just let me have a cry if I need to. Words can’t explain how grateful I am to the staff here.” Another relative told us, “I reckon the doctors spend about a quarter of their time asking about me, my needs, my health and three quarters on my Dad. It really gives me reassurance that they have us all at heart.”

People’s families were supported to visit the hospice at times to suit them and the person receiving care. There were spacious facilities provided for people’s visitors and several seating areas where they could relax in private. There were facilities for visitors to make their own drinks and a restaurant served meals and snacks. Where people were near the end of their life, their families were supported to stay overnight. One relative told us, “They have been marvellous. Her husband stayed all night. If any family members want to stay tonight they would accommodate us.”

During our observations we saw people’s dignity was maintained. When personal care was in progress, a light outside the bedroom door prevented interruptions and ensured people’s privacy and dignity was maintained. The doors to each bedroom had an observation window to enable staff to look in and check on the person should they need it. Each window had electronic blinds. People and their visitors could adjust the blinds from inside their rooms which meant they could make the decision whether they wanted to be observed or not. One hundred percent of people and relatives who responded to our questionnaire confirmed that staff always treated people with dignity and respect.

Staff were respectful of people’s cultural and spiritual needs. People told us they received the religious and spiritual support they wanted and needed. One person said, “I like it when one of the chaplains comes around. I’m

not religious and they don’t throw religion down your throat. Just nice men and women who care really.” A relative said, “My father has never been religious but as he gets weaker, he’s become more so – it’s nice that they just listen.” The hospice had its own multi-faith chaplaincy team representing all the major faiths and were able to provide support to those receiving care in the hospice, their families and also staff. If someone did not follow one of the major faiths, community resources were used to secure the appropriate support at the hospice. There was a multi-faith room within the hospice where people could practice their faith or just spend time in peaceful reflection. We joined a multi-disciplinary team meeting during which people’s religious and spiritual needs were discussed. One person’s faith required they pray at specific times each day. These times were recorded on the daily handover sheet so staff were aware the person was not to be disturbed.

Staff were respectful of people’s religious and cultural needs during and after death. One person had received their end of life care in a room facing east in accordance with their religious beliefs. Another person’s family were supported to prepare the body of their loved one in accordance with the traditions of their culture.

Bereavement support in the form of a counselling service was available to people and their families and friends to provide emotional and practical support to those who required it. One person told us, “I access the counselling service here. I find it very good.” A relative explained, “I know they provide counselling for relatives and we’ve been told what to do if we need it. We’ve never needed the service as yet.”

There was a clear ethos that people and their friends and relatives could still build memories during a stay in the hospice that would endure and sustain them after their family member had died. One of the bereavement counsellors explained, “A lot of my work is very creative, doing memory making with people, memory boxes, emotional wills such as my favourite recipe and my favourite books. If you engage people in something creative, they will be very willing to tell their story.” One relative told us, “At a family celebration, we all gathered in the café and the staff wheeled him into the café. We, and he, enjoyed it.” We were also told of one person who was very ill whose child was getting married. The wedding reception had been held in the hospice so the person was able to be part of the celebration.



Is the service caring?

The provider was exploring ways to ensure that bereavement support carried on for people after the death of their family member. Plans included a 'Men's Shed Club' to provide social interaction and the teaching of domestic skills to widowers, and a Sunday lunch club for bereaved family and friends to prevent social isolation.

The manager informed us that more children were starting to visit the hospice because either their parent or grandparent was ill. A children and young person's counsellor provided one to one counselling support to children aged between four and 17 years of age and worked with an adult relation to support children under four years of age. This work was one of the key mechanisms through which people using the hospice who had young family members were supported emotionally. The counsellor told us that if people with children or grandchildren were to be appropriately and sensitively supported, care for the children themselves was vital. We spoke with one young person who was visiting a family member in the hospice. They told us, "It is very homely. They make you feel comfortable as well. If I was here and getting a bit upset I can go for a little walk."

There was a light and airy atmosphere within the building. All bedrooms were on the ground floor with direct access to landscaped gardens. If people were unable to leave their beds, the doors on to the patio areas were designed so the person could be moved outside on their bed.

The provider demonstrated a caring attitude to staff. Staff had access to counselling to support their emotional wellbeing. The counselling team also ran a support programme which any member of staff could attend. Each session within the programme had a theme and provided an opportunity for staff to share their experiences, thoughts, feelings and emotional issues in caring for people and their families. Staff were able to make personal connections with patients and colleagues because they had an understanding of their own responses and feelings.

The hospice had recently moved location from the building it had previously occupied for many years. The provider understood the move would be difficult for staff who had many memories invested in the old building. There had been a ceremony for staff to celebrate the move whilst acknowledging those memories. A staff member explained, "Everyone brought a pebble down from the old hospice, it was symbolic from old to new."

Is the service responsive?

Our findings

People told us staff were responsive and their health needs were met by the hospice team. One person who received care in their own home said, “I am in early stages of support treatment. I am overwhelmed at the care and support given by my nurse and hospice team. What a wonderful service Marie Curie offer – excellent.” Another said, “Never feel rushed or worried about raising any issues I may have. Always dealt with honestly and without compromising my dignity. Terrific knowledge, support is there 24/7. Amazing nurse.”

People were admitted to the in-patient unit for a variety of reasons. For example, for an emergency stay, respite care, pain relief, management of a long term life limiting health condition and end of life care. Each person had a care plan that was tailored to meet their individual needs. People and their relatives were fully involved in outlining what was important to them and what outcomes they wanted to achieve. A relative told us, “We have sat and discussed [person’s] care needs and what outcomes we are looking for.” Another said, “I feel very much involved in what is going on with my relative’s care, they keep you informed as you go along. The doctor will talk to you and let you know what’s happening.”

A full overview of each person receiving treatment was discussed in the staff handover meeting between each shift. The views of people in respect of their care were included in this meeting.

This information was recorded on a handover sheet so staff could see at a glance what the person’s essential nursing and care needs were. One member of staff told us, “The rooms change every day so when you go to handover there is always somebody new. We get a copy of the handover. These are quite detailed and provided for every shift. Staff can then write their own notes.” Each week there was a multi-disciplinary meeting involving medical, nursing and therapy staff as well as a social worker and a member of the chaplaincy team. The meeting had a holistic approach and the physical, psychological, social and spiritual needs of each person were discussed in detail, together with the needs of those closest to them. This included symptom control, nutritional and psychological needs and pain requirements.

People’s care plans and care records were kept on computer under a system that was also used by 95% of the GPs in the local area, district nurses and other healthcare professionals. This meant that with the person’s consent, external healthcare professionals involved in their care were able to have immediate and up-to-date information about changes in health, treatment and medication. This supported the smooth transition between the various agencies and helped to ensure decisions about people’s care and treatment involved professionals who were properly informed. The registered manager explained, “As long as people have given consent to share this information, it is so helpful. It saves people having to tell the same story all the time.”

Staff were responsive in dealing with concerns people had when their conditions and the changes they had to face when their health deteriorated. For example, one member of the therapy team told us about people who as their health declined were unable to eat or drink and required a percutaneous endoscopic gastrostomy (PEG). A PEG delivers a nutritionally complete food preparation directly into the stomach through a surgically fitted device. People could be shown the PEG and how it worked so they knew what it was like and what to expect before it needed to be fitted.

The registered manager told us that around 85% of those supported on the in-patient unit had a cancer diagnosis. Work was being done to ensure that hospice staff were able to meet the needs of the remaining 15%. For example, if a person entered the hospice with a condition which required specific care which the staff might not be familiar with, such as a neurological problem, they obtained as much information as possible from the person, their family and the specialist health and social care professionals involved in their care to put together a detailed care plan. The hospice also had a close and positive working relationship with their local health trust which was used to ensure people got the right support.

We were told the hospice was now seeing more people with a diagnosis of dementia. A dementia working group had been established to look at how the hospice team could best support people living with dementia and what training, tools and equipment staff might need. This would ensure that staff were best able to respond to the specific needs of a person living with dementia.

Is the service responsive?

An occupational therapist was now based on the unit to explore ways to enhance the quality of life for people during their stay in the hospice. This was in response to concerns from staff that some people were isolated in their bedrooms.

There was a multi-disciplinary approach which managed the discharge of people who chose to go home to for their end of life care or who were discharged after a period of rehabilitation or symptom and pain control. People's on-going care and support was planned proactively with people's involvement. Each person had a discharge care plan which ensured all the nursing and healthcare support the person required was in place when at home. Two of the therapy team involved in discharge planning explained that a home assessment helped them identify what equipment people needed to manage their condition and keep them safe. One therapist explained, "Tomorrow I am doing a home visit with a patient. I am taking him home because he wants to be in control of where the equipment goes." They also told us of another person who wanted to go home, but their family were concerned they would not be able to manage. After a home visit the therapist was able to explain the challenges the person would face within their home environment and the person made an informed decision to remain in the hospice. They went on to explain. "So we looked at bringing bits of home into the hospice. Photographs, pictures and other possessions."

The principal social worker at the hospice told us they had a close working relationship and regular dialogue with community social workers. When someone entered the hospice for respite care, they checked whether or not a care package was in place in the community. If so, they worked pro-actively during the person's stay to ensure the package was kept open for when the person was discharged. This meant that people with continuing health needs had the best possible care and support because they had continuity of care.

The day unit provided a range of facilities and equipment to support people's care needs. The purpose of the day hospice was to "support people who have been referred to the hospice but are still well enough to be at home." People attending the service were given the opportunity to participate in hobbies and interests of their choice and in complementary therapies. For example, an indoor greenhouse enabled people to do some gentle gardening. People from the in-patient unit could access the day unit at

any time to join in with the activities. All the people we spoke with in the day unit were overwhelmingly enthusiastic about the care and support they received during their visits. One person told us, "I'm amazed I didn't even know it existed. My interpretation of a home like this was it was the end of the line. When she said try it, I thought it didn't look good, but when I came here it was amazing." Another said, "You can ask them (staff) anything. They will find out for you and sit and talk to you."

The provider held regular information events for both people and their families and carers to meet people in similar situations, receive help and advice in an informal setting or just to provide people time away from their home environment.

In the last 12 months the provider had established a rehabilitation programme which targeted people early in their medical treatment. After an initial assessment by the nursing, medical and therapy team people were given an individual 12 week exercise programme. The therapy team spoke positively about how the programme had benefited people to improve their quality of life. They told us of one person who was unable to do anything following radical surgery, but after completing the programme were able to return to some of the physical activities they previously enjoyed.

As well as their own equipment store, the hospice had links with other organisations so they could respond quickly to ensure people could have the equipment they needed in their own homes when they needed it. One person who received care in their own home told us, "I needed a walking frame with a seat. She (physiotherapist) went down but they had not got one in the store. I said, I'm going away next week and I really need it. She said right and she got me one. She also got me the bed and mattress."

The provider had a positive approach to using complaints and concerns to improve the quality of the service. Every person had an information file in their bedroom which contained information about how they could raise concerns or make a complaint. There was also clear and accessible information throughout the building about how they could make suggestions or complaints about their care. Records demonstrated the provider had responded to issues raised and meetings had been held with those concerned to explore their concerns in detail. Each

Is the service responsive?

complaint was assessed to establish the lessons learned and where necessary, appropriate action taken to improve the service provision for everyone using the services at the hospice.



Is the service well-led?

Our findings

People and their families were all very positive about the care provided and the management of the hospice services. One person told us, “It is lovely. I would recommend anyone to come here because you couldn’t get better treatment off anybody.” A member of staff explained, “The people who work here do a fabulous job. The people are naturally empathetic and caring. It makes for a great team spirit.”

There was a clear management structure with senior staff allocated lead roles. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards. All the staff we spoke with were enthusiastic about their work and shared the values and aims of the service. One member of care staff told us, “It is a lovely place, I have made friends since working here. I have got lovely supportive nurses. I do understand we all have a different role but at the end of the day we are caring for the patient.”

The management team ensured all aspects of running the hospice were well organised. This included the policies and procedures that were available to support effective management of the hospice service. There were systems for checking the quality and safety of people’s care and evaluating the care and treatment people received. Where the need for improvements was identified, the group responsible for ensuring they were completed, were identified and the actions taken were recorded. The progress of actions were updated on a monthly basis to demonstrate changes or the improvements made. For example, in a governance audit the provider had identified there were areas around nutritional support for people that could be improved. The management team were currently making a bid to fund a part time dietician prior to piloting a nutritional screening tool on the inpatient unit. The provider had also recognised that the recruitment process was taking too long and impacting on staffing levels and the use of agency staff. Work was being undertaken to review the process to ensure it was more efficient and effective.

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

Many of the medical staff had other NHS related roles outside of the hospice. The registered manager explained the provider supported these roles as they encouraged effective communication and the sharing of information supported service development of good end of life care in different health settings. For example, one of the doctors worked as a GP and had used their experiences at the hospice in their role as a facilitator introducing the Gold Standard Framework (GSF) into GP surgeries. The GSF is a national framework of tools and tasks that aims to deliver a ‘gold standard of care’ for all people nearing the end of their lives. The registered manager told us that this member of staff’s work as a GP, was helpful in informing their partnership working with the GPs in the local community.

Throughout our visit we found the provider valued the importance of quality, improvement and learning. Each member of staff had a personal development plan and the provider held a variety of regular meetings and events to provide opportunities for shared education and learning. The provider also promoted learning and development within the wider medical community. The hospice offered placements for trainee doctors and nurses. Medical and nursing staff provided training sessions in care and nursing homes on topics such as syringe drivers, pain management and general end of life care. This training helped homes avoid hospital admissions for people who wanted to remain in their care as they neared the end of their life. Four times a year the palliative care consultants from the hospice offered training to local GPs to support them in providing appropriate care to patients nearing the end of life. Reciprocal arrangements were being developed with the local hospital trust for nurses to work across settings. The registered manager explained, “This will provide their nurses with a better understanding of what hospices do and provide our nurses with an opportunity to keep up to date with what is happening in an acute trust.”



Is the service well-led?

Staff were involved in the development and improvement of the service. There were a variety of groups with a cross section of staff looking at improving people's experience of their care and treatment. For example, a dementia steering group was looking at how the provider could improve care provision to those with a dementia diagnosis. This included a reassessment of the premises for dementia care in partnership with the Alzheimer's Society. A grant had been applied for which, if successful, would introduce Namaste services to the hospice and the community. This is a service that can improve the quality of life for people affected by advanced dementia by providing meaningful activities and sensory stimulation in a safe environment. A group had been convened to review ways of working and communicating more effectively and as a result an occupational therapist was now based on the in-patient unit to improve the flow of communication.

The registered manager understood the importance of using feedback from people, staff and visitors to the home to examine the quality of care provided. They told us, "Our problem is we don't get enough feedback and enough criticism. There must be something we are getting wrong but they don't tell us. We are always looking at more ways of getting feedback." Two or three days each week volunteers supported people, families and visitors to complete questionnaires. Comment cards were also available throughout the building. A 'You Said, We Did' board was produced monthly following feedback and as a result of comments received, the time of the evening meal had been moved to later.

There was a strong commitment to making improvements to the wider health landscape in the local area. The service worked in partnership with the local general hospitals and other national organisations and charities to support care provision and development. For example, the day unit had recently expanded their blood transfusion service so 10 more patients each week attended the unit for their transfusions. This opened up beds in the local hospital which enabled them to support ten more patients to access their chemotherapy earlier. The hospice pharmacist had completed a specific piece of work with a colleague from another hospice around people's access in the community to specialist palliative and end of life medicines. The pharmacists identified that a scheme where people could access these medicines from selected pharmacies was no longer functioning adequately. This had been highlighted to the appropriate bodies and action

taken to ensure people and their carers could access urgently required medicines promptly. This had been recognised by the local clinical commissioning group as going above and beyond their job role.

McMillan Nurses had office space within the hospice and worked closely with the Marie Curie nurses to ensure people received the support they required when they needed it. The provider was in discussions with the Alzheimer's Society and Admiral Nurses to develop the sharing of expertise. Regional support groups were being developed for those with pancreatic cancer in partnership with Pancreatic Cancer UK. A motor neurone network group had been set up which involved healthcare professionals from all areas. Meetings were held every two months in the hospice and provided an opportunity to discuss the specific needs of people with this diagnosis.

The provider was committed to improving end of life and palliative care and recognised the value of research. Staff were encouraged to take part in research projects to support and inform improvements in the care people received when living with life-limiting conditions. The provider also contributed to university based research. Information was available so people were aware they may be invited to take part in research projects. The registered manager met regularly with other hospice managers within the provider group to share excellence within the charity. They explained this was an opportunity to explore what was working well in other hospices and to share good practice.

The provider was a member of several good practice initiatives including the West Midlands Specialist Care Audit and Guidelines Group (one member of staff being the Chair of the group), West Midlands Palliative Care Partnership and other forums and partnerships working to improve the quality of palliative and end of life care within the locality.

The hospice team had strong links to the local community, many of whom were involved in events to raise funds for the service. However, the hospice team were passionate about raising awareness of what a hospice can provide to people with life limiting conditions apart from end of life care. The registered manager said, "It is quite shocking the ignorance of what a hospice does. People think you go there to die, but we offer so much more. If we could get people six or nine months earlier in their illness, we could help so much more." One way of raising awareness was by encouraging people to use the building. Some charitable



Is the service well-led?

groups and organisations in the local area were invited to and now held their meetings in the hospice and the café was open to the public. The registered manager explained, “We need to draw more people in to understand what a hospice can do and what we can offer.” By raising awareness the provider was encouraging more people to use the range of services they were able to provide.

The provider was aware of the importance of forward planning to ensure the quality of service they provided could continue to develop. The provider’s strategic plan for 2014 –2019 demonstrated service objectives reflected against known challenges such as an ageing population with changing needs at the end of their lives. The strategy was developed through talking to people with a life limiting illness and their families and carers, to staff and volunteers and outside organisations. The strategy included objectives to reach more people and their families living with a terminal illness and improving the way terminally ill people are cared for. The registered manager explained that part of

that work included developing satellite outpatient clinics (in other premises in the locality) and group sessions within the community to ensure services were more accessible and barriers to care were broken down.

We were told the service had received 144 compliments in the last 12 months. The PIR stated: “The main theme that came from our compliments are thanks to the staff for the care they provide to not only patients but also to families and friends. Also noticeable is families state that due to them knowing their loved ones are being well cared for, they have peace of mind, also the time they have with the patients is as a loved one and not as a carer.” Everyone we spoke with told us the atmosphere in the home was “wonderful” and praised the staff and volunteers. The very positive feedback we received indicated that people found the management of the hospice to be of a high standard. One person told us, “I can’t believe such a place exists.” When we asked what improvements they would like to see they responded, “You couldn’t. I don’t see what you could improve.”