

Eden Valley Hospice, Carlisle

Eden Valley Hospice

Inspection report

Eden Valley Hospice
Durdar Road
Carlisle
Cumbria
CA2 4SD

Tel: 01228810801

Website: www.evhospice.org.uk

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection took place on 16 May 2016 and was unannounced. At our last inspection the registered provider was meeting all the regulations that were assessed.

Eden Valley Hospice is located in the outskirts of Carlisle. It is registered to provide palliative and end of life care for up to 12 adults and five children. The hospice has a 12 bed adult in-patient unit with eight single ensuite rooms and one four bed room. Care and support services for children and young adults with life limiting conditions are provided within a separate unit on the site called Jigsaw. Adults and children may be admitted for care during the last weeks and days of their life, symptom control, and assessment and / or respite care. There is a Day Hospice that provides care and support for up to 15 people a day, four days a week. The hospice provides bereavement support, complimentary therapies, counselling and carer support services and wellbeing programmes. There is a multidisciplinary team who are all experienced and trained in palliative care. Medical cover is provided by dedicated doctors who are supported by a Palliative Care Consultant.

At the time of our inspection there were 10 people using the adult inpatient unit and two children in Jigsaw.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The management team demonstrated a desire to learn about and implement best practice throughout the service. There was a clear organisational structure and a visible management presence throughout the service. Feedback from people and families using the service, health and social care professionals and visitors was very positive and people praised the care and compassion of the staff and volunteers.

The hospice environment was calm and it was open to families to visit and stay 24 hours a day. Hospice staff facilitated pre and post bereavement support for children, young people and adults through the hospice's family support team. Those offering bereavement support and counselling had specific training for this role in line with ethical practice.

We saw people had been able to discuss with staff their spiritual and cultural beliefs and how they wanted these to be met. There was a well established chaplaincy team to offer pastoral and spiritual support whatever a person's individual beliefs.

Hospice nursing and medical staff spent time with people and planned ahead to find out what people's needs and goals were. A holistic approach was used to help make sure people's emotional, spiritual and social needs were met as well as their physical needs. This meant people approaching end of life or with life limiting conditions were supported to lead a full and meaningful life. People told us they could speak openly

about what they wanted and how they felt about their illnesses and were given the information needed to help them make their own treatment decisions.

Records we looked at demonstrated that staff took a lot of time working with people and giving them the time and information they needed to make decisions about their care and treatment. We saw that this process was led by the adult or child's family.

There was a safeguarding policy in place that included information about the protection of adults and children. The safeguarding policy covered both adult services and Jigsaw and referred to relevant policies and national guidelines.

There were policies and procedures in place covering all aspects of the management of medicines within the adult inpatient unit and the Jigsaw unit. Medicines were stored in appropriate cabinets and fridges and were administered in accordance with the prescriber's instructions. Controlled Drugs were handled appropriately.

We made some recommendations regarding medication good practice that we discussed with the management team. We made a recommendation in regard to areas that required review to incorporate current best practice and to include this in policies and procedures being used. Also we made recommendations about assessment in aspects of security and action planning following audit findings. We agreed the actions that would be taken and some were addressed on the day..

Records demonstrated that people were being well supported physically and emotionally and had been consulted throughout their care and treatments. There was evidence of risk assessments for people before and on admission that stated the actions staff were to take to reduce the possibility of harm without applying any unnecessary restrictions on people's freedom. The records in people's care files indicated that consent to support, care and treatment was being sought in line with legislation and guidance.

People's care plans included clear planning with regard to the control of distressing symptom and pain management that were being updated on a continual basis. The updates included changes in people's health and what was agreed when people experienced changes in their conditions, symptoms or pain levels

Care plans in use in the hospice included risk assessments using accredited measuring and monitoring tools. Records demonstrated that incidents, accidents and near misses were reported, recorded and reviewed through the management reporting process and action taken where any trends were identified.

There was a high ratio of staff to people/children using the service of suitably experienced and skilled staff to keep people safe and meet their needs and expectations. Safe recruitment practices were followed when new staff were employed or volunteers taken on. The hospice has its own bank staff to cover for holidays, for training and sickness and they had been recruited using the same process as permanent staff.

The hospice had a training and development strategy in place and there was a comprehensive mandatory and statutory training programme for all those working or volunteering in the hospice. All staff received supervision and support and an annual appraisal of their work.

Nutrition risk assessments were carried out and used to identify specific risks associated with people and these were subject to continuous review. People and their relatives were very complimentary about the food provided which was cooked daily from fresh ingredients. We were told "The food is lovely".

There were clear strategic plans in place for the continual development of hospice services and a business plan which clearly summarised the organisation's aims and objectives, with forward planning strategies being implemented.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People felt safe and protected from harm. Staff knew what action to take if they suspected abuse was taking place.

There was a high staff to patient ratio to meet people's needs safely and in a person centred way. This was regularly reviewed and adapted to reflect people's changing needs.

The service followed safe recruitment practices when employing new staff.

Staff handled people's medicines safely and focused on effective symptom control. Good practice issues around medicines management were dealt with promptly.

Is the service effective?

Good ●

The service was effective.

People and their representatives were involved in making decisions about their care and support.

There was a training plan in place to provide structures staff development and action was taken to make sure staff could refresh skills. Staff were well supported by the managers and the staff team.

People's liberty was not being unnecessarily restricted and people/parents were fully supported to make choices about their day to day lives and treatment options.

People were provided with a suitable range and choice of nutritious food and drink.

Is the service caring?

Good ●

The service was very caring.

People who had used the service and carers we spoke with in the day hospice happily told us what a difference it had made in their

lives. People spoke highly about their care and they said staff were compassionate and sensitive to their needs.

People's spiritual and religious needs were recognised and respected. The service worked closely with the spiritual care team which offered comfort and support to adults, children and families.

People using the service and their families had access to bereavement support, counselling and day services to promote their emotional and psychological wellbeing.

People's privacy and dignity were respected. Visitors could visit at any time and could stay for as long as they wanted.

Is the service responsive?

Good ●

The service was well led.

People were at the heart of the service and were actively involved in developing all aspects of the service. They spoke positively about the service and were confident that their views and opinions were listened to and acted upon.

The philosophy of care and values of the service were person-centred and staff and volunteers understood and practiced these values and made sure people were placed at the centre of the service.

Systems were in place to monitor the quality of the services provided and there were audit systems in place intended to measure effectiveness of the services and care provided.

Is the service well-led?

Good ●

The service was well led.

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Eden Valley Hospice

Detailed findings

Background to this inspection

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

The unannounced inspection took place on 16 May 2016 with follow up telephone calls on 19 May 2016. The inspection was unannounced and the inspection team consisted of a lead adult social care (ASC) inspector, a pharmacist specialist advisor and a specialist paediatric nursing advisor. These advisors provided specialist knowledge to inform the inspection.

During our inspection we spoke with two people who were using the adult inpatient services and one young person on Jigsaw. We spoke with two relatives and the parent of a young person using Jigsaw. We spoke with a volunteer supporting the 'Sunflower Group'.

We spoke with the Chief Executive of the service, the Head of Care, the Head of Hospice Facilities and support services, senior nurses on the adult and children's units one of the senior clinicians and a GP who was one of four clinicians providing medical cover. We spoke with two registered nurses on the adult inpatient unit and two registered nurses on the Jigsaw unit. We spoke with two health care assistants and with the hospice chaplain who led the chaplaincy team. We also spent time talking with the two catering staff on duty.

We attended a meeting of the 'Sunflower Group' that provided support for people who were caring for people with terminal or life limiting illnesses. We were able to speak with those attending and the palliative care social worker, based at the hospice, who facilitated the group. We attended a staff handover on the adult unit involving nursing, support and medical staff.

We reviewed four care records of children of different ages who used the Jigsaw unit and case tracked two of them. We reviewed the care plans for four people on the adult unit and case tracked two. This meant we spoke with staff and read people's care records to see how the people were supported.

We looked at records, medicines and care plans relating to the use of medicines in detail for people being cared for on the adult inpatient part of the hospice and also the children's hospice, called Jigsaw. We observed medicine rounds and how medicines were being handled and we discussed medicines handling with nursing staff.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about incidents that affected the service and people attending the hospice. A notification is information about important events which the service is required to send us by law. We looked at the information we held on safeguarding referrals and any applications made under deprivation of liberty safeguards.

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 any improvements they plan to make. This was completed promptly and in detail.

Is the service safe?

Our findings

We spoke with people who used the hospice services and relatives/ parents and all the comments we received were very positive and appreciative of the services provided. People said they felt "safe" and "very well cared for and supported" within the hospice. We were told "I trust them all, the nurses, carers, doctors, cleaners, cooks, they are all great" and "From the first day I came here I had confidence in them [staff], there are so calm and professional". We were also told "It's a lovely place to come, it's open and friendly and you can talk about things here that others would shy away from". We were told "the only thing I would be afraid of here is if they told me I couldn't come here anymore".

There were policies and procedures in place covering all aspects of the management of medicines within the adult inpatient unit, the Jigsaw unit and the day hospice. The hospice had recently changed its pharmacy service from the local hospital to a local community pharmacy. Clinical support was still obtained through the hospital however this was no longer under a contract. This was discussed with the management team at feedback. We recommended that for good practice the guidance of a pharmacist (including visits to the hospice) from the community pharmacy should be included in the contract.

Medicines on the units were stored in appropriate lockable cabinets, trolleys and fridges in dedicated medicine's room within the ward and the temperature of the medicine's fridge was monitored on a daily basis. There was appropriate storage for medicines within people's rooms if they were self-medicating. Records were kept of the ordering, receipt, administration and disposal of medicines. Separate charts had been developed to support the safe use of syringe drivers and pain relief patches. A dedicated document (blue card) was also used to record the patient's medicines upon discharge to support their adherence.

Medicines for use in emergencies were available. These were all within locked cabinets which required key access. The keys were held by the member of nursing staff who was in charge of the unit. There was not a risk assessment regarding whether this may cause a delay in administration. This was discussed with the management team at feedback. We recommended that guidance and advice was sought on assessing control measures regarding the possibility of any delays in the administration of emergency medication.

Medicines were administered in accordance with the prescribers' instruction by two nurses either using patients own medicines or stock medicines. Within Jigsaw medicines were brought in to be used during the stay. A Medicines Administration Record (MAR) was written by the Hospice doctor to support administration during the people's stay. There was a list of medicines prescribed by the doctor following an assessment which could be administered to patients for any additional pain relief during their stay. Jigsaw had introduced a robust reconciliation of medicines process in collaboration with families.

The bedrooms in both the adult inpatient unit and the Jigsaw unit had piped medical gases. The Head of Facilities and Support Services was responsible for the system on site. A new medical gas package was being developed and this included the training of two authorised persons for the hospice including the head of facilities and support. There was involvement of a pharmacist in the quality control of the pipeline and recent work on the pipeline had been under the permit to work scheme. Signs were available to display if

medical gases were being used.

Controlled Drugs were handled appropriately. There was an Accountable Officer for Controlled Drugs and a designated witness for Controlled Drug disposal. Records were kept of receipt administration and disposal of both stock and patients own Controlled Drugs. The book being used to order the Controlled Drugs was not in the new standardised format. This was discussed and it was confirmed that it would be followed up with the community pharmacy.

Different parts of the hospice had their own separate secure entrances to promote privacy. The main entry to Jigsaw was via a separate entrance to the one used to enter the adult services. This enabled the children, young people and their families to immediately access an environment which was child and young people friendly. The external door opened with a key fob which was held only by staff who worked on Jigsaw. Other external doors in Jigsaw included doors from the 'smoothie room' and from the corridor into the sensory garden. These doors were locked during the inspection and the keys were kept in a key cupboard. The key cupboard was unlocked and each key was numbered to correspond to the door it unlocked. There was therefore a risk that children, young people, visitors and staff without authority to do so could access keys. The Chief Executive and Head of Care were informed of this at feedback and took action to address the possible risk.

There was a safeguarding policy in place that included information about the protection of adults and children. The safeguarding policy covered both the adult inpatient unit and Jigsaw and referred to relevant policies and national guidelines such as 'Working Together to Safeguard Children 2010'. The review date was June 2017. Staff on the adult inpatient unit confirmed they had received training on safeguarding adults and were aware of the action needed. Two staff on Jigsaw had up to date level three safeguarding training for children and young people. The remaining staff had safeguarding children and young people at level two training that had expired. However staff were aware of what was required should they suspect abuse.

The Jigsaw unit manager had recently done a review of training needs and was already aware that updating the safeguarding training for staff needed to be urgently addressed. This training had been included in the comprehensive training and development programme on the unit starting on the 6th June 2016.

Records demonstrated that people were well supported and consulted where the assessment or potential risk was involved. There was evidence of risk assessments for people before and on admission. Risk assessments described the actions staff were to take to reduce the possibility of harm without applying any unnecessary restrictions on people. Jigsaw encouraged appropriate risk taking as agreed with the families to allow children to have a full life.

Care plans in use in the hospice included risk assessments using accredited measuring and monitoring tools. This included for skin assessments and pressure care, falls, the use of bed rails, mobility, moving and handling needs and nutritional and hydration risks and needs. Detailed assessments were also undertaken for counselling and bereavement services to make sure people were safe and received the right support. This approach meant that risks could be identified and action taken to reduce them and help people achieve a good quality of life.

However environmental risk assessments for areas of Jigsaw were not clearly completed. For example in the kitchen area The kitchen door was open and not locked during the visit; child proof locks on kitchen cupboard doors were damaged and not fully functional. This posed a risk as cleaning fluids were stored in a base cupboard and sharp objects were available in drawers. The Chief Executive and Head of Care were informed of this and it was addressed straight away.

Records demonstrated that incidents, accidents and near misses were reported, recorded and reviewed through the management reporting process and action taken where any trends were identified. This investigation and analysis was overseen through the Clinical Governance Committee at its monthly meetings. Minutes of the meetings showed that learning points and improvements were discussed and used to inform practice.

There was a high ratio of staff to people/children using the service of suitably experienced and skilled staff to keep people safe and meet their needs and expectations. There were two registered nurses on the adult inpatient unit 24 hours a day to provide nursing care. Staff we spoke with told us that they "always" had the time they needed to give people person centred and individual attention. Staff levels were kept under frequent review and a dependency tool was being introduced on the adult inpatient unit to support this continuous assessment. When the dependency tool was established on the adult unit and evaluated the tool would be introduced in Jigsaw as well. The management team anticipated that the information recorded using this tool would be used to contribute to decisions on future staffing levels, skill mixes and ward design.

Currently Jigsaw has 12 registered nurses on the rota and 11 of those were registered children's nurses. The aim of the staffing on Jigsaw was to provide a 1:1 ratio of 1 member of staff to 1 child/young person. We found that as most of the admissions to Jigsaw were planned in advance the off duty rota was able to meet this ratio. A parent told us that, "There is a good ratio of staff and there are always enough staff available".

Safe recruitment practices were followed when new staff were employed or when new volunteers were taken on. Staff files showed that proof of identity had been looked at, two suitable references had been obtained and people's suitability to work with adults and children had been checked with the Disclosure and Barring Service. Regular checks were carried out on nurse's professional registration to make sure they were all registered and fit to practice and on medical personnel with the General Medical Council (GMC). The hospice has its own bank staff to cover for holidays, for training and sickness and they had been recruited using the same process as permanent staff and volunteers.

Is the service effective?

Our findings

Staff had the knowledge, expertise and communication skills to provide people with a high standard of holistic care and treatment. People we spoke to told us this and the survey results and general feedback given to the service from people using the hospice services also confirmed this. People who used the hospice in patient and day services had commented, "I look forward to coming here, it feels like a family" and "Here I feel respected". One person who used the service said, "They discuss things openly here and then work with you to make sure you get the most out the place".

People and their relatives were complimentary about the food provided which was cooked daily from fresh ingredients. We were told "The food is lovely" and survey comments said that "The meals are wonderful, I don't know how they do it". A relative commented "I had Sunday lunch in the canteen, it was absolutely first class".

The hospice had a training and development strategy in place and supporting policies and procedures to follow. This included using face to face and classroom based training, individual mentoring, e- learning to update knowledge and distance learning for more individualised courses of study. Staff had completed relevant work books or answered set questions and took tests that required a pass mark to help in the evaluation of their learning. There was a small library on site to support staff in their development.

All staff and volunteers in the service had an induction and training tailored to the roles they would fulfil and any specific needs. There was a comprehensive mandatory and statutory training programme for all those working in the hospice. Mandatory training was concerned with minimising risk, providing assurance against policies and ensuring that the organisation meets external standards. This included, confidentiality, Health and Safety in The Workplace, Fire Safety, Infection Control (clinical and non clinical settings), safe moving and handling and Food Safety, Confidentiality and Data Protection. Nursing and non clinical staff received training on dementia care, how to look after their own wellbeing, equality and diversity, nutrition the Mental Capacity Act (MCA), 'deciding right' (an integrated approach to making care decisions in advance) and deafness awareness. Nurses with specific areas of interest acted as link nurses. Health care assistants were also encouraged to develop areas of expertise and one was a moving and handling coordinator.

All clinical and family support staff were required to have safeguarding adults training at level two and basic child protection training. The registered nurses and children's nurses and clinical managers required level three training in child protection. On Jigsaw there were two members of staff who had up to date level three safeguarding training for children and young people. The remaining staff had safeguarding children and young people at level two training that had expired. This did not meet the service's policies and national guidance that all children's nurses must have safeguarding children and young people at level three.

We discussed this with the Jigsaw unit manager and at feedback with the management team. The Jigsaw unit manager had recently taken up their post and had immediately done a review of training needs and was aware that this matter needed to be urgently addressed. This training had been included in the comprehensive training and development programme starting on the 6th June 2016 when Jigsaw would

close for four days for training and staff development. During this closure level three safeguarding children and young people training would be provided for all Jigsaw staff to make sure they had all the up to date training to fulfil their roles.

The unit manager on Jigsaw was very aware of the gaps that existed in the training and development of staff on the unit and this one of the first areas that they addressed. A newly developed partnership with Cumbria Partnership Foundation Trust (CPFT) was enabling them to increase training and development opportunities within the unit. The Assistant Director of Operations at CPFT confirmed that it is had been recognised by the hospice team and the CPFT that training and development needed to be embedded further within the Jigsaw team. We could see that education and development was being given a high priority in the service and that actions needed to improve had been identified and were being acted upon in a systematic way.

Staff across the service received supervision and support and an annual appraisal of their work. This allowed for staff to have the opportunity to discuss their work and look at the educational needs for the organisation and themselves. Trustees for the hospice were also appraised.

Nursing staff were trained in palliative and end of life care and the use of equipment required by their roles such as ventilators and syringe drivers. All nursing staff did basic life support training including anaphylaxis (Anaphylaxis is a severe, potentially life-threatening allergic reaction that can develop rapidly) The children's nurses had done basic paediatric life support. Resuscitation equipment was kept in a small drawer unit of 3 drawers on the units. The drawers were not locked or secure and therefore there was a risk that resuscitation equipment could be removed or damaged. There was a monthly checklist to check the resuscitation equipment which had been done. The unit manager had already taken steps to undertake a review of the systems in use. The Resuscitation Officer from Cumbria Partnership NHS Foundation Trust (CPFT) would be visiting the week commencing 6th June. This was so they could review the resuscitation equipment and systems and make recommendations about current best practice and the storage and stock of equipment.

The Resuscitation Policy was in date with a review date of March 2017 and included current guidance from The Resuscitation Council. Records were kept of discussions with medical staff that had taken place with people about do not attempt cardio pulmonary resuscitation (DNACPR) decisions and what their choices were.

The records in people's care files we saw indicated that consent to support, care and treatment was being sought in line with legislation and guidance. Records demonstrated that people were assisted to make informed decisions about their care and treatment options and that their care wishes were explored and recorded including the use of deciding rights principles. Management and staff we spoke with understood the requirements of the Mental Capacity Act (MCA) and its application.

The service had policies and procedures for obtaining consent or assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests We noted that the consent policy in use for both adults and children and young people had passed the stated review date 1 March 2016. The policy did not make reference to the Gillick competency for children and young people and so did not meet current guidance from for example the GMC and Royal College of Nursing (RCN) guidelines. The Gillick competency guidelines help to decide whether a child is mature enough to make decisions for themselves. We recommended that the service sought advice and guidance from a reputable source on incorporating this best practice into existing policies and procedures.

Nutrition risk assessments were carried out and used to identify specific risks associated with people and these were subject to continuous review. This identified people's dietary needs, if they needed assistance to eat or drink and what type of food they had to have soft, pureed or normal diet. There was also information available if the food had to be provided via a percutaneous endoscopic gastrostomy (PEG) This is a systems by which people who are unable to take food or fluid by mouth receive supplements via a tube directly into their stomach. Many of the children who used Jigsaw had PEGS and the care for this was documented in their care plans. Where people were identified as being at risk of malnutrition referrals had been made to the dietician for specialist advice.

We spoke with one of the cooks working in the kitchen who provided all the food for the hospice. The menus in the hospice were flexible and offered a wide choice. The cook visited the units daily to find out what people enjoy and about particular preferences or dietary needs. The cook had just completed a training course on providing appropriate diets for people with swallowing difficulties and told us how they were putting this into practice with special menus. This was being piloted in the day hospice to get people's views and suggestions.

Staff told us how important it was that they offered people choices, favourite foods and high calorie snacks if their appetite had reduced. They said they could offer people high calorie drinks or snacks if people felt they were unable to eat a full meal.

Children and adults could use the dining room in the hospice or eat on the adult inpatient unit or Jigsaw. The children can order from the menu provided daily by the kitchen or take their personal preferences for example fish fingers or pizza. The hospice kitchen also provided ingredients to Jigsaw so that the children can make snacks and do baking. On the day of the inspection one young patient had just made a batch of cookies and their pleasure in making them was very evident.

Is the service caring?

Our findings

People and relatives were entirely positive about the care provided by the hospice and how much they valued the services offered. People spoke of the friendliness, approachability and empathy of staff and of "welcoming smiles and warmth". A survey comment said "I feel loved here" and another that "You [hospice staff] remember my unique story". Everyone we spoke with commented upon the caring approach of staff and being treated with "dignity" and "respect" and "compassion". One person who used the services said "I know they do far above what they have to, they definitely go the extra distance for you".

People who had used the service and carers we spoke with in the day hospice happily told us what a difference it had made in their lives. We were told that the hospice had "Turned me around" and that carers had found it a place to meet others and get the help and practical support they needed. Another comment was that there was "Always someone to talk to and help with problems, they know when you need help in any way". One person using the hospice told us "Until you've actually been in there you don't realise that it's all about living life not dying".

We attended a meeting of the 'Sunflower Group' during the inspection. This is a group specifically for carers. It offers carers an eight week programme covering a wide range of topics designed to give practical help to carers, such as financial support, nutritional needs and practical aspects of giving personal care to someone. The aim of the group was to support carers and help them to be able to deal more effectively with the many challenges and difficulties their caring roles presented. It also provided an environment where they could relax and meet new people who may have encountered similar situations to their own.

Those attending the meeting valued this service very much as it helped them in daily life and how to get what they needed to support their loved ones. The group facilitators included the hospice social worker, nursing staff and a volunteer. The hospice team recognised the huge contribution carers made and that it was easy to become overwhelmed with caring. This showed how the hospice was caring for the whole family not just the individual and giving those involved in caring useful practical and emotional support. During the inspection on the adult inpatient unit and Jigsaw we saw that staff provided person focused care and responded to people's needs, giving them the time and support they required and acknowledging the practical and emotional needs of family members as well.

Hospice staff facilitated pre and post bereavement support for children, young people and adults through the hospice's family support team. Those volunteers offering bereavement support and counselling had specific training for this role in line with ethical practice. The service also had two dedicated social workers working in the hospice to offer support and assistance to adults, children and families at all stages of their illnesses and at any stage of their individual journey. Counselling Volunteers were used extensively throughout the hospice and in the bereavement, counselling and support services. They were valued in the service and received supervision and support in their different roles and had access to training and development in their roles. The management team told us "We could not manage without them".

In 2015 the hospice took part in a service evaluation done by the Association for Palliative medicine of Great

Britain and Ireland (APM). This was undertaken on a national level within specialist palliative care services to find out bereaved relatives satisfaction with the end of life care that had been provided. This research and the information it provided added to the body of knowledge being developed in palliative care and allowed services to look at areas where bereaved relatives may not have been satisfied or felt well supported. This was one of the ways that the hospice was actively seeking views on care and constantly looking for ways to support people and their families and meet their needs and goals.

The way individual's care was planned was holistic and focused on the person's history, experiences, views and life choices. This level of information was used to support people in a way that met their personal wishes, beliefs and choices. Records we looked at demonstrated that staff took a lot of time working with people and giving them the time and information to make decisions about their care and treatment. We saw that this process was led by the person themselves or a child's family. If they did not want to express their wishes or consider an option this was also respected. Care records included a spiritual assessment and advanced care plan wishes and levels of intervention a person desired.

We saw people had discussed with staff their spiritual and cultural beliefs and how they wanted these to be met and respected. There was a well established chaplaincy team to offer pastoral and spiritual support whatever a person's individual beliefs. The chaplain and staff we spoke with told us of the importance of providing a level of caring that continued after someone died. We saw in care planning records that advanced care planning assessment and end of life care plans were done with people. This allowed people to be clear about their expectations regarding their end of life care. This informed staff of the person's wishes at this important time to ensure that their final wishes could be met. Records indicated that people's wishes were treated with the same respect in death as in life. For example advanced planning had allowed a person to have a particular funeral service they had asked for.

The team had 13 volunteers representing five different religious denominations and also a network of contacts from other world religions who could offer help and comfort. The team was available outside normal working hours as well and had a rota so staff knew who was on call. We spoke with the hospice chaplain who was clear that the focus was upon spirituality in all its many forms and they were there to offer support how the individual wanted it and to "offer a listening ear" to anyone who needed it. The chaplaincy team also provided individual support for adults such as reading books to them or their favourite poems when they could not do this themselves. The hospice had also arranged care for pets if needed so people did not worry about them whilst in the hospice.

The chaplaincy service had been able to support three weddings in their chapel at the request of people using the service. The chaplaincy service supported and helped facilitate the 'Family Days' and 'Summer Fun Days' and also the 'Family Forum'. The forum provided a place where parents could discuss any issues and problems they encountered and to "unload" should they need to. The service held remembrance ceremonies to remember when a child passed away and this service was led by families who chose to do this. The chaplain told us that the feedback received from relatives was that they appreciated that time was taken to do this act of remembrance and mark that moment and that person's passing.

Family support days were developed so that siblings of children could attend as well and it could be an occasion involving the entire family. From our observations and speaking with staff and people coming into contact with the service we saw that the hospice saw itself very much as a community. People's survey comments indicated this for example "It feels like a family". As a community it also cared for its staff as part of that community with health and wellbeing programmes that included complimentary therapies, meditation and mindfulness sessions. Special events also provided the opportunity for people living in the area to visit the hospice and find out more about its work in a social way.

The hospice was constantly looking for ways it could provide support for people in the area that they wanted or needed. One such project was to develop an area on their new website specifically for people referred to the hospice for reassurance and information. The new website was part of the on-going development of a new website being led by the Head of Marketing and Income Generation. The hospice already provided a wide range of information for people coming into the hospice, including advocacy, and this would further help people access information as soon as they were referred.

The hospice environment was calm and it was open to relatives and visitors to visit and stay, if they needed to, 24 hours a day. There was a twin bedded guest room and a family flat so people could stay close to where their loved ones were cared for.

A range of spaces were available for people to use as they wished including the chapel for prayer or reflection, the coffee lounge, reception area, lounges, garden, sensory gardens, children's play area and a quiet room for care and privacy after death. Privacy and dignity was prioritised and all discussions and medical consultations were held in private. Staff told us how they worked in a way that protected people's privacy and dignity. For example, the importance of knocking on people's doors and asking permission to come in before opening the door. We saw that doors were closed while any care, consultations or treatment was in progress.

Is the service responsive?

Our findings

Everyone we spoke with who used the hospice service confirmed that the staff teams in the hospice had responded to their individual needs. A person who had come in to the hospice to have pain control reviewed had nothing but positive comments about their stay and how well they had been involved in this review. They said they had been unable to move due to the pain before the stay but was now able to go home and control the pain and was easily able to move around. Another person who used the service told us "They [hospice staff] want you get the very best you can in the time there is. They work well with others to get things done for us".

Nursing staff explained how the care plans were developed and maintained and how they were stored securely on EMIS. This is an electronic patient record system that connects patient information across healthcare settings. We saw that written records being kept as back up were stored in a locked office and were clear and legible and had review dates that were met.

The service had responded to local needs in a proactive way by holding clinics in the hospice to improve access to clinics and consultant appointments and access to services. This included holding a paediatric clinic for children in Cumbria with muscular conditions and a twice yearly consultant led clinic for some rare conditions. This meant that adults and children did not have to travel long distances to access the consultations they needed. The hospice had made good links with Newcastle upon Tyne hospitals in relation to Motor Neurone Disease (MND) and had multi-disciplinary meetings at the hospice. The hospice's link nurse also attended such meetings and a clinic held in Penrith. This allowed services to work together to help get the best outcome for people in Cumbria.

People could be referred to the hospice by a range of professionals, including GP's, members of the palliative care team and hospital and community teams. The decision to admit someone was based on a multidisciplinary assessment which defined the need, urgency and reason for the referral. Staff at the service carried out their own multi-disciplinary team (MDT) assessment of needs on admission and discussion took place at the morning unit meeting. The admission procedure to the inpatient unit ensured that people agreed to an action plan in relation to their symptoms, emotional and spiritual support, pain relief and specialist care.

We attended a staff handover on the adult inpatient unit and saw that information was passed on in some detail and all staff were brought up to date with people's conditions and changes and any discussions that had taken place. This was also recorded on the electronic system. Forward planning and detailed planning for discharge was started at an early stage to make sure everything a person needed was in place for discharge and that people had been able to discuss any anxieties and their medications on discharge. A person who was due for discharge that day told us they had been "Very involved" in the arrangements and was at the discharge meeting with staff. They told us they had been referred for therapy from the complimentary therapists and also to the occupational therapist for assessment. They told us they believed the service had done everything possible to make sure they had got the care they needed and in the way they wanted it.

We reviewed the assessment and care planning documentation for four people on the adult inpatient unit and four care records of children, of different ages, using Jigsaw. People we spoke with who used the service told us they had been fully involved in drawing up their plan of care and making their own care and treatment decisions. Risk assessments within care records were reviewed and they were all detailed, completed, legible and with review dates being met. People`s constantly changing needs were assessed on a daily basis or more frequently throughout the day in order to address them promptly.

People's care plans included clear planning with regard the control of distressing symptom and pain management that were being updated on a continual basis. The updates included changes in people's health and what was agreed when people experienced changes in their conditions, symptoms or pain levels. Discussions with people about their wishes and their consent about any changes in their treatment were recorded. This meant that when people's conditions or symptoms changed or their pain increased they could be confident that quick action of their choice was taken in response by staff who knew them well.

Medical care was provided on Jigsaw by doctors from the adult inpatient unit. This included the Consultant and GP's who were attached to the hospice and who had a special interest in palliative care. There was currently not a Paediatrician with a specialist interest in palliative care attached to Jigsaw. The unit manager on Jigsaw told us that they hoped that an attachment could be developed in the near future. Children and young people could be reviewed at any time by the medical team within the hospice. They could also access medical support and review from their own GP if that is what families preferred.

We looked at copy of the complaints procedure that was included in the information people received on referral to the hospice. The procedure gave people timescales for action and who to contact. Discussion with the registered manager and staff confirmed that any concerns or complaints were taken seriously. The service had received numerous compliments and cards with very positive and deeply felt feedback and these were displayed on the notice board in the communal areas. There was a review undertaken of the complaints and compliments recording systems. People we spoke with and relatives said they had not needed to make a complaint and they could talk openly about or discuss anything that they wanted. They were confident that any issues they raised would be acted upon straight away.

Is the service well-led?

Our findings

Everyone we spoke with who used or came into contact with the hospice spoke positively about the way the services were being organised, about the care provided and expressed that they had confidence in the management team. The management team promoted a culture of openness and transparency and staff confirmed this. We were told "If you have a good idea its listened to" and also "I never feel isolated or ignored and things don't take forever to get done". Staff told us they could discuss developments and put forward ideas at their monthly meetings and at supervision.

Records we reviewed showed the service had a range of quality assurance and clinical governance systems in place to monitor and also update. There was an auditing programme for all the services the hospice provided and a system to monitor the service provision for example retrospective analysis of admissions and where referrals were coming from and for what reason. All were reported back at trustee board level and such analysis helped to inform forward planning.

We noted that there were some areas being monitored that had not being acted upon promptly. For example there were policies and procedures that had not been reviewed by their stated review date to make sure they still reflected best practice and current legislation. This included the referral and admission policy that should have been reviewed in January 2014 and the Access, the Security Policy that should have been reviewed in 2014 and the End of Life policy that should also have been reviewed in 2014. Medication policies and procedures had not been reviewed to ensure that they reflected the new pharmacy contract with the community pharmacy.

On Jigsaw checks had been carried out by staff on resuscitation equipment and it had been noted that some items were missing. However this had not been followed up to ensure all was put in place. We also noted that medicines management had been audited and a report had been written which summarised the issues. However, the same issues were still being identified in subsequent audits therefore indicating that actions to address the issues were not being undertaken. This was not the case generally and we found that following a review of staff training it had been highlighted that staff had training needs that needed addressing. These were being addressed with four days of training on Jigsaw. We recommended that guidance was sought on action planning processes following an audit to ensure that all issues requiring attention were addressed in a timely manner.

Procedures and monitoring arrangements were being followed in the event of accidents and incidents relating to people's care. Records showed that incidents were analysed and the results communicated to staff along with any required actions. Appropriate notifications had been submitted to CQC.

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We found there was a clear management and organisational structure within the hospice. The staff we spoke with were aware of the roles of the management team and of their own responsibilities. They showed a commitment to providing a good quality service for people who they supported. Staff told us that the senior management team were

approachable and were accessible to staff and people using the service. We were told by staff that the Trustees were also a regular presence within the hospice and at hospice events and fundraising.

The governance and management structure provided clear lines of accountability for decision making that focused on service and staff development and quality monitoring within the hospice. The management team told us that services were shaped and developed to meet the needs of those who used them. For example, the children's community team was to be accommodated in the hospice to allow them to develop closer links with the Jigsaw unit. This was aimed at enhancing the care and support delivered to the children and their families across the county.

All staff we spoke with talked with passion about the work of the hospice and the people in their care. They told us they enjoyed their work and what a "privilege" it was to be able to provide the care people needed and "deserved". They told us they valued the support they received from their peers and senior managers to make sure they could do the job to the high standard required. One staff member told us "Lots of opportunities to develop here and we are so well supported and have the time and space to discuss and debrief after dealing with a difficult situation".

There were clear strategic plans in place for the continual development of hospice services and a business plan which clearly summarised the organisation's aims and objectives, with forward planning strategies being implemented. This helped the registered provider to focus on continuous improvement by regular assessment and monitoring of the quality of service provided. Minutes of board meetings demonstrated that participants had a good understanding of their role and were accountable for the strategic direction of the service.

The hospice had in 2012 participated in a board development programme with 'Help the Hospices' looking at the key principles of effective governance by the board. The hospice Board of Trustees had undertaken a further review of Eden Valley Hospice and Jigsaw in March 2016 using the business school of City university in London to monitor their overall progress and identify where they might be able to make further improvements. In comparison there had been improvements made to governance processes in a number of areas, for example formalising terms of reference and strengthening stakeholder relationships. The hospices new strategy document had included the perspectives of different stakeholders and their input had helped shape the hospice's strategic planning. It also highlighted areas that still needed to be progressed and the board was aware of what remained to be done.

The hospice management team looked for ways to keep up to date with what was happening locally and nationally in the care sector. The attended local intelligence networks including the Cumbria Controlled Drugs Local intelligence Network (CD LIN). This helped make sure updates, practice and procedural issues and changes in any guidance, best practice drug licencing and legislation were shared across the county. Also this forged important cross boundary working and information sharing with other agencies, such as the department of health, (DoH), home office, the police and the CQC.

The hospice used a range of surveys to gather views and suggestions from people using all sections of the organisation, health care professionals and staff working in it. Feedback about the service was welcomed. Comment boxes and leaflets asking for people's views and experience of the hospice services were easily accessible within the hospice. We looked at the last survey results and found they were very positive and indicated the service was held in high esteem by those using it and their families.

Staff we spoke with fully understood the hospice philosophy and aims and everyone we spoke with felt they worked together as a team to meet these aims. People's experience both verbally to us and via surveys was

that staff were meeting these aims. The service also had a track record of providing a very good service and of seeking continuous improvement. We found that staff and volunteers were wholly engaged with the culture of the service and were committed to helping people lead full lives.