

Severn Hospice Limited

Severn Hospice Bicton Site

Inspection report

Severn Hospice
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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place on 6 April 2016 and was unannounced.

Severn Hospice Bicton Site is registered to provide specialist palliative care and clinical support for adults with life limiting illnesses. The service provides care on their in-patient facility which catered for up to 16 people over two wards. At the time of the inspection there were 15 people using the inpatient service. The Hospice at Home service was based on site and provided a service to both the Apley and Bicton sites. At the time of our inspection two people were receiving support from the Hospice at Home team. The clinical nurse specialist team also provided expert advice, support, liaison with other healthcare professionals and signposting for people in the community.

The service provided counselling and bereavement support, day hospice care, family support, chaplaincy, out-patient clinics, occupational therapy, physiotherapy, complementary therapies and a lymphedema service (for people who may experience swellings and/or inflammation following cancer treatment).

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

Medicines and related confidential data were not always stored securely in treatment rooms and audits were not completed on the safe storage of medicines. Some medicines, requiring extra security arrangements that had past their expiry date, were not always separated from other medication. The provider had safeguarding procedures that were well understood by staff and ensured people were kept safe. Audits were undertaken to make sure all equipment and the building were checked and serviced as required. Risk assessments reflected how care should be provided to the person to minimise any risks to them; they were regularly reviewed to adapt the level of support needed in response to people's often rapidly changing needs.

There were sufficient staff on duty to care for the needs of each individual. Ongoing learning was encouraged and staff were supported to access a variety of training courses which included communication skills, care of the dying and mentorship. The service had an education lead who was responsible for arranging training programmes to meet the needs of staff. All new staff had a thorough induction which included working alongside other disciplines both within the hospice and externally in order to gain an understanding of how the services worked together. Staff were able to access clinical supervision and were provided with an annual appraisal. Robust staff recruitment systems were in place which ensured that only applicants who met the service's high specifications regarding qualifications, experience, character and caring abilities were employed.

The provider recognised that people's capacity to make informed decisions about their care could fluctuate,

so this was reviewed at regular intervals throughout their stay. Documentation in relation to people's decisions about resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were flexible. These could be transferred for use within the hospice and also remained valid when people were at home. People were complimentary about the food on offer; it looked appetising and people's specific dietary needs were well catered for. The provider employed a range of healthcare professionals including a team of doctors who worked across all the services provided by the hospice to ensure all aspects of people's health was considered.

People described the care and compassion they received from staff. Staff were motivated and showed a high level of empathy and kindness to people. Staff used warmth and caring terms when discussing people's needs, including their psychological and emotional well-being and those of their family. People's spiritual and cultural needs were considered and met by staff with support from the chaplaincy service and the social work team. People were fully involved in the planning of their care and were encouraged to express their views, preferences and wishes in regard to their care, support and treatment. People were supported by staff in a dignified and respectful manner, with a focus on how they could maintain their optimum level of independence. Staff were knowledgeable about how to access independent advice and support for people when this was required.

People told us they were enabled to achieve a good quality of life from the support of staff and this had helped them to adapt to the changes brought about by their illness. The Hospice at Home service enabled people to be at home if they had chosen this as their preferred place of death, with the assurances they needed that their needs would be met in a timely manner. An emergency discharge pathway was in place to facilitate people being able to go home quickly if they changed their mind and wished to die at home. Staff demonstrated to us they knew people well and understood their individual needs. People's preferences and wishes were always respected by staff, with clear examples of how they made significant efforts to ensure these were possible. Staff were familiar with the complaints procedure, it was clearly displayed and leaflets were also available for people to refer to. Arrangements for recording, acknowledging, investigating, responding and learning from complaints were comprehensive.

The provider, management and staff team demonstrated an open and inclusive culture existed which focused on people and supported its staff to provide high quality care. Staff were happy in their work and were clear about their roles and responsibilities; they felt supported by management and involved in the development of the service. The registered manager had recently completed a program of education in order to expand their knowledge and in turn used this to improve the leadership within the hospice environment. As a result of analysis and investigation of incidents, learning had taken place and changes to practice shared and implemented.

The provider promoted quality end of life care for all, not just those people using the service, but also the wider community. The provider provided training and education through the development of external professionals, which included speaking at national conferences. Staff practiced within relevant key guidance as it emerged, for example those set out by the National Institute for Clinical Excellence (NICE) Quality Standards for End of Life Care. Medical staff had also worked in partnership with the local council to provide accredited training in end of life care for all levels of external care staff. A comprehensive program of in-house audits such as medicines, education and the environment were completed and the findings fed into the governance meetings.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not consistently safe.

Medicines and related confidential data were not always stored securely and medicines that had past their expiry date, were not always separated from other medication.

Safeguarding procedures were well understood by staff and ensured people were kept safe.

Risk assessments reflected how care should be provided to each person to minimise any risks to them.

There were sufficient staff on duty to care for the needs of each individual person.

Is the service effective?

Good 

The service was effective

The education lead set up training programmes to meet the needs of staff and staff were provided with a comprehensive induction.

People's rights were protected under the Mental Capacity Act 2005 and no one was being deprived of their liberty unlawfully.

People's specific dietary needs were well catered for.

A range of healthcare professionals including a team of doctors worked across all the services provided by the hospice to ensure all aspects of people health and well-being were considered.

Is the service caring?

Good 

The service was caring.

People were supported by staff who demonstrated high levels of caring and compassion.

People were fully involved in the planning of their care and were

supported to express their views, preferences and wishes in regard to their care, support and treatment.

Staff were knowledgeable about how to access independent advice and support for people when this was required.

Is the service responsive?

Good ●

The service was responsive.

People were enabled to achieve a good quality of life through the support they received from staff.

People using the Hospice at Home service were assured their needs would be met in a timely manner.

Staff knew people well and understood their individual needs.

Effective complaints handling processes were in place.

Is the service well-led?

Good ●

The service was well-led.

The provider promoted an open and inclusive culture which focused on people.

Staff were supported by management in a variety of ways, including receiving updates about developments within the service.

Learning took place and changes to practice was shared and implemented as a result of analysis and investigation of incidents.

Severn Hospice Bicton Site

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 6 April 2016 and was unannounced.

The inspection was carried out by one inspector, a pharmacy inspector, a specialist advisor and an expert by experience. The specialist advisor had the experience of working as a nurse within the field of end of life care. The expert by experience is a person who has personal experience of caring for someone who has used this type of care service.

Before our inspection 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 what improvements they plan to make. The registered manager had submitted the information as we requested.

We also reviewed the information we held about the service including notifications of incidents the provider had sent us. Notifications are reports the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We contacted commissioners from four local Clinical Commissioning Groups (CCG) who had commissioned the service to provide care to people from their own locality to ask for their views on the service. The CCG is responsible for buying local health services and checking services are delivering the best possible care to meet the needs of people.

We spoke with six people who used the services provided by the hospice and four relatives. We also spoke with one volunteer, a consultant, and a student nurse, the chef, 15 staff members, the inpatient matron, the community matron and the registered manager.

We reviewed six people's care records, to see how their support was planned and delivered. We spent time observing staff interacting with people and their relatives. We looked at other records related to people's care and how the service operated. This included eleven medicine records, three staff recruitment records, a range of policies and procedures, quality assurance, clinical and environmental audits, meeting minutes and records of complaints.

Is the service safe?

Our findings

People told us they were satisfied their medicines were always on time, anticipated and if required topped up with no delay. People told us, "Medication is always there and importantly the hand to hold is there as well whenever needed, day or night", "They [staff] completely sorted me out by managing my drugs and they have made my pain non-existent, I was in agony when I first got here" and "Here everyone knows me and the complexity of my condition and my need for pain relief. If I need anything here it is given". All of the people we spoke with told us their discomfort and pain was so well managed their need for top up pain relief had reduced.

Medicines were checked for accuracy when people were admitted to the service and there was a clear system for managing the ordering and supply of medicines. However, medicines and confidential data were not always stored securely in treatment rooms, and unauthorised people had access to these rooms. We found there were no audits completed on the safe storage of medicines at the hospice. Processes were in place to check most medicines were within their expiry date and suitable for use, however we found one expired item still available for administration. We also found some medication, that required extra security arrangements, had not been included in this process and these medicines, once past their expiry date, were not always separated from other medication. This meant that an unnecessary potential for an administrative error existed. Medication that was found to have expired or was unwanted were disposed of safely and correctly.

We found no regular competency checks for staff administering medicines were being provided outside of their initial induction on commencing within their role. The matron told us however that competency checks were regularly undertaken on staff knowledge of using syringe drivers (portable pumps that are used to provide a continuous dose of medicine through a syringe). They agreed to consider this issue and look at implementing such checks.

Daily temperature records were viewed which recorded the temperatures for the medicine refrigerator and the medicine room temperature. However, when found numerous entries over several weeks to be outside the correct storage temperature range; no records were available to show what action has been taken to ensure medicines remained suitable for use.

A medical team based at the hospice prescribed people's medicine requirements. We were told that if advice from a pharmacist were needed, then the team would contact a pharmacist at the local hospital. Although there were regular arrangements in place for a pharmacist to provide a weekly clinical pharmacy service at the hospice, these had not recently taken place as we were told the provider of the weekly clinical pharmacist service was unable to provide this due to staff shortages. This would include involvement with clinical audits, medicine incidents, medicine counselling, and clinical pharmacy support to the prescribing team. Medicines that required additional controls because of their potential for abuse were stored securely and the register for these medicines was up to date. Prescription pads were securely locked away and there was a record of what had been prescribed for audit trail purposes. In the event of a severe allergic reaction, there was provision for the availability of emergency treatment packs. We saw these were readily available

for staff to use if required quickly.

We checked the medicines prescribed on prescription charts and saw these were clearly recorded, and sometimes included additional instructions for safe administration. We found medication charts had not been written up with clear indications for administration of "when required" medication. However, we found one person had been inadvertently, prescribed an increased amount of one medication, due to the use of a different form of the medication.

Medicine incidents were reported with arrangements in place to ensure they were investigated. These were discussed at meetings between the matron and senior nurses and additionally shared at ward meetings with all staff. This helped to ensure lessons were learnt and actioned to ensure safe practice was followed. Staff were able to describe an incident to us, which had resulted in a change of practice, which we observed taking place.

People told us they felt safe. They said, "Thank God I am here, I know I am safe and more importantly my wife knows I am safe; this is important for me", "I do feel very safe and secure, you could not wish or ask for more", "I feel safe and secure, I have no worries, I could not cope with worries now, I need protection and I have got it until I die" and "It is a great relief to me and my family that I am here and safe". Relatives told us, "My husband feels safe now he is here" and "We as a family are so utterly relieved he is here at last and is safe, it is like going from hell to heaven". The relatives we spoke with all confirmed they had no concerns at all and felt only relief their relative was now safe, in the care of the hospice.

The provider had safeguarding procedures in place. Staff members said, "We have had training, although I haven't had to make a referral, I would refer to the policy, run it by the social work team or directly contact the local safeguarding team for advice" and "I would contact the safeguarding team directly and also discuss any concerns with my superiors; there are good structures and guidance in place to protect people". All of the staff had received safeguarding training as part of their induction and ongoing training. Staff explained to us how they would protect people's safety from the risks of potential harm and abuse. They demonstrated how they would recognise and report abuse and told us that they were confident the correct action would be taken.

Environmental risk management systems were in place for the hospice. There were maintenance records for servicing of equipment, fire systems, boilers and the building. Audits were undertaken to make sure all equipment and the building were checked and serviced as required. Systems were in place for the maintenance of equipment such as hoists, specialist beds and equipment. Feedback about any actions outstanding or completed were reported back to regular governance committees. Staff understood how they should respond to a range of different emergencies including fire, and fire training was part of their induction. Staff took part in regular fire drills which helped them to remember the procedures and there was appropriate signage about exits and fire equipment throughout the hospice. Fire safety equipment had been serviced and was regularly checked. We saw that in line with health and safety regulations people who required the use of hoists or equipment to support people to move had been assessed for an individual sized sling to attach to the equipment. Other equipment to minimise any identified risks to people's safety in use included sensor mats to detect movement, bed rails and increased staffing levels for observations.

People's care was delivered as safely as possible. A staff member told us, "As soon as we enter someone's home to support them we sit with them and their family and complete a risk assessment, this is in addition to any other information we have to hand, and it helps us get to know the person better too". Risk assessments we reviewed reflected the care that should be provided to the patient to minimise any risks to them; these were regularly reviewed to adapt the level of support needed to people's often rapidly changing

support needs. Although the records had been updated there was no way of knowing how the staff member had reached the risk level calculated. A completed copy of the risk assessment sheet used was not available in the person's care record, as a separate new score sheet was not completed each time the risk was reviewed by staff. Only the score was documented by the staff member without demonstrating to the reader how this had been reached. This meant it would be difficult to establish how the score had been reached retrospectively, if needed for any reason. Some risk assessment scores entered had not been signed for by the staff member completing them. The inpatient matron agreed to ensure a full copy of the risk assessment tool utilised and any working out would be included in the care records in future.

People told us staff were able to respond to their needs quickly and without delay. A person said, "I can press a button and people come and they come quickly here, I am not left to hang on". We spent time with one person and they began to feel unwell; they pressed their call bell for assistance and staff responded immediately. Their needs were met promptly and the person visibly relaxed. On the day of the inspection there were sufficient staff on duty to care for the needs of each individual. The provider had its own nursing bank and if any short staffing did occur there was some flexibility across the provider's two hospices to cover any shortages. Staff we spoke with confirmed this and all told us they felt staffing was always of a good level at the hospice.

The service had a robust recruitment procedure to ensure staff appointed were suitable and safe to work with people. A staff member said, "I had to go through all the usual checks and give references". These procedures included requesting and validating references, criminal records checks and checks on people's identity. Application forms included a full previous employment history. An explanation for any gaps in employment history was noted in the records.

Is the service effective?

Our findings

People told us they received excellent care from skilled staff. One person told us, "Staff are skilled at everything and I know that all procedures and hygiene are observed at all times". A relative told us, "The staff made me feel comfortable as you can see, they are so skilled, calm and well trained, they know exactly what they were doing". Another relative told us, "The two ladies who came to see us were so personable and knowledgeable; I was comfortable straight away with them being in my home". We saw on-going learning was encouraged. Staff told us they had applied for various training courses such as communication skills, care of the dying and mentorship and had been supported to access these. We observed that some of the upcoming training on offer included the use of syringe drivers and the pain and symptom management at the end of life.

Staff told us, "Training is essential, you can never know everything.", "There is a real hunger for learning here" and "Training provided here is very comprehensive". The Clinical Nurse Specialist (CNS) service provided an external programme of training twice yearly to groups of district nurses within the locality entitled 'Essential Elements of Palliative Care'. The service had an education lead who was responsible for setting up training programmes to meet the needs of staff. Medical staff told us they had also developed a journal club which they invited external speakers to attend to discuss a variety of subjects, further enhance their own knowledge and share best practice. Staff told us clinical supervision was encouraged and they had a yearly performance review in the form of an annual appraisal. All levels of staff were all able to access psychological support. One staff member told us there were opportunities for psychological support in - house or with a suitably trained person of your own choice. A staff member told us the supervisor they worked with was external to the organisation and this was fully supported and funded by management. All the staff we spoke with described the extensive peer support they could access, both formally and informally.

All new staff had a thorough induction before they started working at the service. □ This included working alongside other disciplines both within the hospice and externally. This was to gain an understanding of how the local services work together to provide effective care. A student nurse we spoke with told us they had been allocated a mentor whom they met with weekly and had received an induction pack to record and reflect upon any learning. They said, "There is a whole different ethos here, it's a good learning environment, I am so glad I came here". Staff told us they did not work alone until they felt completely confident to do so. We saw their progress and learning was supported through regular meetings with a senior member of staff during induction. The induction included the shadowing of more experienced staff until they could demonstrate they had attained the level of competency required for their role, training sessions and reviewing of policies and procedures.

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

interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person told us, "I am consulted about everything that is done, I am asked if I am happy and in agreement". We saw each person was assessed in relation to their mental capacity on admission and the appropriate documentation was completed by them or their representative in relation to their consent to treatment. We observed staff always asked if people were happy for things to be done and discussing their preferences with them. Staff had a good understanding of what a deprivation of liberty was, what constituted restraint and when a DoLS referral might be necessary. They also recognised people's capacity may vary depending on circumstances such as physical and mental wellbeing, so staff reviewed this throughout their stay, which was evident in the records we reviewed. At the time of our inspection no one was subject to DoLS.

Documentation in relation to people's decisions about resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were in place. These were flexible and could be transferred for use within the hospice and also applied when people were at home. This meant that any unnecessary distress was reduced for people as these delicate conversations were not repetitive in relation to their choices in regards to resuscitation. Discussions were also underway with the ambulance service to ensure patients who are transported at end of life or in an emergency situation were taken to their place of choice to die. DNACPR records were signed by a doctor, completed in full and were with the patients and a relative's knowledge, participation and agreement.

People were complimentary about the food on offer. One person said, "I am on a soft diet, but anything I fancy they prepare for me. They [staff] cut up all my food but not in a way that makes me feel bad or a real nuisance or worse like a child". Other people told us, "The food is fantastic" and "The food is second to none". We saw the menus were well balanced and varied. Relatives told us food was served in the way their family member preferred. People were provided with drinks within their reach and these were replenished throughout the day and night. Meals were prepared using fresh ingredients and included plenty of fresh fruit and vegetables. We observed the food served looked appetising and was served in a timely manner.

People's individual preferences, special diets and any allergies were catered for. Staff alerted the kitchen staff, about people's specific dietary needs, which was recorded for all the kitchen staff to refer to. However, the chef told us the system was sufficiently flexible to meet the needs of new admissions of people. They said, "The staff are good at telling us about any changes". Each person was approached individually each day and asked what they would like to eat. Dietary recommendations from healthcare professionals were followed. The chef understood people's individual requirements for example, preparing soft diet food or pureed meals when people had difficulties with swallowing. Staff we spoke with were knowledgeable about people's nutritional needs and any related risks and we observed staff had time to help people to eat and drink effectively, providing them with encouragement when necessary. Some people were identified as requiring nutritional support in the form of supplements and these were given as a supplement to meals not instead of meals.

A person told us, "They [staff] have managed quite quickly to stabilise my oxygen intake and pain, so much so I cannot believe I am well enough to go home tomorrow; everything is set up there for me". The service employed a range of healthcare professionals including a team of doctors who worked across all the services provided by the hospice. To ensure all aspects of people's health was considered each person was discussed at nursing and medical handovers between shifts and at weekly multi-disciplinary meetings. These were attended by representatives from all professional groups where physical, social, psychological

and spiritual care needs were discussed and plans for care reviewed. If required, people were referred for input from other healthcare professionals. For example, occupational therapists and physiotherapists then assessed and recommended treatment which staff provided with this care on the ward or in their home. This system ensured effective continuity of care and that staff were knowledgeable about people's individual care, treatment and any relevant updates. Records we reviewed demonstrated people were referred appropriately and without delay to a variety of other healthcare professionals both externally and internally.

Is the service caring?

Our findings

People spoke highly about the care and compassion shown to them by staff. They told us, "They tick all the boxes here, the staff are wonderful and their care is second to none", "The care here is out of this world they make sure I am comfy at all times; it's all done for my ease", "It is an unbelievably caring place, they care for me and my family", "They all have such passion and care here it's all about the person and the family", "The staff are fantastic and always there for you" "Staff are all so knowledgeable and kind" and "It is very comfortable here, the staff are all marvellous". Relatives said, "The care here is wonderful nothing is too much trouble. We have only been here a few days but it is excellent, caring and compassionate with nothing being too much trouble ever" and "The care, the kindness, the reassurance, everything is good". Testimonies in relation to the Hospice at Home service included, "Superb people who give of yourselves in support of patients and families", "The care they give is exemplary", "The staff are kind and considerate, you couldn't ask for better" and "All the staff are amazing".

During our inspection, we observed staff being kind and compassionate to patients and their families. People told us how staff showed concern for their comfort and well-being at all times. One person told us how staff had spent a lot of time with their daughter helping them understand what is happening and going to happen to me, they went on to say, "She was baptised last week in the chapel and my wife and I are going to renew our vows before I die and while I am able, staff have supported us to do this". Another person said, "If I cannot see what is being done to me and it isn't explained it is frightening and you feel unsafe and vulnerable, I have never felt like that here, they tell me everything at all times". A relative told us, "Even though [relative's name] is probably going to die in the next 24 hours, his room is nice for him, as he can watch the birds and he has always enjoyed bird watching; they [staff] make sure he is content, nothings too much trouble for them". A staff member described the special relationships they made with people and families during their stay. They said, "It's not just the patients but the relatives too, you build up special bonds with both. Some relatives have come back and visited us for many years after their loved one has passed".

We observed a staff handover and were able to hear the genuine warmth and caring terms used by staff when considering people's needs. This included their psychological and emotional well-being and those of their family. The chaplaincy service was available to offer people spiritual and /or religious guidance and support. People we spoke with were aware of the support available to them from the chaplain. A chapel was open to all for quiet reflection or prayer and the chaplain and a team of volunteers were visible and available at all times. The chaplain told us their support was available to everyone, whether or not they had a particular faith. People's more diverse needs were considered throughout their care and treatment both on the wards and in the community, often assessed by the Clinical Nurse Specialists (CNS) in community. For example accessing interpreters if English was not the person's first or preferred language.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in developing advance care plans. A person told us, "They [staff] are helping me with an advanced directive so that all my wishes are taken into account.

It has been a relief to me to know when I am powerless as I will be that my preferences will be observed. I feel I have a voice here and that I matter". Records we reviewed demonstrated people entering the dying phase had been supported to develop an individualised care plan to be followed as they near the end of their life. This included their wishes and preferences. These were agreed by the multidisciplinary team and the person or their representative. One person told us, "They [staff] have talked through everything with me which has been a huge relief to me as I am worried about my family. I know all of my preferences and wishes will be honoured". We saw people and those important to them had bereavement support during and for those that matter to them after death. When the death certificate was issued to the next of kin, they were provided with a leaflet given explaining what to do next. This identified the steps taken to register the death, of their family member and may also give points on bereavement and what emotions to expect as this may be the first death a family has ever witnessed or had to deal with. A staff member said, "The person's preferences are always met, as this is our purpose, to give people a good death and this should be done with their wishes in mind".

Throughout our inspection we observed staff treating people with dignity and respect. One person told us, "I have my dignity and respect shown me all the time here. My privacy is respected and I am comfortable in body and mind. Being here has given me my self-respect back again". Another person said, "It is very important to be classed as a person not an illness, which is what is done here". All of the people we spoke with had nothing but praise for the staff and how they enabled them to have a good quality of life and their independence promoted. People told us, "When I came in here four weeks ago I was in hell, I am now in heaven; they have saved me", "My independence is not only maintained here it has been enhanced, with some very small adjustments and that means a lot to someone like me", "This special bed enables me to independently change my position which means a lot and I have a remote TV control which works, so I can choose my viewing. Small things I know but big for me" and "I have improved so much I am going home tomorrow with the support of Hospice at Home. I have arranged with them that I am coming back in here to die when it is time". People confirmed their consent was always sought and they had their independence given back to them in the way their care was provided. A staff member said, "People aren't all the same, some people are very private so you need to get to know them and what suits them".

We observed staff were always calm and respectful when entering people's rooms and asked their permission to enter. A relative said, "[Relative's name] dignity is respected at all times and his terrible pain is controlled. They [staff] have given him back some quality of life in his last remaining hours, for which we are so very thankful". Relatives were able to visit without restriction. Beds for families to use in a dedicated room for overnight stays were available just a short distance from people's rooms, where they could stay whilst people were receiving treatment. Alternatively comfortable recliner chairs were available in each person's room if relatives preferred to stay nearer to their loved one. One relative told us, "The facilities here are first class for [relative's name] and us. I have a bed if needed but I am staying at his bedside and the recliner is very comfortable as I want to be with him at the end". This meant people could retain and find comfort with family nearby and in routines that were familiar to them.

People had access to information about the services provided by the hospice, including advocacy services, their internal and other external bereavement services. For those people who did not have a family member or carer who was appropriate to support them to make decisions, staff told us an Independent Mental Capacity Advocate (IMCA) was sought. This was so that any decisions made on the person's behalf are in the person's best interest. At the time of the inspection there were no people who required an IMCA; however staff were able to explain how they would respond should a person require one.

Is the service responsive?

Our findings

People told us they were enabled by staff to achieve their optimum quality of life by adapting to the changes brought about by their illness, from the point of a life limiting diagnosis. People told us, "I am not frightened because my needs are met no matter what they are and the reassurance is always there, that means a lot to me and my family" and "Everything is here for me and it has aided my recovery in order to face the next stage without fear". A relative said, "The staff are always there, they anticipate everything and they have got him out of pain".

The Hospice at Home team enabled people to be at home if they had chosen this as their preferred place of death. One person told us, "Hopefully I am going to improve and I am then hoping for Hospice at Home until I come back finally". One relative we spoke with whose family member had recently used the Hospice at Home service said, "The whole thing was well managed, and it was great. It all went so smoothly, everything just fell into place and that minimised the stress for us all". Two people we spoke with were hoping to go home and be supported by Hospice at Home team. They told us all the appropriate arrangements had been put in place including an alarm device which they could press and someone would respond quickly from the team. This meant people were able to receive treatment at home with the assurances they needed that their needs would be met in a timely manner. Testimonies in relation to the Hospice at Home service included, 'We could not have carried out mom's wishes to stay at home without your help and support', A service that is second to none' and 'We are most grateful for the speed and efficiency with which care was put into place'. The hospice provided a 24 hour telephone service for people, their families and other healthcare professionals to access the support, guidance and advice they needed.

A person told us, "I have a little dog that I miss, he could come in but he would probably trash the place so they arranged for me to go home for 24 hours to be with my family and the dog. He never left my side; it meant so much to me and him. They organised the bed, equipment everything. I am so glad I did it, it tired me but it was worth it". Another person said, "I am going home and all the plans have been made with me, the nurse will come daily and I will have a special alarm bell". We saw that physiotherapists and occupational therapists conducted joint visits to people's homes to look at how adaptations may be utilised. This was to support people's preferred wishes to stay at home to be achieved in a safe manner. The provider had an emergency discharge pathway in place in order to get people home quickly if they changed their mind and wished to die at home. The ease and speed at which this could be achieved was crucial; we saw the process was simplified due to the range of services operated by the provider, including Hospice at Home that could facilitate people's safe return home. Appropriate support could be put into place quickly. This support ensured the person was transferred to the place they wanted to be with the appropriate multidisciplinary team members aware of their return home. There was also a discharge checklist which included the DNACPR document which could be transferred into the community with the person so that it does not have to be repeated by the person's own General Practitioner (GP). This meant people's preferences and wishes could be met flexibly by the service, as the need arose.

People told us and we saw staff were reactive and available to respond quickly to people's changing needs, including answering call bells in a timely manner. Each person's care, progress and treatment were reviewed

at regular meetings in detail and this included input from all members of the MDT. We observed the staff team demonstrated through their input at the meetings they knew people well and understood their individual needs. They discussed the progress of physical symptoms including pain management, spiritual needs, emotional and psychological well-being and social support. All of these aspects of care had been assessed and discussed with the person and their family. We saw discussions took place in MDT meetings in relation to people wanting to go home. For example for a 48 hour period and then return to the hospice as their preferred place of death. This meant the provider was continually updating, attending to and reviewing people's needs and preferences.

We saw care at the end of life was personalised. One person was assisted to visit their optician and said, "At least I will be able to see properly for the time I have got left, which means a lot to me as I love reading and it's getting difficult". Other people said, "Do you know they are so thoughtful, they have provided a little smoking room so I don't have to go and stand outside in the cold for a smoke", "I have relaxing complimentary therapy massages and soothing music which really helps me. I feel so much better afterwards". A person told us how they were supported to go out to lunch with a relative with the help of a portable oxygen pack and we saw that another person had been enabled to have their dog brought in to the hospice as was their wish and the dog was present at the person's death. Care plans we reviewed showed care was individualised and people told us it was provided to them as per their expressed preferences. A staff member said, "If someone smoked and wanted a cigarette we would wheel a bed in there if we had to". This meant the staff enabled people to access the activities and facilities that were important to them as they approached the end of their life.

People knew how to raise concerns or complaints and were clear about who they should speak to if the need arose. A relative said, "We as a family have no complaints about this place, it is all wonderful". Staff we spoke with were able to tell us how they would support people to make a complaint in line with the complaints procedure. A staff member told us, "We do get feedback about complaints. I am confident that anything people raise as a concern is dealt with properly".

The complaints procedure was displayed and leaflets were also made available in communal areas and provided to people using the Hospice at Home service. There were arrangements for recording, acknowledging, investigating and responding to complaints and implementing any actions taken or changes made as a result. Records showed outcomes from complaints were clearly documented and were communicated to staff.

Complaints received were a rolling agenda item at regular clinical governance meetings, held with managers, senior nursing and medical staff. We saw changes to practices were made following complaints to improve the service provided formal debriefs to discuss any changes to practice were also conducted with staff involved and the wider team. We saw the provider routinely used complaints as a learning exercise. For example, as a result of a complaint received provider had changed their policy in relation to the use of photography. They had put up notices around the hospice including the day hospice relating to the change, to both update and advise people visiting or using the service. This meant the provider actively encouraged staff to improve their practices and people experience better care. We saw that staff had received numerous compliments which contained very positive feedback and these were displayed, collated and shared with staff when they were named individually. A staff member said, "I am proud to say I have been mentioned by name on a few thank you cards and it makes you go home feeling good about yourself".

Is the service well-led?

Our findings

The provider demonstrated they promoted an open and positive culture which focused on people. People's feedback about the way the service was led said, "There is a wonderful atmosphere here and anything you could want is here" and "My summing up of this place is spend some time here and you will see how well managed it is, it's excellent on all counts". Relatives described the service as, "Excellent", "The best there is" and "So professional". A staff member said, "I have to say the hospice is brilliant to work for, the management are great".

All of the staff we spoke with were passionate about their experience of working within the service. Comments included, "I love it here, I came from a hospital and didn't want to nurse anymore, but now I love coming to work" "I am very happy here, I definitely enjoy working for Severn Hospice" and "I absolutely love it here I wish I had come to work here twenty years ago". We observed that staff were happy in their work, were enthusiastic about their role and clearly committed to providing a high quality service to people and their families.

Staff we spoke with were clear about their roles and responsibilities. The registered manager had also led on a series of training sessions with a focus on the leadership skills required of all senior nurses through all departments. This was to ensure senior nurses were clear about how they should be meeting the requirements of their roles. Staff at all levels told us they felt involved and supported by management in a variety of ways, including clinical or multi-disciplinary team (MDT) meetings to discuss patient care and also team meetings where they also received updates about developments within the service. A staff member told us, "We have speakers from other areas of the service coming into our team meetings; recently someone from human resources came in, so you get to know other staff which is good". Other staff told us about the ways they were kept updated about developments within the service, saying, "We get information passed to us in meetings, email updates on what's happening and a newsletter that comes around" and "I am supported on a personal and professional level, there are good management structures in place and I feel valued". A doctor told us MDT or clinical meetings encouraged 'challenge to each other's views openly', going on to say the management promoted a culture of 'everyone feeling valued and their opinion matters'.

The registered manager was also the deputy chief executive and director of care. They consistently notified us of any significant events that affected people or the service. We requested information in the form of a Provider Information Return (PIR), this was fully completed and returned to us within the given timeframe. We saw senior staff were visible at all times around the hospice. Staff told us management were 'approachable' and said they were always visible, with one staff member adding, "You can talk to the matron at any time". One person was asked about how they felt the service was managed and said, "Everything runs like a well-oiled machine".

Staff were aware of the structures in relation to leadership within the service. Healthcare professionals we contacted prior to our inspection gave positive feedback about the leadership within the service. Some staff spoke of their contact with the Chief Executive Officer (CEO) saying, "The CEO is very approachable" and "Management always thank us for what we do and you do feel appreciated, the CEO comes in to see us at

various gatherings and thanks us too". The registered manager kept themselves updated with latest research that related to hospice care. They had recently completed a master's program in hospice leadership to expand her knowledge and continually improve the leadership within the hospice environment.

Staff explained to us how they completed incident forms and they received feedback from management relating to these. They said learning was identified and changes to practice adopted if necessary. Statistics were collated in relation to all incidents that occurred and these were shared and discussed at the clinical governance group meetings. Updates were given and actions taken or to be completed recorded. We saw as a result of analysis of incident reporting it had been identified that staff required education in relation to the differences between the types of pressure sore to ensure accurate reporting and this had been provided.

The registered manager spoke about the importance of partnership working and sharing good practice. They stated, "It is vital that if we want to continue to grow, that we secure ongoing funding for service developments which meet the needs of the local population, this includes working alongside external organisations and sharing best practice". The provider worked hard to promote quality end of life care for all, not just those people using the service, but the wider community. They were attempting to achieve this through the development of external professionals, which included educating staff in residential care settings. Clinical Nurse Specialists (CNS) provided an external programme of training for District Nurses (DN) and comments from the evaluation of the course feedback in October 2015 included, 'This course was an excellent learning curve, was informative and educational' and 'Most enjoyable, varied subjects and ways of teaching, kept my attention and was good to share experiences and job roles'. Hospice at Home staff worked alongside the GP and DN's to provide community support to people, with CNS staff acting as coordinators for people's care from initial referral. As people's illness progressed the clinical nurse specialist team provided on-going liaison with all services within the hospice and other external agencies to ensure they received an appropriate package of care. People we spoke with told us the service they received had been efficient and they were openly communicated with about their care at all stages.

We saw the provider practiced within the relevant key guidance as it emerged, for example those set out by the National Institute for Clinical Excellence (NICE) Quality Standards for End of Life Care. This defines clinical best practice and the National Cancer Peer Review, which is a quality assurance programme that is aimed at reviewing services to determine their compliance against national measures. The service maintained strong clinical links with external agencies and other allied professionals, including links with lead professionals for non-cancer long term conditions to ensure best and up to date standards of practice and further learning. A variety of external teaching was also provided by the five consultants from the two Severn Hospice sites at Apley and Bicton in a variety of settings such as hospitals, community and as speakers at a numerous events and national conferences. The provider organised and has hosted the National Association of Palliative Medicine's Ethics Conference for the past three years. Evaluation of the conference was undertaken and analysed, which we saw was wholly positive. Comments included, "Quite possibly the most thought provoking and engaging course" and "Will definitely change and hopefully improve my clinical practice". The medical staff had also worked in partnership with the local council to provide accredited nationally recognised qualifications in end of life care for all levels of staff from health care assistant's to ward managers. These courses were provided for hospitals, community staff, residential and nursing home staff.

We found there was an effective system in place to regularly check and monitor the quality of the service. A comprehensive program of in-house audits such as medicines, education and environmental were completed and the findings fed into the governance meetings and were also considered by the trustees. We saw action plans were put in place for any shortfalls identified and these were monitored and followed up

by managers and the board.

The board of trustees also had a role in monitoring the performance of the senior management team to assure robust systems of governance within the organisation. We saw the board of trustees were engaged and interested in the operations and achievements of the organisation. Inspections were undertaken by the trustees annually which focussed upon areas identified through consultation with senior managers. This included what worked well and what could be improved. Their feedback and analysis of their findings was shared and any actions identified were shared as part of the on-going improvement plans for the service. The bi monthly clinical governance committee agenda was focused on all aspects of care and service provision including care standards, audit, incidents, complaints, duty of candour and other performance indicators. We saw action plans were put in place for any shortfalls identified and these were monitored and updated regularly by management and the trustees. Plans for improvement and actions taken based on audits and trustee inspection were shared with people through their annual quality report, which was available to the general public, on the services website.

As part of the services quality monitoring programmes, surveys were sent to people, their families and professionals who had referred people for treatment annually. This feedback was analysed and shared within the service at Clinical Governance Group Meetings, with actions and reviews of elements of the service outlined a result of comments received. However, the provider had no system for sharing this information and actions taken as a result of feedback with the participants, other users of the service or the general public. The registered manager accepted this was an aspect of quality assurance that needed some thought and development in the future.