

Severn Hospice Limited

Severn Hospice Apley Site

Inspection report

Severn Hospice -Telford
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Shropshire
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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 21 March 2016 and was unannounced.

Severn Hospice Apley 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 eight people. At the time of the inspection there were five people using the service. People within the locality of the hospice could also access support from the hospice at home and clinical nurse specialist services in their own homes and or community which were based at the provider's sister site in Shrewsbury.

The services provided included 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.

People were kept safe by staff who were trained in the safeguarding of adults and health and safety. They were able to fully describe their responsibilities with regard to keeping people, in their care, safe from all forms of abuse and harm. There were safe systems in place to safely manage and administer medicines to people. Medicines were prescribed, recorded, stored, administered and disposed of in safe and appropriate ways. People received their medicines in a timely manner and in line with their preferences.

Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm. Recruitment practices were safe and ensured staff employed were safe and appropriately skilled to care for people using the hospice. Systems were in place to ensure records related to accidents and incidents captured the relevant information and this was considered and analysed without delay. Appropriate remedial actions were taken following such occurrences and action was taken to minimise any immediate or future risks to people.

Staffing was at a level which allowed staff to meet people's needs in a safe, timely and personalised manner. Staff were well supported with the provision of a wide range of support in the form of training, a comprehensive induction, ongoing supervision and appraisal along with peer support and debriefs. Learning within the service including adopting and sharing best practice was highly prioritised. People were supported to access the nutrition they needed and were monitored for any changes in their dietary needs.

Management and staff understood their responsibility to comply with the requirements of the Mental

Capacity Act 2005 (MCA) and supported people in line with these principles. Staff established consent from people before providing care and supported people to access independent advice and support when necessary. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were flexible and could be transferred for use within the hospice and also applied when people were at home, thus reducing any unnecessary distress and repetition.

Staff were very caring and showed people and their families kindness. Staff demonstrated they were both motivated and passionate about their work and had a clear commitment to providing the best quality care in a compassionate way. People were encouraged to remain as independent as possible by staff. Staff acted in a way that maintained people's privacy and dignity whilst encouraging them to remain as independent as possible.

People were fully involved in decisions about their care, including when identifying their preferred place of death. People benefitted from the environment within the hospice which was homely and had been designed and equipped in a way that was clearly comforting to people using the service. 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.

The staff team demonstrated through their input at clinical and multi-disciplinary meetings that they knew people well and understood their individual needs. People's progress including pain management, spiritual needs, emotional and psychological well-being and social support were all considered on a daily basis. All aspects of care and treatment were assessed and discussed with the person and their family. The whole staff team could access the most up to date information about a person's treatment including changes in people's health and about how to respond when people experienced changes in their symptoms or pain levels. People spoke positively about how their care had been tailored to meet their needs and preferences. Families were included in all aspects of the persons stay, where this was an expressed wish of the individual person. People and staff felt comfortable about sharing any concerns, complaints and ideas for improvements with management.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. Regular ward and management meetings took place to discuss every aspect of the service, including staff training, incidents, service policy and development reviews. Staff praised the provider and the leadership team for their approach and consistent, effective support. The provider had a well-defined management structure that provided strong, effective and innovative leadership. There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. All records relevant to the running of the service that we saw were well organised and reviewed regularly.

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.

Staff knew how to recognise and report any allegations of abuse.

Risk assessments were centred on the needs of the individual and there were sufficient staff on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

People received their medicines from staff who were trained and qualified in safe administration of medicines.

Is the service effective?

Good ●

The service was effective.

Staff had effective training and support to carry out their roles.

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

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were supported in all aspects of their health and well-being and referrals to healthcare professionals were made promptly when needed.

Is the service caring?

Good ●

The service was caring.

Staff were kind and compassionate and people and their families with dignity, supporting them wherever possible to maintain their independence.

The service was very flexible and responded quickly to people's changing needs or wishes.

Staff communicated effectively with people and treated them with the utmost kindness, compassion and respect.

Is the service responsive?

Good ●

The service was responsive.

People and their families were fully involved in the assessment of their needs and planning how their care should be given.

People's care was personalised to reflect their wishes and what was important to them.

People knew how to make a complaint and felt confident that any issues they raised would be dealt with effectively.

Is the service well-led?

Good ●

The service was safe.

The service was well-led by a management team who placed people and staff at its heart.

There was an open and positive culture evident within the service which fully involved people, families, staff and the local community in its development.

Staff felt very well supported in all areas and felt involved, listened to and appreciated at all times.

There were systems in place to monitor safety and drive improvements in the quality of the service, including learning from accidents, incidents and complaint investigations.

The provider practiced within the relevant national key guidance and shared and adopted best practice.

Severn Hospice Apley 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 21 March 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 healthcare professional 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 that services are delivering the best possible care to meet the needs of people.

We spoke with three people who used the services provided by the hospice and three relatives. We also spoke with one volunteer, a consultant, a kitchen staff member, ten staff members, the chaplain, the inpatient matron and the registered manager.

We reviewed three 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 four medicine records, two 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 using the service told us they felt safe and protected. People told us, "Yes I feel very secure, safe and comfortable here and my husband isn't worried" and "I feel safe and protected because staff are always around and here so you don't worry". Relatives told us, "This service is absolutely safe and the care is gentle and exemplary" and "[Person's name] has been here for four weeks and I know and he does that he is safe and secure, I also feel safe and secure here".

Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns, and were fully aware of the provider's 'whistle-blowing' policy. This included reporting issues to the appropriate authorities outside of the organisation, if necessary. All the staff we spoke with told us they would also liaise with and discuss their concerns with the wider multi-disciplinary team if they needed support in relation to any safeguarding concerns, for example the social work team. Staff members told us, "I know how to go about reporting abuse, we have training and we have a social work team too if we wanted to discuss any concerns" and "I would refer any issues about abuse or harm to the access team at the local authority, I might approach our social work team for advice too". Training in relation to how to protect people from abuse or harm had been provided to all levels of staff within the service. Clear records were kept of all safeguarding events and reported to the appropriate external agencies.

We saw each person had an individual risk plan that incorporated control measures to minimise harm. A relative told us, "His [relative's name] safety is always of paramount importance during his stay here and all the risks are managed. Problems are anticipated and dealt with before they cause him pain". Potential areas of risk such as nutrition, medicines, moving and handling and pressure sores were considered. Records showed evidence of preventative action taken by staff through the use of equipment and provision of extra support to people who for example, displayed the signs of deteriorating mobility, skin care, breathing and nutritional intake.

Staff demonstrated to us they were knowledgeable about the level of risk related to the people they were caring for. Regular multi-disciplinary meetings took place on site to discuss and review the rapidly changing care needs of people using the hospice. Records showed that any risks were updated and reviewed regularly, using a variety of tools for the various risks; some of which required the staff member completing this to calculate the risk level after answering a series of questions. However the records we reviewed, although they had been updated failed to clearly demonstrate how the staff member had reached the risk score calculated. A completed copy of the risk assessment sheet used was not available in the persons 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 were not 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.

Staff understood how they should respond to a range of different emergencies including fire. Staff took part in regular fire drills and we saw there was appropriate signage about exits and fire equipment throughout the hospice. Fire safety equipment had been serviced and was regularly checked. Audits were undertaken to make sure all equipment and the building were checked and equipment serviced as required. Robust 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, to monitor that the appropriate levels of safety were in place. .

Staff were aware of how to report incidents and accidents. Staff had adopted any learned and gained feedback from such occurrences. They could describe to us the incident procedure including making the person safe, calling for help and reporting the incident immediately, alerting the person's family and completing the incident form. A staff member described the incident procedures as a, "Stringent process which does change practice". They gave an example of a person who used the service who was confused and who had had a fall whilst they had been moving around unsupervised. Learning and changes to practice were implemented as a result and those people at risk of 'wandering' were given a 'wander alarm' which they wore and they then could be traced. This was always explained to the person and their family and permission was sought.□

Robust staff recruitment policies and procedures were in place. A staff member said, "I had to have all the necessary checks done and returned before I was able to start work here". These included checks with the Disclosure and Barring Service, references provided by former employers, checks on professional registration and qualifications, identity checks and full documented employment histories. Interviews were well structured, properly recorded, and demonstrated a commitment to employing appropriately qualified people with suitable skills, attitude and character.

People told us there were sufficient staff on duty to meet their needs. One person told us, "There are always staff on hand to deal with anything you need or require". Relatives told us, "Staffing here is always through the roof, everyone is there for you immediately from the junior staff through to the most senior all are full of humility and kindness", "The staffing here is excellent" and "They [staff's name] have done wonders for my husband and they are there immediately when he calls – he panics if I am not there but they manage that well". The registered manager told us they did not use a dependency tool but used their knowledge of the needs of those people due to stay and their experience to ensure safe staffing levels at all times. The hospice had its own nursing bank and if any short staffing did occur there was some flexibility across the provider's two sites to cover any shortages. Staff we spoke with confirmed this and told us they felt the service was well staffed. During our inspection we observed there were plenty of staff on duty.

People told us they were happy with how staff provided them with and managed their medicines. One person told us, "My discomfort has really eased since I came in, my pain is reduced and if I have pain I call and they come immediately and it is sorted". Relatives told us, "His [relative's name] pain was always so very well managed. When he first came in here he had his phone set on alarm for the times his medication was due; he never needed it as they were always so good with his medication" and "Medicines are always given spot on by the staff and they are always asking if there is more they can do or is anything further needed".

The medical team within the service managed medicine requirements. We were told that if advice from a pharmacist was needed, then the team would contact the pharmacists at Princess Royal Hospital. Medicines were checked for accuracy when people were admitted to the service and we were shown a clear system for managing the ordering and supply of medicines. Medicines were stored securely in a locked treatment room, and only authorised staff had access. Extra security storage and recording arrangements required for controlled drug medicines (medicines which are at higher risk of misuse and therefore need

closer monitoring) were in place. However, we found some medication, that required these extra security arrangements, had not been included in this process. We informed staff, of this and it was corrected. An accountable officer ensured controlled drugs were managed safely. Prescription pads were securely locked away and there was a record of what had been prescribed on each prescription 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 found that medicines were stored within safe temperature ranges.

We also found that robust processes were in place to check most medicines were within their expiry date and suitable for use. We noted there was clear recording of the prescribed medicines, which also included additional instructions for safe administration. Medication charts had been written up with clear indications for administration of "when required" medication.

We observed the administration of medicines by one nurse who took the medicine and the prescription chart to the patient to ensure the correct medicine was given. The chart was then signed for following the administration of the medicine. This followed NMC guidance for the safe administration of medicines. Some medicines required specific times for administration and these were being correctly followed. Arrangements were in place to enable patients to look after and self-administer their own medicines following a risk assessment.

Medicine incidents were reported with arrangements in place to ensure they were investigated. They were discussed at monthly meetings between the matron and senior nurses and cascaded down to other staff at ward meetings. This helped to ensure lessons were learnt and actioned to ensure safe practice was followed. We found that 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.

Is the service effective?

Our findings

All of the people we spoke with could not praise the knowledge and skills of the staff enough. People said, "The staff seem very well trained" and "They [staff] are so good at what they do, I couldn't ask for any better". A relative said, "The staff know everything". The staff we spoke with told us they enjoyed their work and felt competent and supported in their practice. We saw there was an annual training programme in place for all staff and also specialist training provided by internal and external experts, which were sought based on staff learning and development needs. Staff described the management team as having 'a learning culture' and they 'encouraged learning at all levels'. Other staff told us, "The training here is of good quality, it's mostly classroom taught rather than just online" and "I attend lots of study days and can access additional training, which is great". Staff received an annual appraisal which they told us allowed them to highlight their development and training needs or areas of interest. The provider had an education lead who was responsible for setting up training programmes to meet the needs of staff.

Staff received a comprehensive induction, appraisal and had access to supervision. A staff member described the induction programme for new staff in the team and could also remember her own induction three years ago as she moved from a volunteer role into permanent role. She described this as comprehensive and that it had prepared her to take on her role with more confidence; this had included shadowing more senior staff and attending training. A relative told us, "If anyone new starts they always come and introduce themselves and they know everything about us which is so good". A staff member told us, "I have never had such an in-depth induction, the programme was very interesting". Staff told us they were able to access supervision. One staff member told us staff were also able to access support through debrief meetings which were set up for any of the staff to join after a complex or challenging death. These debriefs were for anyone to attend who had been involved and these were usually led by a social worker or medical staff. Staff also described regular informal debriefs at the end of each shift. A staff member staff said, "This is a difficult job but it is a lovely job, you are supported and you do develop coping mechanisms". Another member of staff told us, "We do have access to supervision and we also meet as a team and have peer supervision or group supervision, we are able to share and reflect upon the challenges of the job".

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. People were encouraged to make decisions and choices for themselves. People's consent to care was obtained and was noted in their care plan along with other relevant areas such as information sharing. One person said, "Everything that happens here is my choice I am always asked about what I want". A relative told us, "We have been involved every

step of the way; being involved and consulted about his care was very important to my son and this was always respected". We observed that choice and consent was implicit in everything that happened within the hospice, for example we saw all levels of staff consulting with people and their relatives about proposed actions, care and treatment. Staff had received training in relation to the principles of MCA and DoLS and they were able to demonstrate to us their understanding of how this should be applied in practice. A staff member said, "I have had training and know that we are never to restrict someone movements unless it is legally agreed to do so". Records we reviewed showed the multi-disciplinary team considered people's mental capacity throughout their stay at the hospice.

Documentation in relation to people's decisions about resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) was 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 regarding resuscitation. DNACPR records were signed by a doctor, completed in full and were with the patients and a relative's knowledge, participation and agreement.

People told us they were impressed by the quality of the food on offer. One person told us, "I am vegetarian and the food is lovely", describing the portion size as 'very large'. Another person told us, "The food is nice. I like the food". A relative said, "The first time [relative] was in here to stabilise him and his pain, he was able to eat and they [staff] always tried to do things that would tempt him and he enjoyed the food then". One person and their relative told us how when they had no appetite and found solid food difficult to manage, a liquid diet was being provided which they could manage to eat. They said they were 'enjoying' the range of different soups and soft puddings such as custards, they were being offered. Drinking vessels provided with a long spout had enabled the person to continue to drink independently, which they stated was "very convenient". Their relative told us they were well looked after when at the hospice and also had their meals at the hospice if they chose to.

Staff were aware of the importance of nutrition and hydration at the end of life. Records showed and staff told us people were screened on admission using the malnutrition universal screening tool and this was regularly reviewed. Staff we spoke with were aware of the individual nutritional risks relating to the people they were caring for. Care plans included any advice staff received from dietitians. The chef told us, "We approach each person and ask and record their preferences, like and dislikes". They told us any changes to people's appetite or dietary needs, for instance swallowing issues were relayed to them by staff straight away. We saw these were recorded for all the kitchen staff to refer to.

People's health and well-being needs were met by staff that helped them to stay as comfortable and free from pain as possible. A relative told us, "Since [relative] came here from hospital they [staff] have stabilised him, he is functioning and in no pain now and he has picked up. He is dying but not in distress". Each person's healthcare needs were described in their care plans and how these should be met. Staff were able to describe the frequent liaison and working relationships with a wide range of services both internally and externally to meet people's needs. We were able to hear during the weekly multidisciplinary meeting about how staff accessed external services to meet people health needs. For example a nurse from the heart failure team had been asked to see a person in the hospice to provide their expertise and advice. Records we reviewed reflected that staff were responsive to the immediate and more specialist health needs of people.

Is the service caring?

Our findings

All the people we spoke with told us how much they appreciated the service that was provided and the manner in which staff supported them. All their comments were overwhelmingly positive, they told us, "The care is excellent", "Everyone is lovely here, they can't do enough for you", "The staff all look after me, nothing is too much trouble; the doctors and staff are first class" and "The staff here are so wonderful, caring and kind, they have a special touch and they go the extra mile at all times". Relatives said, "I feel so humbled by the care my son has received here and the care as a family we have received and seen, sometimes it is so difficult to put things into words" and "I think he has been looked after fantastically".

The inpatient matron talked about the importance of caring, saying, "Maintaining a compassionate approach is so important at all levels and should be automatic no matter where the care is being delivered, hospice, hospital or care provider". Two written testimonies received just before our visit included, "All the doctors and staff made my relatives last few days very comfortable" and "Thank you for all the kindness you showed me and my family and the amazing care you gave to my beautiful mum. There were plenty of special moments during our time at the hospice which helped to make our last days with mum so lovely. We can never repay you for this".

The environment within the hospice was homely and had been designed and equipped in a way that was clearly comforting to people using the service. One person described to us how much they enjoyed the facilities and the peace and quiet of the hospice. They went on to say, "I use the sun room it's so relaxing". One person said, "When I came in I was so surprised, it was such a lovely place and when I came into this room I couldn't believe how comfy it all was". A relative talked to us about how their needs were equally of concern to staff not just supporting her loved one. They told us, "They [staff] bend over backwards for me here, even in the middle of the night when [relative] is usually very restless. They wanted to put a bed up for me but I wouldn't let them, my choice, so I lay in a recliner chair. However after a week we agreed a bed would be better for me as they told me my welfare was important to them. When I am not here the staff and volunteers sit with him and calm him as he panics if I am not there". Other relatives said, "The complimentary therapist comes in and gives [relative's name] relaxing treatments which really help, he really enjoys those sessions; the relaxation is so important" and "It is like home from home here as a relative".

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They told us 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. One person said they were informed and aware of how the team were trying to treat their pain and said, "I have been fully involved in making decisions about my care". Another person said, "I am not put under any pressure but I am kept informed about what is going on".

The service enabled people to access spiritual and emotional support from staff, the chaplaincy service and the social work team, for bereavement support. One relative told us, "[Relatives name] was not overly religious so when the chaplain from here came to see him, I thought this won't last long but he was with him

for over two hours. [Relative's name] said to me afterwards that the chaplain had made sense of religion for him for the first time. In fact the chaplain from here is going to conduct his funeral which is of great comfort for us and was also a great comfort to him". Another person told us the chaplain had been involved in supporting them to ensure her spiritual needs had been met. The chaplain told us, "It's not just about religious needs; it's about spiritual care, so caring for the person as a whole and it's about what's important to the person". The chaplain joined the multidisciplinary team meeting each week and got referrals from all levels of staff. They told us they worked with a range of different faith establishments outside, for example if a more local minister knows the person well in order to meet the person's needs. One person and their relative told us how about how consideration had been given to their spiritual needs. They told us their minister from their church at home had visited a few times and given them communion and they had also been to the hospice sanctuary for a service led by the hospice chaplain.

People told us, "Visitors can come and go as they please; all of his family were here yesterday and it was lovely it might be the last time some of them see him". Another said how their family were able to come and go to fit in with their working days and other commitments. They added, "It is much easier for them to come in compared to the hospital when they have to come at a set time to visit". Relatives told us they were able to visit without restriction. Relatives were able to use a dedicated room for overnight stays which was just a short distance from people's rooms, where they could stay whilst their family member was receiving treatment if they chose to. One person said, "The chairs are wonderful for my husband; he can rest while he is with me as this has been so hard for him". Some relatives told us they preferred to use the recliner chairs which were available for them to utilise in each individual room; they all told us they were comfortable and appreciated. This meant people could retain and find comfort with family nearby and in routines that were familiar to them.

People told us they were encouraged to keep their independence and control in as many areas of their life as possible, for as long as they were able. One person told us how they had been helped by the therapists to get a wheel chair and walking trolley to support them to be more independent and mobile. Care plans described how staff should encourage and support people to do as much for themselves as they could. People had access to information about the services provided by the hospice, including advocacy services and information of other organisations that provided support and their own bereavement service.

People's privacy and dignity was observed, for example, we saw staff knocking on doors before they entered people's rooms and greeting them courteously. Bedroom doors were left closed or open at people's request and staff checked regularly on people's well-being. When staff introduced us to people, staff were very respectful and we observed that there was a comfortable, quiet rapport between them and the person. Relatives told us, "Dignity and privacy for both of us is respected; I would give them all 11 out of 10 for everything" and "His dignity and privacy were absolutely respected at all times in everything that was done for him". Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal care needs. We observed dignified interactions with people at all levels throughout the inspection. For example, a discussion between a relative and the consultant was undertaken with empathy when dealing with sensitive issues. However, there was still some appropriate humour displayed which they clearly appreciated. Staff were engaging and stopped to listen to people, responding to them with apparent genuine interest. We observed they followed people's pace when they helped them and when they talked with them. A staff member said, "I love being part of a team that helps patients, I find it a privilege".

Is the service responsive?

Our findings

People told us staff responded very well to their needs. Relatives said, "They are always there for them, the person is at the centre of everything they do from the top to the bottom" and "This service is always responsive to whatever people need or require to the end, thankfully my husband won't suffer and that helps me". One person described how they had been admitted for symptom management, with severe pain. Records evidenced that people received regular pain reviews using an assessment tool; their care plan set out how to manage their pain using conventional medications and complementary therapy. The person told us they appreciated the different approaches used and also enjoyed the warm baths being offered in the hospice, which helped them to relax and further reduced their pain.

Each person's care, progress and treatment was reviewed at regular meetings in detail and this included input from all members of the multi-disciplinary team (MDT) who were present. We observed the staff team demonstrated through their input at the meeting they knew people well and understood their individual needs. They discussed the person's progress from all angles 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. A person told us, "The care here is so good, I am always asked about everything although they [staff] just seem to know my preferences so everything flows". Additional meetings with the person and their family were also arranged to discuss and update them regarding progress, plans, discharge or other changes to treatment, following MDT meetings. Notes from these meetings were updated during the meeting and projected onto a screen so that the whole team present could read the actions agreed and recorded these in people's care records. This meant that the whole staff team could access the most up to date information about a person's treatment. The updates included changes in people's health and about how to respond when people experienced changes in their symptoms or pain levels. Discussions had with people about their wishes and their consent to any changes in their treatment were also recorded.

People told us their care and support was planned in partnership with them and they felt in control of their own treatment. Upon first contact with the service, often through the clinical nurse specialist service staff spent time with people and encouraged them to ask questions, discuss their options, including where they wished to spend their last few days of life and reflect upon them. A relative told us, "[Relative's name] was cared for by the hospice at home team initially and had a wonderful nurse, she liaised at all times with us, the doctors and GP and this enabled [relative] to live a life of relative independence. When he deteriorated she liaised on his behalf and he came into the ward here".

Care plans included information about the individuals personal history and individual preferences, for example their favourite foods and interests. A staff member said, "The care team always ask patients about their preferences and record the information in their plans". Another staff member described how families were supported to be involved after the person's death. They outlined how they assisted families to help with last offices with support from the team if they chose to and went on to say, "This is always a choice, it is not for everybody". Records showed care plans were updated, revisited and reviewed throughout people's palliative journey. Although some were standardised there was room for personalisation and they were

focused on the person living well with their condition.

People spoke positively about how their care had been tailored to meet their needs and preferences. Families were included in all aspects of the person's stay, where this was an expressed wish of the individual. A relative told us, "I have been enjoying complementary therapy at the hospice and had found it relaxing". Another person told us how staff "Went out of their way" for them to celebrate their wedding anniversary by providing a surprise party. Staff had provided them with sandwiches, a cake and space for all the family to enjoy this together, they told us, "It was very moving". One relative told us, "[Relative's name] was very 'techy', it was his life, so when he came in they arranged for a lot of his technology to come in with him and it was all set up in his room; so he was able to use it right up to the end". A staff member described to us how they had come up with an effective way of completing a dressing change for a person who found the experience very distressing and painful. So it was decided with the person's permission and as part of an MDT discussion to change his dressing at the same time as they received complementary therapy. The complementary therapy resulted in the person falling asleep ahead of his dressing change and when they woke up they were surprised to find the dressing had been done and they had not felt anything. The staff member went on to say, "Complementary therapy and medicine worked together for the benefit of this patient and gave relief; it's about addressing individual needs". Another staff member told us they liked to help with hairstyles the patient likes to have done, assist with people's hygiene needs in the way the person chooses for example bath, bed bath or shower. People using the hospice services also had access to the hospice at home service if home was their preferred place to receive end of life care. This meant care was centred on the individual to ensure the treatment they need could be delivered effectively.

Staff told us people were supported to develop an advanced care plan, which detailed their end of life care wishes. Advance decision care plans were utilised on the unit, however on the day of our inspection none of the patients had one completed to observe. People confirmed to us they had been supported to make choices about their future care and in relation to where they wished to die.

People told us if they wanted to raise complaints or any concerns they knew who to speak with, but those we spoke with all told us they had no need to do so. A relative said, "I have no complaints at all only compliments for this wonderful service, it is truly unique". One person told us they knew how to complain as information was available in leaflets, but said they had never had any concerns but felt confident that if they did staff would listen. They said, "They would put it right straight away, I am sure". A staff member said if someone wanted to make a complaint they would, "Support them to do so if necessary in writing and pass this on to managers and also use the complaints procedure to guide me, as we don't get many complaints".

The complaints procedure was displayed and leaflets were also freely available in communal areas. There were arrangements for recording, acknowledging, investigating and responding to complaints and any actions or changes made taken 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 practice were made following complaints to improve the service provided and formal debriefs to discuss any changes to practice were conducted with staff involved and the wider team. We saw the provider routinely used complaints as a learning exercise. For example, further consideration had been given as a result of a complaints investigation about how clearly staff set out expectations of the service on admission to people about their length of stay, where appropriate. We saw the provider had received numerous compliments which contained very positive feedback and these were displayed, collated and shared with staff when they were named individually.

Is the service well-led?

Our findings

People and staff were complimentary about their experience of using or working at the service and how it was managed. A person told us, "This hospice is a wonderful place to be, I am in no pain and I am very lucky and glad to be here in such a fine place". A relative said, "Everyone here has everything managed properly and everything is always done to the highest standard". Staff told us, "I am proud of working here and proud to be a hospice nurse" and "It's a really special place to work".

The registered manager was also the deputy chief executive and director of care. They consistently notified the Care Quality Commission 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. Staff described the service as 'well managed' and senior managers and medical staff as 'supportive and approachable'. Staff also said, "The hospice management team is very supportive" and "I love working here and feel supported". One member of staff described an issue they had when they first started working at the hospice, where a product used for cleaning was affecting their health; management responded quickly to this and changed the product. They continued to have regular review meetings with the staff member for several few months afterwards to ensure their wellbeing. Another staff member said, "The management are very approachable and supportive, one thing I can say is you can talk to any of them and they will always take the time to listen". 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.

The provider encouraged involvement in the development of the service from staff at all levels. We observed the Multi-Disciplinary Team (MDT) meeting and this demonstrated excellent team working and showed clear, transparent communication with a holistic approach to care. There was evidence of team work with open discussion and challenge taking place. The meeting demonstrated staff understood their roles and responsibilities and that of the wider team. A series of staff briefing meetings were set up through October to December 2015 to 'ensure key business and developments are communicated to all staff groups'. The purpose of the meetings was that staff had a forum and opportunity for discussions.

Staff described the hospice as having a 'strong community care focus'. One staff member told us "There is good support and ownership by the community as they help raise much needed funds for the service". One of the consultants told us, "Local support for the hospice has been really strong". Events and fund raising were advertised, including midnight walks and fun runs to enable local people to support the charity. As part of the services quality monitoring programmes, surveys were sent to people, their families and those professionals who referred people to the service for assessment for care and 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 as a result of comments received. However, the provider had no system for sharing the findings and any 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. Volunteers provided essential support

to people using the hospice services and they all received the necessary training and support.

Learning from past incidents and any improvements made following investigations was shared with staff. A staff member said, "There is a report generated which is shared with us, which shows key learning and the actions taken when incident happens". Staff told us about improvements that had been made within the service following incidents and accidents. All outcomes for patient and non-patient related accidents and incidents as well as medication incidents were all investigated, analysed and discussed at monthly clinical governance meetings attended by senior managers, nursing and medical staff.

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 that defines clinical best practice and the National Cancer Peer Review. This 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, at a variety of settings such as hospitals, in the community and as speakers at a number of events and national conferences. The service organised and had 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, including comments such as, "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 national qualifications in end of life care for all levels of staff from healthcare assistant's, carers to ward managers. These courses were provided for staff in hospital, community, residential and nursing home settings.

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 were fed into the governance meetings and were also reviewed 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 hospice 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 their findings was analysed and any actions needed 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 the trustees inspections were shared with people through their annual quality report, which was available to the general public, on the services website.