

St. Barnabas Hospices (Sussex) Ltd

# St Barnabas House

## Inspection report

2 Titnore Lane  
Worthing  
BN12 6NZ

Tel: 01903706300  
Website: [www.stbh.org.uk](http://www.stbh.org.uk)

Date of inspection visit:  
22 February 2016  
23 February 2016  
24 February 2016

Date of publication:  
24 May 2016

### Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Good 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

# Summary of findings

## Overall summary

St Barnabas House hospice is a local registered charity that provides specialist palliative care to adults with advanced progressive life-limiting illnesses, both within the hospice and in the comfort of their homes. Palliative care is the total care of people whose illness is not responsive to curative treatment.

The service includes a 20 bed In-Patient Unit, a Day Hospice with 18 places, a Community Palliative Care team, a Family Services team, a 'Hospice at Home' team and an Education Department. The care is delivered through a team that consists of doctors, nurses, social workers, counsellors, a chaplain, physiotherapists, complementary therapists, an artist-in-residence, a Hospice at Home team and volunteers. Services are free to people and St Barnabas House is largely dependent on donations and fund-raising by volunteers in the community.

This inspection was carried out on 22, 23 and 24 February 2016 by two inspectors and one pharmacist inspector. It was an unannounced inspection.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the Director of Adult Nursing and oversaw the running of the service. They were part of a senior leadership team that included a chief executive officer and a deputy, a director of human resources, a finance director and an income generation director.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. 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 or ensure people were protected from harm.

There was a robust system in place to monitor accidents and incidents and identify how the risks of recurrence could be reduced.

There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place which included the checking of references.

Medicines were ordered, stored, administered and disposed of appropriately as per legal requirements. The hospice had opted to be part of a national study on benchmarking of medicines administration errors which meant that it continually reviewed its practices. The hospice shared learning with other local hospices and pharmacists at the local hospital. People could be confident that the service paid particular attention to all aspects of practice relevant to medicines.

There was an effective system in place to ensure people remained as safe as possible from the risk of acquiring an infection. The premises were cleaned and maintained to a high standard.

Staff understood how they should respond to a range of different emergencies and creative thinking underpinned practices in regard to keeping people safe from risk of fire, such as when practising fire drills.

People described the delivery of care as, "Exceptional" and "Second to none." They told us, "The staff are so knowledgeable and incredibly efficient, they are obviously very well trained as they have exceptional skills, they really understand me."

Staff had appropriate training and experience to support people with their individual needs. Staff told us, "The training we get here is just phenomenal." The service had creative ways of training their staff that made sure they put their learning in practice to deliver outstanding care that met people's individual needs.

There was an effective system of communication between services that ensured effective continuity of care. Communication was very effective within the service, with people and with external healthcare professionals. This meant that duplications of documentation were reduced and people did not have to reply to the same questions during multiple assessments.

Staff knew how to communicate with each person and understood their individual needs. Consent was sought from people, obtained and recorded before any aspect of their care and treatment was carried out.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable in the main principles of the MCA that they applied in practice. They assessed people's mental capacity when necessary and when applicable they held meetings to make decisions on their behalf and in their best interest. This meant that people's rights were protected and respected.

Staff protected people effectively from the risks of poor nutrition, dehydration, swallowing problems and other medical conditions that affected their health. People praised the food that was offered and told us it was, "Truly excellent" and, "Remarkably good."

People were referred to healthcare professionals when necessary and their advice was sought and acted on by staff.

The premises had been adapted to meet people's needs effectively. They were well designed, welcoming, well maintained and suited people's needs.

People were proactively supported to express their views and staff were skilled at giving people information and explanations they needed and the time to make decisions.

People valued their relationships with the staff team and told us that they often went 'the extra mile' for them, when providing care and support. The service took account of people's cultural, religious and linguistic needs. The staff valued practice that acknowledged diversity and promoted equality.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors through a wide range of methods, to enable them to make informed choices.

Family support was recognised by staff as vital to people's wellbeing and staff strived to meet the emotional

and practical needs of people and their families. Continual emotional support for families was provided in addition to the provision of care for people.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. People, relatives, visitors and health care professionals shared very positive views and opinions about how people's needs were responded to. Individual needs were met and responded to in a way that may exceed people's expectations. Staff anticipated how people felt when planning their care and support so people felt valued and understood. Staff delivered support to people according to their unique support plan and responded to their specific needs.

People 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 'advance care plans'. Their views, wishes and plans were respected.

Staff understood how to respond to people's artistic and emotional needs at times that mattered to people. Innovative activities were provided to stimulate people's interests and creativity.

The service actively sought the views of others through creative and innovative methods. The feedback that was sought and obtained from people, relatives, healthcare professionals and staff was extremely positive. A comment included, "Your professionalism, warmth, responsiveness and effectiveness have been an inspiration." People were actively encouraged to give their views and raise concerns or complaints. Complaints were addressed promptly and followed up with an action plan in order to drive improvement and lessons were learned as a result.

The service took a key role in the community and was actively involved in building further links. It had the support of approximately a thousand volunteers.

There was an open and positive culture which focussed on people. People's feedback about the way the service was led described it as "Really excellent management" and, "If more businesses were run like this, the world would be a much nicer place".

Staff praised the provider and the leadership team for their approach and consistent, effective support. All of the staff we talked with spoke extremely positively about the registered manager's style of leadership and told us they led by example. They described them as, "Exceptional", "Totally approachable" and, "Inspiring." The registered manager worked in partnership with other organisations to raise standards of care at a national level.

The service took part in several projects to reach more effectively an increasing number of people in the community and meet their needs. A particular Outreach Project had been implemented and sustained over time which had a positive impact on people in the community as it promoted inclusion.

There was a robust system in place to maintain and monitor the quality of the service across all departments, which was effective in driving continuous improvement. Comprehensive audits were carried out about every aspect of the service to identify how it could improve. When needs for improvement were identified, remedial action was taken to improve the quality of the service and care.

## 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 were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

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

Medicines were stored, administered and monitored safely.

There was an effective system in place to ensure people remained as safe as possible from the risk of acquiring an infection.

Robust and safe recruitment procedures were followed in practice to ensure staff were suitable for their role.

### Is the service effective?

Outstanding 

The service was outstandingly effective.

The service had researched and provided specific and original training that enabled staff to develop coping strategies and resilience, so they could support people effectively. Staff were trained in acquiring specialist communication skills to help people and their families at difficult times. Staff had the opportunity to visit other hospices and learn from different models of care to bring new ideas that could benefit their practice and people.

Staff were effectively trained in the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and were very knowledgeable about the requirements of the legislation. They assessed people's mental capacity and held meetings in their best interest appropriately to promote their rights.

There was a very efficient system of communication within the

service, with people and with external healthcare professionals to ensure continuity of care and avoid duplications of documentation. Therefore people did not have to repeat themselves unnecessarily. Clear and comprehensive information was provided to people and their relatives to help them make informed decisions.

There were effective links with healthcare professionals whose advice was sought and acted on to benefit people.

### **Is the service caring?**

The service was very caring.

People valued their relationship with staff and gave very positive feedback about the caring approach of the service and staff. Staff were kind, patient and respectful when providing care and treatment for people. People's dignity and privacy was respected.

People were pro-actively supported to express their views and staff were skilled at giving people face to face information and any explanations they needed to enable them to make informed decisions.

People's cultural, religious, linguistic were taken into account when care was planned and delivered. The service valued practice that acknowledged diversity and promoted equality.

**Good** 

### **Is the service responsive?**

The service was outstandingly responsive to people's individual needs.

People were placed at the heart of the service and were fully involved in the planning of their care, treatment and support. People's care was personalised to reflect their wishes and what was important to them. Staff delivered support to people in accordance with their unique support plan and responded to their specific needs.

Staff understood how to respond to people's emotional needs and their sense of creativity. Innovative activities were provided that stimulated their interests, developed their artistic ability and

**Outstanding** 

promoted their creativity.

People were actively encouraged to express their views and an innovative way to capture their current experiences of the service was used.

The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

### **Is the service well-led?**

The service was outstandingly well-led.

People's feedback about how the service was run included, "Really excellent management" and, "Extremely well organised."

Staff praised the provider and the leadership and management team for their approach and consistent support. They described the registered manager as, "Inspiring." They felt valued and supported by the service.

The service was actively involved in building further local community links. The service took part in several projects and worked in partnership with other organisations to raise hospice care standards at national level.

The provider's system of quality assurance was very effective in driving continuous service improvement.

**Outstanding** 

# St Barnabas House

## 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 carried out 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 was carried out on 22, 23 and 24 February 2016 by two inspectors and one pharmacist inspector. It was an unannounced inspection.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. This included a Provider Information Return (PIR) which the registered manager had completed prior to our visit. 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. This helped us plan and inform our inspection.

We looked at the premises and equipment. We looked at 12 sets of records that related to people's care and examined three people's medicines charts. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We looked at documentation that related to staff recruitment, training and management, and records relevant to the storage, ordering and administration of medicines. We observed the administration of medicines. We looked at checks that were carried out regarding the monitoring of the safety and quality of the service. We sampled the services' policies and procedures.

We spoke with three people who stayed in the Inpatients Unit, nine of their relatives and four volunteers. We also spoke with relatives of four people who received support from the community palliative care service and the 'Hospice at Home' service in the community.

We spoke with one Trustee, the registered manager, two palliative care consultants, the Head of Community Services, the In-patient Unit (IPU) team leader, the Head of Family Services, a team leader and two care workers in the Hospice at Home team, three clinical specialist nurses and two nursing assistants in the IPU, one clinical specialist nurse in the Community Team, one nursing assistant and one team leader in the Day hospice, the Facilities Manager, the health and safety advisor, a Hospice at Home team leader, a



fundraising manager, the artist in residence, a chef, and two volunteers.

We also spoke with three managers of care homes where the Hospice at Home team was providing support and advice, a GP and three district nurses who oversaw people's care in the community. We obtained their feedback about their experience of the service.

At our last inspection on 05 March 2014 no concerns were found.

## Is the service safe?

### Our findings

People in the In-patient Unit (IPU) told us they felt safe living in the service. They said, "If there is one place on Earth to feel totally safe and not afraid, this is it" and, "It's not just about safety here, it's about getting peace of mind and not having to worry anymore." Relatives told us, "Our relative could not be in safer hands" and, "There is so many staff here there is no way that anything could happen without one member of staff rushing to anyone's aid straight away." Two relatives described the safety aspect of the Hospice at Home service as, "Marvellous, totally reassuring" and, "Extremely safe place in every aspect."

Staff knew how to identify abuse and how to respond and report their concerns internally and externally. Staff knew how to access the safeguarding of adults and whistle blowing policies. The safeguarding policy reflected the guidance provided by the local authority and had been updated in April 2015 to reflect the Care Act 2014 and changes in legislation.

Staff training records confirmed that training in the safeguarding of adults was part of the induction for all members of staff. This was complemented by annual training and refresher courses which were up to date. Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. A nurse told us, "Safeguarding is part of what we do and we are always vigilant for signs of possible abuse which can take many forms."

There were sufficient care, nursing and medical staff on duty, to support and care for people in the In-Patient Unit (IPU), the Day Hospice Services and the Hospice at Home Service. Staff told us there were enough staff to care in the way people needed and at times they preferred. Staffing rotas indicated that staffing levels were always sufficient to meet people's needs. Staff confirmed that although they were particularly busy at times, they were able to spend one to one time with people. Staff ensured that people had their call bells within easy reach and people we spoke with commented on the speedy response from the staff when people called for help.

The registered manager adapted the staffing levels according to people's needs and made sure enough staff were deployed throughout all areas of the service. There were suitable arrangements to ensure staff cover during absences. Agency staff were rarely used and if used, nurses requested familiar staff who were acquainted with the hospice. Staff were always able to have additional support if required. A nurse assistant told us, "Sometimes we have extra staff because of special needs, for example if a person has severe dementia or shows severe agitation and needs 24/7 supervision in their room."

The provider was actively recruiting more specialised staff, such as clinical nurse specialists in dementia and renal failure. The registered manager told us, in relation to recruiting the right staff, "This endeavour is in partnership with hospital services and aims to reach people with terminal illness in the community who may not have been under our radar before." Owing to the complexity of people's needs in the IPU in the last twelve months prior to our inspection, nursing staff had been increased accordingly. With sufficient staff having the appropriate specialist skills and experience being deployed, people could be confident that their needs will be responded too in a timely way to keep them safe.

Safe recruitment procedures were followed to ensure that staff were suitable to work with people using this service. When applicants had been interviewed, the questions they were asked were bespoke to the roles they applied for and were based on scenarios that could arise. This helped identify applicants' suitability. Disclosure and Barring Service (DBS) checks had been completed before staff started working. These checks also applied to volunteers and therapists. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed. Regular checks of staff professional registrations were carried out to ensure they were correctly registered to carry out their roles.

Disciplinary procedures were in place to ensure staff respected their code of conduct. There was a detailed process in place to manage staff performance issues which was included in staff handbooks. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual. Risks associated with people's skin integrity, levels of mobility and risks of falling were assessed by the IPU manager as soon as they came into the hospice to stay. These were reviewed daily by nurses and were updated appropriately. Staff were aware of the risks that related to each person. Control measures to minimise risks to people included the provision of specialist equipment and instructions to staff to work in pairs when necessary. A risk assessment in the community had highlighted difficulties for staff to access a person's home. As a result, a referral to have a 'keysafe' fitted had been implemented. Another risk assessment was in regard to a household history of behaviours that challenged, and as a result staff went in pairs to visit. Emphasis was placed on ensuring that people and families were aware of potential risks and knew how to use equipment to remain safe. Informative safety data sheets were provided to people and their relatives.

People's own medicines and stock medicines were kept securely. Appropriate arrangements were in place for ensuring medicines were not used past their expiry dates. We saw detailed, clear records of medicines which had been ordered and received by the hospice. Emergency medicines and oxygen cylinders were available, in date and stored appropriately. Waste medicines were stored securely and disposed of appropriately. Medicines safety alerts and recalls were received and acted upon.

Controlled drugs (CDs) which are medicines that need closer monitoring were stored securely. Their destruction was undertaken and recorded appropriately. Staff conducted accurate balance checks of medicines and high-strength preparations of CDs were kept separately from other strengths in the CD cupboard to help prevent incorrect selection. Blank prescription forms (FP10s) were stored securely and we saw records which showed their use was tracked; these also included records of what medicines doctors prescribed on the forms. This is important in preventing misuse of prescriptions. A system was in place to appropriately record and monitor the temperatures for the fridge in the treatment room where medicines were kept to ensure they remained safe to use.

Prescribing was undertaken by in-house doctors and consultants. At least one consultant was always on-call out of hours. Pharmacists visited at least twice weekly to provide additional screening of prescribing and advice on medicines. One of the pharmacists was a palliative care specialist who actively shared learning from conferences and her hospital experience with clinical staff at the hospice.

Processes were in place to ensure that medicines for management of pain and other symptoms were administered in a safe and timely manner. We saw two trained nurses safely prepare a syringe driver for a patient (a portable pump which allows medicine to be administered by slow release over a period of 24 hours) and safely prepare an injection of painkiller for administration to a person. Staff had good access to

up to date resources which they may need for medicines administration, including guidance on the use of syringe drivers.

Staff were able to clearly explain information people were given about unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms). Staff administering medicines were assessed to check their competency and these checks were appropriately documented.

We checked prescription and administration charts for three people. We found that these were fully completed, inclusive of reasons for missed doses and patients' allergies. The application of pain relieving patches was checked at every medicines round. The hospice had effective processes in place to allow patients to take out medicines when on day leave.

A range of audits to help continuously monitor and improve the overall quality of service were seen. The hospice had opted to be part of a national study on benchmarking of medicines administration errors which meant that it continually reviewed its practices. The hospice shared learning with other local hospices and pharmacists at the local hospital. Additional processes to promote patient safety were seen in action. For example, syringe drivers were colour coded when more than one was in use to prevent errors. We also saw examples of practices which were responsive to peoples' needs. This included bespoke medicines administration times to ensure people were able to take their medicines at the same times they usually would when at home.

There was a robust system in place to monitor accidents and incidents. A 'clinical risk group' had been formed, chaired by the IPU manager that included the consultants and speciality doctors. At these group meetings, any slips, trips or falls were discussed. At one recent meeting, a risk had been discussed and as a result the system for having printed instead of handwritten prescriptions had been introduced.

There was an effective system in place to ensure people remained as safe as possible from the risk of acquiring an infection. Staff were trained in infection control and were aware of who the infection control lead was should they need further advice. There were robust infection control policies in place that included cleaning, staff protection and the management of infectious diseases. Regular infection control audits were carried out in the IPU and in the Day Hospice to monitor staff practice and ensure risks of infection were minimised. A recent audit had identified shortfalls such as a build-up of ice in a kitchen freezer, a need for deep-cleaning a fridge and a lack of hand washing by some of the volunteers. Remedial action had been taken as a result. Staff were knowledgeable about how to manage possible outbreak of infection and described the appropriate steps they had taken to prevent a person's infection from spreading to others.

The premises were cleaned to a high standard and records were kept to evidence frequent cleaning throughout the day. A person who stayed in the IPU told us, "The cleaners are ever so efficient, the place is always very clean, it feels all 'germ-free'." There was ample provision of personal protective equipment which the staff used throughout the day. Staff washed their hands appropriately, and guidance about hand washing was on display throughout the service. Alcohol gel was available outside every room and used by staff and visitors. Systems in place for the segregation of laundry and the management of waste were implemented appropriately. The temperatures of served food, fridges and freezers were monitored and documented. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe.

Information about people's individual levels of mobility was reviewed at each staff handover. This up to date information was ready to be used in the event of an emergency such as the evacuation of the premises.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, power outage, IT failure, data loss, building security breach, pandemic and infection in clinical areas. This included clear guidance for staff to follow.

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 home.

Creative thinking underpinned practices in regard to keeping people safe from risk of fire. A local Fire and Rescue service had inspected St Barnabas House and had identified the IPU as being a high risk area. As a result, the health and safety advisor had implemented five evacuation practises over two days involving 27 IPU staff. A wing had been kept empty and used for undertaking five different fictitious scenarios given to staff. A member of staff told us, "This was absolutely amazing; It brought every procedure and guidelines to life and made us think outside the box about people's safety." There was a report from this exercise that clearly detailed staff response, observations made during and after the exercise, a summary of significant actions, and an action plan which was followed through to completion. As a result, the Fire policy and procedures, guidelines for evacuation and the IPU Fire information pack had been reviewed and updated. With such pro-active approach from staff, people could be confident that staff maintained their knowledge and skills to keep them safe.

Fire safety equipment was routinely checked and serviced. There were nine first aid stations and seven designated first aiders who checked first aid boxes throughout the premises to ensure they were replenished when needed.

The Facilities manager worked closely with the health and safety advisor and oversaw a premises officer, the housekeeping team, one gardener and 25 volunteers. Throughout the service, fittings and equipment were regularly checked and serviced. There was a reliable electronic system in place to identify any repairs needed and action was taken to complete these promptly. Checks and service records of hoists, slings, baths, suction pumps, nurse call system, wheelchairs and of the lift were up to date and a system flagged when next checks were due to ensure nothing was missed. A person had brought several electrical portable appliances and within one hour of their admission into the IPU these had been checked to ensure they were safe to use. Oxygen was stored in a secure compound that was outside of the premises.

The premises were secure for people due to a robust security system in place. The system linked with the fire alarm system to allow evacuation in the case of a fire.

## Is the service effective?

### Our findings

People said they were very satisfied about the way staff gave them the care they needed. People described the delivery of care as, "Exceptional" and "Second to none." A relative told us, "All the staff know how to talk with people, they communicate ever so well and this is so special when you are in pain or worried and a nurse bends down to say it is Ok to feel this way." A care worker in the Hospice at Home team told us, "The training we get here is just phenomenal." A care home manager whose service was supported by the hospice team said, "The hospice team are just fantastic in the way they help us and support us, they are so confident and efficient." People in the hospice praised the food that was offered and described it as "Delicious" "Well presented" and "In small quantity because they know I can only have a little bit at a time."

All care and nursing staff had a thorough induction before they started working at the service. This included the shadowing of more experienced staff for at least four weeks until they could demonstrate they had attained the level of competency required for their role. Checks were made regarding their skills, the application of their knowledge and their decision-making ability.

Staff had appropriate training and experience to support people with their individual needs. People told us, "The staff are so knowledgeable and incredibly efficient, they are obviously very well trained as they have exceptional skills, they really understand me" and, "I get everything I need straight away, sometimes I think they [staff] can read my mind." The hospice education team provided essential training that was up to date, and an effective training matrix colour system identified whose training was due to be renewed and the degrees of urgency, so staff were scheduled for refresher courses in due time. Each service adhered to a one to one and group supervision programme to support staff and give them an opportunity to discuss any concerns they may have. Staff underwent an annual appraisal that included a personal development plan.

Staff had the opportunity to visit other hospices and learn from different models of care. A number of senior clinical staff visited other hospices services periodically, to assess the hospice's current practices against other regional providers. There had been an exchange of IPU managers between the hospice and another for a period of three weeks. The IPU manager told us, "This was invaluable experience for my professional development and I brought back a lot to my team."

The service had creative ways to training their staff that made sure they put their learning in practice to deliver outstanding care that met people's individual needs. This included researching and providing additional training that aimed specifically at staff support, so staff could acquire more skills and be able to support people more effectively. Staff told us they were "Extremely well supported" to carry out their roles and described their training experience as, "Absolutely amazing" and "Phenomenal." Such training included 'compassionate care training', which addressed scenarios where staff may experience 'compassion fatigue'. A member of staff told us, "That is such useful training; it showed us the pitfalls and how to avoid them not only in theory but in practice which is where it counts the most." Four staff nurses had completed an advanced communication course. Staff attended external workshops based on the 'SAGE & THYME' model, which was designed to train all grades of staff how to listen and respond to people or carers who are distressed or concerned. Therefore people could be confident that staff held specialist communication skills

that enabled them to connect effectively with them.

Staff had acquired certificates at foundation and advanced level. Two clinical nurse specialists in the Community team had achieved their 'Do Not Attempt Pulmonary Resuscitation' (DNACPR) competencies, which meant they were now able to not only have conversations with patients regarding resuscitation, but also to complete the DNACPR forms to leave in a patient's home and communicate this to other healthcare professionals involved in their care. This was effective in relieving potentially distressing duplication of conversations for people.

An external counselling service was available if staff required additional support. Six training sessions on 'mindfulness' had been provided to nurses and nursing assistants on a trial basis. These helped staff develop coping strategies and resilience should they experience emotional difficulties in their work. As staff had reported this to be very helpful and effective in reducing stress levels, the programme had been extended to 24 sessions. An external instructor with a background in nursing and holistic health provided regular 'Looking after yourself' relaxation sessions to clinical, housekeeping and catering staff. These explored techniques to help staff relax and cope with challenges. The feedback collected about this training showed that 100% of the staff who attended had rated it as "Excellent." The IPU team manager had attended a workshop on the topic of resilience, and had reflected on how best to support her team when they experienced difficulties. As a result, they had developed an action plan that included a project on creating a new policy on emotional safety.

An occupational health nurse came one day a week to the hospice to discuss with staff topics of their choice. They had recently done a presentation on mole awareness, and had held a session for staff who may not have visited their own GP for some time. A member of staff told us, "As we have our own occupational health nurse we can always contact her for advice, this is brilliant."

Staff were able to nominate each other for the 'Jelly Bean Award' in recognition of 'going the extra mile', for example for stepping in to help their team, for "Establishing excellent team morale in a service", "Excellent team work", or for "Excellent care and hard work with a particularly complex patient". A member of staff told us, "This award means a lot, we are very proud to get it and it does motivate us to do well." There were awards to acknowledge staff's long service in the hospice.

Staff were actively encouraged to gain qualifications and progress within the service. Four managers had gained a certificate through an 'Institute of Leadership and Management' course created by the service. Four staff nurses and four clinical nurse specialists had completed a degree module in end of life principles of care and an advanced physical assessment module. A robust medical revalidation agreement with the local acute trust ensured that medical staff maintained their clinical competence. A care worker in the Hospice at Home team told us, "I was encouraged from the start to study and I am now studying for my diploma in end of life care at level three." A GP told us, "The nurses have a sound knowledge of all aspects of end of life care and are very experienced in their field." Therefore people could be confident that they were cared for by knowledgeable and competent staff.

There was a system of allocations that established an effective link between the community and the IPU. For example, each of the three consultants in the hospice was responsible to cover a specific geographical area both in the community and in the IPU. This meant that people could retain the same consultant if they were to go from one service to another, and consultants remained fully acquainted with their history. There were daily multi-disciplinary admission meetings in the hospice where people's individual needs in the community were discussed. This system ensured that staff were knowledgeable about people's individual care, treatment and history when they came in the IPU.

Each person in the IPU had a named keyworker and a named nurse. A key worker is a named member of staff with special responsibilities for making sure that people's individual needs were met. There were staff who specialised in different fields and took the lead in Infection control, falls, helping children in bereavement, spirituality, tracheostomy (the insertion of a tube into the windpipe to help you breathe), PEG post-care (when a tube had been inserted into a patient's stomach to help them eat), manual handling, neuro-disorders, wound care, intravenous therapy and blood transfusion. The IPU manager was the lead for falls and chaired a working group that looked at strategies to prevent falls from happening. Specialised staff provided guidance to other staff and checked their competency, working alongside them. Therefore care was delivered by staff who developed their knowledge and shared it effectively with each other to benefit people.

Staff shared information about people's care following the consultants' 'ward rounds' in the IPU and at handovers to ensure continuity of care. The consultants talked with each person on the IPU and discussed their options with them. They then discussed their findings with a team of doctors and ascertained the best way forward to manage people's symptoms. There was always a speciality doctor present on the ward and people were seen by a doctor or consultant every day or less, depending on their condition. Therefore people could access medical advice when required and without delay.

The minutes of monthly staff meetings in each department, such as the community service and the Hospice at Home service, were circulated within the hospice to ensure that each department was kept informed of any development. The registered manager told us, "No department is an island; we are all strongly connected and work together." For each individual person using the service, end of life and advanced care discussion were documented in a specific area in the data computerised system, so that all members of the multi-disciplinary team had easy access to them. This system was effective in reducing possible duplication of assessments. Therefore people did not have to repeat themselves unnecessarily. As access to information about their care was effectively communicated, people could be assured that their needs were met without delay. There was also an effective system for communicating people's needs to the GPs and this ensured prompt actions including making sure prescriptions were prepared at short notice.

Staff knew how to communicate with each person and understood their individual needs. There was a full loop system in the hospice for people who had hearing impairment. A demonstration had been carried out by 'Action for Deafness' team. The service had access to an interpreting service if necessary. Staff talked with people making sure they were at eye level. When people were feeling unwell, staff used a gentle tone when they spoke and appropriate touch to communicate their empathy. We observed how staff communicated with a person who was experiencing discomfort and staff allowed plenty of time for the person to express themselves and checked that they understood them correctly.

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. Staff were trained in the principles of the MCA and the DoLS and the main principles of the MCA were applied in practice.

Consent was sought, obtained and recorded before any aspect of people's care and treatment was carried



out. When people declined, this was respected and documented. A relative told us, "The patient is the one who is in control here, the staff takes their 'cue' from the patient, not the other way round." They assessed people's mental capacity when necessary and when applicable they held meetings to make decisions on their behalf and in their best interest. Staff in the Community team carried small printed cards with them that included the five main principles of the MCA as a reminder. When applicable, authorisation to restrict people's freedom in their best interest had been sought with the DoLS office. The registered manager had considered the least restrictive option for each individual. The provider and registered manager had commissioned an audit from an external qualified expert in mental capacity, to assess and review related processes, procedures, policies and overall care. The expert had provided a master class on MCA and DoLS to all clinical staff in November 2015, additional to their training. A member of staff told us, "This was fascinating as it made us think outside the box."

Staff protected people effectively from the risks of poor nutrition, dehydration, swallowing problems and other medical conditions that affected their health. People praised the food that was offered and told us it was, "Truly excellent", "Remarkably good", "Presented in an attractive way" and "Cooked with my special needs in mind." The chef told us, "We don't have a rolling menu; we plan them weekly; it means we can respond to seasonal changes and ensure plenty of variety." Food surveys were carried out and the feedback was overwhelmingly positive. Staff were aware of people's individual preferences and patterns of eating and drinking. Each person's tray in the IPU was named and laid up and had people's individual preference sheet for staff to refer to. The information sheet showed the size of meal, whether the person needed help, adapted cutlery and plate guard needs, drinking vessel, whether food was liquidised or pureed, and special nutrition requirements. This effective system ensured that people's dietary requirements and preferences were met.

There were volunteers that specialised in helping people to eat. When people made late choices or changed their mind, this was accommodated. People were offered alternatives and staff told us they were able to have "Whatever they want whenever they want." There were effective links with dietetic professionals. A dietician had been commissioned to review how food and nutrition was appraised at the hospice. Following their recommendations, a working group had been formed to develop a strategy to formalise the role of nutrition and hydration across the hospice.

People were referred to healthcare professionals when necessary and their advice was sought and acted on. A person had been admitted to the IPU from hospital with a particularly innovative pain relief system. Staff had requested the hospital pain specialist nurse to come to the hospice and show staff how to manage this system. They also had requested them to bring details of the system in order to purchase one for the hospice. The Hospice at Home staff referred people to district nurses in the community. One district nurse told us, "The hospice team are first-rate."

The premises had been adapted to meet people's needs effectively. There was an extensive library room for staff that was fully stocked with reference books and up to date journals on palliative care and four computers, to enable them to do research and expand their knowledge. There were three training rooms so training in different topics could take place simultaneously. The out-patients area included three consulting rooms and complementary therapy rooms where people could have aromatherapy, massages, and physiotherapy.

All bedrooms in the IPU were en-suite with ceiling track hoist to enable people to go from their bed to the en-suite and back. All beds could be wheeled outside if people wanted to access the garden. The bathroom had a shaped-designed bath with adjustable height. There were four 'quiet rooms' where people or relatives could spend time if they wished. In each of the five wings ('pods') there was a family room with a pull-down

settee for relatives to stay. The area included a lounge with comfortable seating and a play area equipped with a TV and toys for young children to keep them entertained. There was a kitchenette where families could make hot drinks. Such an environment had been designed to promote an atmosphere of calm and comfort where people may be able to unwind and relax effectively. The 'Independent Living team' from the local authority had carried out an audit of the environment in January 2016, to check the general layout, lighting and colour contrasts levels in regard to helping people who may live with dementia or people with visual impairment orientate themselves. Their report was very positive.

## Is the service caring?

### Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were overwhelmingly positive in regard to staff in the IPU, Hospice at home, Day hospice, community team and family services teams. People told us, "The staff are the best" and, "Brilliant staff; there is nothing they won't do to make you feel at ease." The registered manager told us, "Caring is very much at the heart of what the hospice delivers."

There was a homely feel throughout the service and a social atmosphere where people were encouraged to chat if they wished, and were listened to. Staff were smiling and engaging; they stopped to listen to people and responded to them with apparent genuine interest. They followed people's pace when they helped them and when they conversed with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names. Staff were kind and used appropriate touch when needed such as gently stroking a person's arm while they experienced some discomfort. They always checked to assess whether such gestures of empathy were welcomed by people. They offered companionship to people who stayed in their bedrooms when they considered that people may not wish to be on their own. The staff responded quickly to people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected, updated in their care plans, and staff communicated the updates with each other.

People were proactively supported to express their views and staff were skilled at giving people face to face information and explanations they needed and the time to make decisions. The doctors held frank discussions with people and tactfully presented a range of options to people outlining the positive and negative aspects of each option. One person told us, "The doctor was straight talking with me which is what I wanted." With such an approach from the medical staff, people could be confident that they could be fully informed to make their decisions.

People valued their relationships with the staff team and told us that they often went 'the extra mile' for them, when providing care and support. Staff did not monitor the time their visits to people's homes took. They said, "Our visits take as long as it takes to make sure we leave people absolutely comfortable." A care worker in the Hospice at Home team told us how they had stayed long after a person had passed away in their home, to support the family. They told us, "This is very special work, and we can get very attached to people and their families; it is important to leave these families in the best possible state and as settled as they can be." Another told us, "Our job is simply fantastic, a real privilege; we often find ourselves staying on after our shifts have finished, everybody goes above and beyond and give that extra input that is so often needed." The Chief Executive Officer told us, "Families will live with these moments for the rest of their lives, so we must make these moments as painless as possible." The IPU team leader told us how the staff had put aside their own feelings of grief in a particularly difficult situation to support a relative through his own sorrow. Staff had been given time to debrief and support one another before returning to duty, "To make sure we remain present for people." A relative told us how staff had provided "Unwavering and genuine

support" throughout the night when they loved one had passed away. As a result of such staff approach, people felt really cared for and that they mattered.

The relationships between staff and people receiving support consistently demonstrated a respect of their dignity. A relative told us, "The staff never made a fuss when they had to help my relative with her continence needs; they always smiled at her and chatted with her when they did the task and made sure there was no embarrassment." All staff knocked gently on people's bedroom doors, and waited before entering to respect their privacy. Signage was used on people's doors indicating when it was not appropriate to enter, or when a person had requested limited visiting. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing.

Visitors were welcome at any time in the service double beds were available should a person's spouse wish to stay with them at night. Relatives were able to bring people's pets to visit their owners in the service, to bring them comfort and lift their spirit. Staff told us, "We have had dogs, cats, a parakeet and even a budgie that ended up living here. A person was able to have their dog staying with them, with the help of their relative. A care plan had been written for a hamster in response to a person's anxiety about its wellbeing. Such measures ensured that people could retain and find comfort in routines that were familiar to them, as well as reduce isolation.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. A wide range of 'patient information' leaflets was displayed in the service covering a wealth of topics. For example, the Day Hospice leaflet provided information on their referral system, the outpatients' clinic, access to other hospice services, attendance arrangements and Carers drop-in sessions, transport, resuscitation, activities and therapies. The IPU information booklet was comprehensive and included information about the whole service and how to complain. There were leaflets about carers groups, and about how the Family services team could provide emotional and spiritual support and advice. Information about the service was also shared with people and visitors via a close circuit television monitor. A leaflet was provided to local GPs, hospitals, leisure centre and library to inform and invite people in the community of 'free fun and informal events' for the year ahead. The Community Team provided information to people in colour coded envelopes, to distinguish the information that was meant for people or for their carers, so as to remain sensitive to people's psychological needs. The hospice website was comprehensive, regularly updated and easy to navigate. Regular newsletters were available.

The service took account of people's cultural, religious and linguistic needs. A weekly service of non-denominational faith took place in the hospice's chapel. A local Imam (worship leader for people of Muslim faith) and a local Rabbi (spiritual leader for people of Jewish faith) visited upon request. The registered manager had found that there were people speaking seven different languages in the catchment area. As a result, they had requested leaflets to be printed in these specific languages that said, "We want to ensure that we provide you with care and support that is right for you. If you need an interpreter please tick this box; this will not cost you anything and will help us to understand how we can help and support you." The IPU team leader had discussed with the registered manager how to obtain and upload a translation application onto portable computers for staff. This was being implemented.

The staff valued practice that acknowledged diversity and promoted equality. The registered manager had liaised with the local lesbian, gay, bisexual, transgender and queer (LGBTQ) mental health services to introduce 'affirmative practice' training for staff that addressed issues in regard to discrimination, stigma, mental health needs and care pathways to use for LGBTQ people. This training was scheduled to take place.

Family support was recognised by staff as vital to people's wellbeing and staff strived to meet the emotional and practical needs of people and their families. The Family Services team provided psychological, practical and spiritual support through three counsellors, 24 trained volunteer counsellors, social workers and the chaplaincy team that included a chaplain with 30 years of palliative care experience. They supported people in house as well as in the community. They signposted to the Macmillan Nurses who are specialist nurses in the care of people with life-limiting illness, to the local Citizen Advice Bureau, and to legal advisors. They gave advice regarding benefits, funeral arrangements and provided information about processes to follow after a person had died. Ongoing bereavement support was tailored to individual needs and could be extended to respond to people's needs. The team leader of the Family Services told us, "We provide 12 counselling sessions but if more is needed we of course extend this; should a relative want to come back to the service even five years after a person has died, we would re-assess, look at triggers and provide more support." Therefore the service provided continual emotional support for families in addition to the provision of care for people.

The hospice held a memorial book and the deceased person's name was added to the book. A relative told us, "This was strangely comforting seeing the name there; it helped us." People were able to record their messages on a wall of remembrance. A bereavement counsellor and the chaplain held a 'Time to remember' reflection event four months after a person's death, and monthly social evenings were held to get bereaved relatives and friends together. There were thanksgiving services held twice yearly, and an annual 'Light up a life' event where people could light a candle in the memory of their loved one and sing and pray.

## Is the service responsive?

### Our findings

Staff understood people's needs and responded to these needs in an empowering way. The artist in residence told us, "People have control at a time when all control is eluding them, we help them make the most of that precious time."

All the people we spoke with, their relatives, visitors and healthcare professionals described in emphatic terms the way staff responded to people's needs, such as, "They are amazingly receptive and ready to help even before we realise it is needed", "They not only respond, they pre-empt and put themselves in patients' shoes" and, "The staff have exceptional skills", and, "I have never been to a place where you felt so understood." A GP told us, "The hospice staff are very skilled at providing end of life care in a compassionate way that focuses especially on how patients may feel." A care home manager who was supported by the hospice team said, "They are an exceptional team; they are quick to respond, provide excellent advice and make sure individual symptoms are managed."

People were able to self-refer to the service via their GP and their needs were assessed as soon as they came into the IPU for respite or for a longer stay. Newly referred people met with a member of the clinical team so that their individual needs could be understood. In the community, when people's needs were urgent, the team made contact with them the same day and visited them within 48 hours to make sure people could be helped as soon as possible. A pain assessment tool was used to describe people's levels of discomfort, and an assessment was carried out about what the person knew about their condition and whether they wanted to be fully informed of developments regarding their health.

People were referred and signposted to appropriate services without delay in order to respond quickly to their needs. Some people were referred straight away to the Family Services team for psychological, spiritual and emotional support, and appointments were made for them to see complementary therapists when needed. Some people were referred to 'Community Companions', who are hospice volunteers who come and sit with people, participate in activities with them or accompany them on outings.

A medical plan was written about how to manage the person's symptoms. The clinical nurse specialist had suggested an alternative option to a pain relieving medication when a person had experienced nausea. A relative told us, "It was good to hear what options there were for pain relief so we could choose." Initial assessments were faxed to people's GP and prescriptions were obtained to relieve people's pain without delay. Nurses closely liaised with GPs, district nurses and followed up to check that new medicines had relieved people's symptoms to relieve their discomfort.

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the IPU and when people received support from the Community Team or Hospice at Home service, staff sat with people, enabling them to spend as much time as they needed, encouraging them to ask questions, discuss their options and reflect upon them. As people and staff worked as a team to ensure each support plan was unique and responded to specific needs, people felt valued and understood.

People were fully involved and supported with the planning of their care and treatment 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 and were invited to take part in 'advance care plans'. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they wished to be their legal representative.

These advance decisions were recorded, effectively communicated to staff and respected. Staff sat with people and encouraged them to express their wishes. The Head of Community Services told us, "We offer a conversation about this at our first meeting although it is not always possible; we persevere and make sure they have this opportunity, we aim at having these discussions within a month so we can ascertain all of their wishes and also find out vital details such as whether they wish to go to a hospital or not." When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. Advance care plans were updated as often as people wished if they changed their mind. As staff demonstrated great understanding and empathy, people could be confident that their individual needs were met and responded to in a way that may exceed their expectations.

Additional plans were updated hourly when people approached the end of their life, to monitor closely their comfort and respond to their changing needs. The care plans were centred on the individual, included food and drink, symptom control and psychological, social and spiritual support. Sensitive communication took place between staff and the person, and those identified as important to them.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. A nurse assistant told us, "We stay with our patients in their last hours if there is no family to support them, but we would have discussed this beforehand with them to make sure this is what they wanted." Therefore people's needs in the last hours of their life were met by well-informed staff who were knowledgeable about people's individual requirements.

People's wishes were at the centre of their care planning. Staff were aware of people's care plans that clearly outlined people's likes, dislikes and preferences. They provided a sheet 'Let us know your preferences' to people and their relatives, and documented people's requests. For example, the Hospice at Home team knew when a person liked a particular routine, to have bubble baths, use a particular flannel, or wanted dry or wet shaves. In the IPU, people's particular wishes were documented and acted on, such as 'Lots of Jacuzzi' and bedtime snacks. When a person had wished to remain in their recliner chair, staff had researched and obtained a chair that was more manoeuvrable in order to nurse them without disruption. A person had requested an informal funeral and staff had helped them research this on the Internet. They had helped their relatives understand this was what the person wanted.

In the community, a nurse had shopped for a person who had specific anxieties relating to appointments and they had purchased an alarm o'clock to help alleviate their anxiety. One person was referred to a national charity so they could see their favourite singer perform. A care worker had ensured a Trust dedicated to looking after pets stepped in when people had become unable to walk them. The Family Services team had contacted a local association to help an older couple who had needed to visit their relative in a local hospital and find accommodation for them. When a person had been too unwell to attend their relative's funerals, the funerals had been held at the hospice. There were frequent weddings held in the hospice. Visiting times were not restricted. One staff member told us, "We would do anything, anything to make people's life as fulfilled as possible."

Staff responded in a pro-active way to respond to people when specific issues arose. For example, a nurse saw that a carer was becoming exhausted looking after their relative who was unable to come in for respite in the IPU. The nurse had researched local nursing homes, had found out about their suitability, availability and cost in order to suggest this option to the carer. As staff approach responded to people's needs, they could be confident that staff understood what was important to them.

In the Day Hospice, people of any age group were invited to spend the day, share a meal and take part in activities and complementary therapies. The Day Hospice team consisted of clinical support staff and 65 volunteers, and offered people the opportunity to access other hospice services and engage in a range of imaginative activities. Although people were booked for specific days, they were able to cancel on the day if they felt unwell, and there was the option of a shorter day for people who experienced shortness of breath or who became tired. Transport was available by way of a minibus for up to 16 people who could not drive to the hospice, and another van that accommodated wheelchairs. A lunch included a choice of hot meals and desserts. Hot and cold drinks were offered throughout the day and tea and cakes in the afternoon.

A person who was a frequent visitor to the Day Hospice told us, "This is my lifeline; the staff know me so well, they know everyone here and have shared very difficult moments with every single one of us; there were times where I was so angry and they knew how to calm me down and put me back on the map." Staff had taken photographs of people and people had taken photographs of staff in return. The registered manager told us, "This exercise helped putting people and staff in someone else's position." Such initiatives showed how staff thought of ways to respond to people's emotional needs.

Two activities co-ordinators provided original activities. One told us, "We think outside the box and we have a can do attitude: if it can be done let's do it." They had organised a talent show and staff from all teams in the hospice had participated to perform in front of people. A mystery day had been organised, and staff had 'taken' people to the countries they wished to visit on an imaginary world cruise week, sampling foreign music food and customs. A summer party had been held where staff and people had dressed up in 1950s outfits. At Christmas, people and staff had produced a pantomime show. There were outings to Worthing Pier, pub lunches, garden centres and impromptu visits to coffee bars although these places had been risk-assessed beforehand to ensure they were suitable. Entertainers, Quiz masters, musicians and guest speakers were routinely welcomed to the Day service. A comprehensive range of games was offered, such as crosswords, word games, and discussions about a chosen topic. People were encouraged to participate in 'My Life' projects. A person told us, "There is no pressure, if we just want to read our papers and not take part in anything it is our choice; they understand the last thing we want is pressure of any kind."

The service aimed to include all generations in their activities and to redress how young people may perceive hospices to be. The Day Hospice had scheduled a specific day for younger people. However as attendance did not meet staff expectations, they were designing a new brochure to entice more young people to the Day Hospice. The team leader of the Day services told us, "We want to shake-off the image of an hospice being for the old generation and want to reach every age group because there is a need for this, so the message is: 'Come, and you will get from us what you want from us'."

We spoke to the artist in residence who provided innovative creative activities. Some people did legacy projects; others participated in one to one or groups art activities. People could develop their photographic, pottery, computer and painting skills. One person who was unable to see clearly had created a painting. The artist told us, "This person told me what colour she wanted, I mixed it and she told me how to compose her painting; we did a texture map first for her to feel the painting; so we found the way for her to be independent in her creative process."



The artist told us, "Often people seize the opportunity to be creative now that they are ill and have more time to focus, we give them that opportunity." Therefore they used ways to capture people's imagination in order for people to be as creative as possible. Using a system of long exposure photography, the artist helped people take a series of photographs which were then incorporated in a 'video footage' and subjected to special effects, light and music through computerised software. They explained how the result was "Very empowering". People who may have difficulties moving around were able to participate as their movements were emphasised through the process. One person who said they could not draw had participated in this activity. They had danced and photographs of their performance had been animated in a short film whose essence reflected the person's feelings. The artist said, "This was extremely powerful; that person had found a way to express herself, and this was transcribed into something that could be shared and understood by people without words."

The artist approach was innovative in suggesting additional ideas that people may not have considered themselves. For example, the artist had helped a person who was a piano tuner with a 'hands project' to capture their sense of identity. One person told us, "It is amazing, I did not know I could be creative but I couldn't wait to tell my family: look at what I can do!" Therefore staff understood how to respond to people's creative and emotional needs at times that mattered to people. The artist researched ways to stimulate people's interest. They had done a survey of all hospices in the South of England to see what art activities they provided, and had followed this up with inviting artists to St Barnabas to establish a network and exchange ideas and good practice.

There was a robust system to ensure feedback was collected, analysed and acted on. Regular surveys were used to gather stakeholders' views of the service by ways of questionnaires and a 'Real Time' system in the IPU and Day Hospice. This 'Real Time' system meant that staff talked with people and captured their impressions and feedback instantly on portable computers.

Feedback was also obtained from informal carers and relatives three months after the death of the individual supported by the hospice. Questionnaires were sent out to all GPs, hospital ward managers and community matrons who referred people into the hospice. The feedback was extremely positive. One person had stated that it was the first time during their illness that they had felt involved in their care. All feedback was analysed and followed up with action plans when any possible improvements had been identified. As a result of a last survey, a new, more simplified version had been provided to people, asking them to state three positive aspects of the service; three areas that could be improved; and three things they would like to see happen in the future. The registered manager told us, "We want to make it easier to use for people and seize what matters the most." As a result of this feedback, staff in IPU had stored more duvets than blankets; the information booklet for people had been updated about self-medication and breastfeeding.

There were overwhelmingly positive compliments from people and their relatives that were received on a daily basis. Several comments included terms such as, "Infinite care to detail", "The can-do attitude of every single member of staff was so helpful we never felt alone", "Angels", "Invaluable support", "There were many comments about how the Hospice at Home team had been instrumental in keeping ill people in their home as per their wishes, and how people had died how they had preferred because of the service provided. A comment included, "The night sitters were wonderful; the undisturbed sleep brought me back from the brink of total exhaustion; we could not have managed without them". Another comment summarised, "Your professionalism, warmth and responsiveness, effectiveness have been an inspiration."

The service took a key role in the community and was actively involved in building further local community links. Current links were maintained through a series of trading shops and fundraising events. For example,

an evening with an author; shuffle board Olympics; Raffles and silent auctions; cottage pie lunches; Quiz nights and Beauty evenings. Sporting events included challenges such as marathon races, sky diving, bike rides inland and abroad, overseas treks, parachuting and swimming. The service maintained close relationships with local corporations for organising dinners, balls, bake sales, dress down days and family days in order to raise funds for the hospice. There were 'Friends Groups' in the community who organised events to benefit the hospice throughout the year, for example a group of women called 'Knitting Noras' knitted artefacts for Easter to raise funds. The fundraising manager told us, "We never stop thinking about new events, new challenges, and how we can engage people further."

There were approximately a thousand volunteers supporting the service. St Barnabas House is a Duke of Edinburgh Approved Activity Provider and offered youth the opportunity to help their local community as part of the volunteer section of the award. A volunteer told us, "This hospice is basically like the heart of the community, it is a highly thought-of place that affects us all and brings us together, like a big family."

People were actively encouraged to give their views and raise concerns or complaints. Complaints were addressed promptly according to the service's policy and to a satisfactory outcome. Each complaint had been followed up with an action plan in order to drive improvement and lessons were learned as a result. The registered manager told us, "On-going improvement is essential; we need to make sure we get it right for each person who is involved with St Barnabas and respond fully to their needs."

## Is the service well-led?

### Our findings

There was an open and positive culture which focussed on people. People's feedback about the way the service was led described it as "Remarkable", "Really excellent management", "It seems to run like clock-work" and, "It is very well structured and extremely well organised." Two relatives told us, "The manager is very approachable and compassionate" and, "This place is exceptionally well run, I have never seen any place like it." A comment from relative stated, "If more businesses were run like this, the world would be a much nicer place".

A Board of 13 Trustees (the provider) ensured the responsibility for the overall running of the service. The registered manager was also the Director of Adult Nursing and was part of a leadership team headed by the Chief Executive Officer (CEO). The leadership team also included a deputy CEO, a Director of Finance, an Income generation Director, and a Human Resource (HR) Director. The registered manager oversaw the running of the Family Services, the Community palliative care Team, the Day Hospice, the In-patient Unit (IPU) and Physiotherapists, and each department was manned by a manager or team leader who reported directly to them.

We spoke with a Trustee (the provider), the CEO and the registered manager about their vision and values about the service. The provider told us they held a "Real passion" for the organisation and aimed at increasing care in the community and "Reaching more people beyond people living with Cancer." The hospice was developing a five year strategic plan that aimed to reach different and new groups of people, and aimed to support earlier discharge for people who wished to be cared for at home. St Barnabas Hospice's vision, mission and values included, "No one should face death or bereavement without the care and support they deserve; to achieve dignity, comfort and choice; to provide a focus of expertise in palliative and end of life care through leadership, training, and development of services, to the community and health professionals." The CEO told us, "We don't get a second chance to get it right, so we endeavour to help people's end of life to be as dignified and comfortable, and as positive as possible. We want to take the fear away from the hospice." The registered manager told us, "We respect individual beliefs, lifestyle and culture. We care for the whole person, focusing on choice and meeting spiritual and emotional needs as well as physical needs, always seeking to improve what we provide." From what people told us and our observations, these principles were implemented by all staff throughout the service.

Staff praised the provider and the leadership team for their approach and consistent, effective support. They said they could come to their team leaders or managers, to the registered manager, the CEO or the provider for advice or help and felt confident this would be provided and their comments would be welcomed. Staff were actively involved in the running of the service and their feedback was actively sought. The provider held quarterly staff briefings to update and involve staff on the strategies of the service, and for sharing successes and challenges. There was a managers Action Group and the newly appointed Human resource (HR) Director acted as a conduit between that group and the management team. A comments and suggestions box was available for staff to use and emptied weekly although this was not used by staff. They told us, "Never used it, why use it, we communicate too well for that."

All of the staff we spoke with, without exception, spoke extremely positively about the registered manager's style of leadership and told us they led by example. They described them as, "Exceptional", "Totally approachable", "Inspiring" and, "A compassionate leader". They said, "He conveys what this service is all about. They told us that they felt valued working in the service, and felt motivated to maintain high standards of care.

The service actively sought the views of others through creative and innovative methods. For example, to supplement satisfaction surveys, the service had introduced 'Real Time' feedback, where staff used 'I-pads' (portable computerised devices) to talk with people and relatives and ask them 12 questions to capture their current experiences. This new method was piloted last year and as it proved to be a particularly way to obtain instant feedback, more I-pads had been provided to staff in the hospice, Day service and in the community to use for that purpose. Feedback was reported at staff meetings to identify how the service could improve.

The registered manager was very visible in the service and worked alongside staff at least one shift a month in the IPU, the Community Service, in the Hospice at Home service and with the triage nurse. A care worker told us, "He is one of us." A manager told us, "He is totally dedicated to the hospice and he inspires the staff." The registered manager, after each training refresher course, outlined the learning points that were made at the training, reflected how their knowledge could benefit the hospice and wrote an action plan that set up how practice could be improved in practical terms. The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service, and exercised the 'Duty of Candour' when mistakes were made, to give frank and comprehensive accounts to people and their relatives.

The registered manager played a key role in the hospice care model. They chaired quarterly meetings with 19 managers of hospices in the South East of England, in the Executive Clinical Lead in Hospice Palliative Care (ECLiHP) group. ECLiHP provides a forum for executive clinical leaders engaged in the strategic plans and operational delivery of hospice and palliative care across the UK. This forum has been established by Hospice UK and aims at 'advancing clinical leadership in hospice and palliative care and develop tomorrow's leaders.' The registered manager acted as a conduit between the regional group and the national ECLiHP committee. They had launched a regional clinical data tool about staff turnover, falls and pressure care, to aid comparison on these issues. They told us, "This is about establishing an effective network for support, information exchange and shared learning at national level; we exchange ideas, initiatives and different models." This approach meant that lessons could be learned at a national level and that the service focused on continual improvement.

The registered manager kept themselves updated with latest research that related to hospice care and ensured staff used tools that were developed as a result, to measure performance and identify improvement. The IPU manager participated in a 'Work force Modelling' nationwide project, where the hospice staffing levels and skill mix were benchmarked against 40 other hospices. They told us, "It gave us clarity about our productivity and confirmed that our nurses can concentrate totally on nursing care; we came top of the league on how much time our trained nurses spent with patients." St Barnabas Hospice had just introduced a suite of 'Outcome Assessment and Complexity Collaborative Suite of Measures' (OACCS) created by Hospice UK Kings College, into their clinical practice and into their system of electronic patient records. As a result, the IPU manager and the Head of Community Services worked together to use this tool and measure the effectiveness of the care delivered. The IPU manager told us, "This was on trial by a small group of hospices and the registered manager told us about it, he was very enthusiastic and we have now started to use this. It is looking at 'snapshots' in certain time of a person's care and see where they are at, at different phases of their illness, for example two days after admission, or after a short time following our

involvement; it demonstrates the actual quality of care we deliver and helps identify any improvement that may be needed."

The registered manager worked in partnership with other organisations to raise standards of care at a national level, and placed strong emphasis on continuous improvement of the service. Several projects were in the process of implementation. The registered manager had identified the need for an 'End of Life Care Co-ordination Hub' and had worked in partnership with the local Clinical Commissioning Group (CCG) to co-design a rapid response team, establish a palliative register and ensure people could access a clinical nurse specialist and a consultant on call 24 hours a day. They had led the project and had worked in partnership with another hospice, a community Trust, a hospital Foundation Trust, a regional MacMillan initiative and a private care homes sector to develop this resource. This was due to take place in July 2016. They had developed a 'Rapid Access Pathway' project in partnership with the local CCG to ensure new pathways were created to provide a more rapid response to people who needed care. They told us, "We seek to be part of the 'bigger solution' and see the bigger picture, in order to keep people at home when they want to be at home and give them all the information they need."

The registered manager spoke to us about the plans that were in place to enhance the service and reach more people in the community. They were involved in a local initiative in partnership with the CCG, The Trustee, the CEO and the registered manager enthusiastically told us about their plan to build a 'Wellbeing Centre' close to the hospice, where care would be more 'therapy-led' and focus more on re-enablement, to bridge a gap that they had identified in the community. This project was in the process of implementation although at presentation and discussion stage with stakeholders.

The Education Centre in St Barnabas House had organised a 'Swap shop' every two months which was a presentation on a particular topic followed by a working lunch where debate and discussions were encouraged to take place. Doctors, nurses, social workers and all health and social care professionals in the local hospitals and in the community were invited to join without paying. Topics ranged from corneal donation, cardiac disease, Parkinson's disease, and mindfulness were discussed. A district nurse told us, "The Swap Shops are really interesting, we exchange different practice models and we all benefit from this."

There was a robust system in place to maintain and monitor the quality of the service. A structured Clinical Governance Committee oversaw a clinical effectiveness group, a clinical risk group, an education group, a formulary group (about medicines) and a patient information and user involvement group. The clinical effectiveness group was led by the registered manager and looked at clinical complaints and updates, all audits carried out in the hospice by designated leads including significant event analysis, and clinical policies and guidance. The registered manager sat on each of the other groups meetings which were minuted. The registered manager ensured that all action planned at the last meeting had been carried out and this included action outlined in audits. An audit calendar scheduled 32 annual audits that included infection control, medicines, consent, advance care planning, mental capacity assessments and admissions. There was an arrangement with the registered managers from other hospices so that they visited each other's services and carried out audits for each other. The registered manager told us that this arrangement was helpful in ensuring the service could be appraised by independent assessors with "A fresh pair of eyes". Audits were effective in identifying shortfalls and action was taken as a result. For example an infection audit had highlighted the need for an improved system of infectious liquid waste disposal and the need to no longer use cotton wool. This had been remedied without delay.

The registered manager had set up regular meetings with clinical leads to minimise duplication of work and maximise clinical awareness at director level. They met fortnightly with the CEO and three consultants. The

majority of Trustees had accompanied staff on shifts in both the Hospice at Home team and the IPU to appraise first-hand the quality of care provided. Two trustees undertook an annual inspection visit and interviewed people, relatives, staff and volunteers. They wrote an inspection report, and when this highlighted an improvement that needed to be made, the registered manager ensured this was implemented. They reported to the provider a detailed account of developments in the service, what changes and improvements had been implemented in the last six months, and any concerns that had arisen as a result of audits. When an audit had identified a shortfall in staff training within a time frame, an action plan had ensued which had been monitored until completion.

The registered manager involved the staff with the running of the service. All relevant staff had been contacted in relation to reviewing policies and leaflets. For example, The Head of community Services had been consulted about updating the service's suicide and deliberate self-harm policy. The policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated on a continuous basis.

The registered manager actively promoted further links with the community and along with the CEO had formed an innovative Hospice Outreach Project (HOP) 18 months ago which was extremely successful in reaching people and raising the profile of the hospice and other services. The HOP is a bus that has been transformed into a mobile unit with a ramp to provide easy access, staffed by a senior nurse who provides information and advice on all aspects of hospice care available at St Barnabas House and out in the local community. The HOP also acted as an education resource for healthcare professionals and the wider community. The aim of this project was to improve the way people access information and support related to end of life care. The registered manager was included in the HOP staff rota and told us that within two hours he had spoken to 44 people about the hospice. As a result of this project, staff had more than 4,500 conversations with visitors during its first six months of operation.

The HOP specialist staff worked closely with GPs and community teams to give advice and support in areas of symptom management, emotional, spiritual, psychological and bereavement support for patients and their families. People had been signposted to a whole range of services as a result, for example ex-soldiers and carers of people living with dementia had been signposted to external support services. The HOP vehicle visited 17 sites and timetables were available on the service's website, from local newspapers, GP surgeries, local chemists, Parish Councils and the hospice. There was a private room at the back of the bus so people's privacy could be respected. The registered manager had implemented a 'portable cube' in the vehicle, to help people put their messages in, and use as a message wall, to evoke memories of their loved ones. They told us, "This HOP has nothing to do with fundraising; it is about opening up and help people who are looking after someone who may be dying; even if a families' relative has not died here, we can support them; we have finite resources but we want to expand and make the most of that resource." In order to "Keep the message and discussions fresh", there were monthly topics the HOP focused on such as, wellness, lung issues, diabetes, 'dying matters', carers support, dementia, advance care plans, will writing and organ donation. The themes tied in with national focus, for example the topic of dementia coincided with the national dementia awareness week. A person who visited the service told us, "My relative has a long term illness and it is hard to cope on my own, I have been quite alone in this; I spoke to them in the bus outside my supermarket and that was really useful as I didn't know there was so much out there to help me, so I have come here today to see for myself".

All records relevant to the running of the service that we saw were well organised and reviewed regularly. All records were kept securely and confidentially. An effective electronic record system had been introduced to store and update data about people's care. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.

