

Woking Hospice

# Sam Beare Hospice

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This inspection was carried out 11 and 12 July 2016 and was unannounced. At the time of our visit seven people were using the inpatient unit and the hospice at home service had around 400 people registered as accessing the service.

Sam Beare Hospice is an independent registered charity for the delivery of care and treatment for people across Surrey, owned by Woking Hospice Trust. The service is provided using the 10 bedded inpatient unit, the hospice at home service and the day hospice service. Medical, nursing, therapy and palliative care clinical nurse specialists (CNS) are provided across the hospice's inpatient unit, day unit and community services. People and their relatives may also receive support from the bereavement service, a telephone advice line and a spiritual care service. All of these services provide specialist palliative and end of life care to people with progressive and advanced disease and a limited life expectancy. The hospice was experiencing a period of change as the service prepares to move location and merge with the provider's other hospice in the next year. The provider was sensitive to the uncertainty this might cause people and staff and a change management programme was being implemented to ease the process.

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

There was a defined governance and management structure in place, which staff understood. This provided clear lines of responsibility and authority for decision making about the management, operation and direction of the hospice and its services. Systems were in place to support the registered manager and board of trustees to identify risk and quality concerns and drive improvement across the service. We saw examples of improvements made in relation for example, to the staff appraisal process, recruitment records and medicine management.

People were protected from harm and abuse and robust staff recruitment procedures were followed to keep people safe. There were sufficient staff to meet people's individual needs and to respond flexibly to changes and unforeseen emergencies.

Systems were effective to manage known risks associated with people's care and treatment needs such as falls, pressure sores, poor nutrition and hospice acquired infections.

People were supported to eat and drink sufficiently and adjustments were made to ensure people at risk of choking could eat and drink safely. Regular reviews took place of people's symptoms and changes were made as required to ensure people's pain would be well managed.

Staff followed and understood the requirements of the Mental Capacity Act 2005 and the Deprivation of

Liberty Safeguards 2009 (DoLS). These set out requirements to ensure, where appropriate, that decisions about people's care are made in their best interests when they are unable to do this for themselves.

There was a holistic approach to people's care with the physical, well-being, social and spiritual needs of each person given equal importance, together with the needs of those closest to them.

People and their families received a responsive service. People were treated as equal partners in determining their care and treatment plans and their rights, wishes, preferences and diverse needs were respected. The service was responsive to the changing needs of people and had developed the service in response to the local communities changing needs. Care, treatment and support were provided within the hospice environment and people's homes in line with their assessed needs and preferences. People, their families and staff felt that they mattered and that their views were taken into account and acted on.

People and their relatives were complimentary about and satisfied with the care provided, which they described as "Excellent". Staff treated people with care and compassion and were motivated and committed to providing people with the best possible palliative and end of life care. People were supported to receive end of life care that met with their needs and wishes and to achieve a private, dignified and pain free death. People, their families and staff were provided with the emotional and bereavement support they needed.

Staff received the training and support they needed to perform their roles and deliver good care. Managers supported staff to undertake professional development, to ensure best practice and make improvements in care when required.

Staff worked closely and in partnership with external health and social care professionals and providers and also health commissioners, educators and national organisations concerned with palliative and end of life care. This helped to ensure that people received the right care at the right time and that knowledge was appropriately shared and used to influence best practice for people's 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 and knew how to protect people from abuse or harm. People felt they were safe being cared for in the service. There were sufficient staff on duty to meet people's needs safely.

Any health and safety or individual risks were identified and action was taken to keep people as safe as possible. The registered manager made sure the staff team learned from any accidents or incidents.

Recruitment processes for new staff were robust to ensure they were suitable to work with vulnerable people.

Medicines were administered safely. Processes were in place to ensure that people received their medicines as prescribed. Qualified nurses were responsible for looking after and giving people their medicines.

### Is the service effective?

Good ●

The service was effective.

People received effective care, treatment and support from a multi-disciplinary team, who received the training and support they needed to perform their roles. People were supported to manage their pain effectively.

People's rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Where people lacked mental capacity families and other professionals were consulted when decisions needed to be made about people's care and treatment.

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs, preferences and wishes. Professional advice was sought and

followed for people's nutrition where required.

### Is the service caring?

Good ●

The service was caring.

People received care from staff who had developed positive, caring and compassionate relationships with them and their families.

A person centred culture shone through when staff spoke about people. They treated people with kindness, dignity and respect.

Hospice staff continued to support relatives following their loved ones' death through a range of bereavement services.

### Is the service responsive?

Good ●

The service was responsive.

The service was proactive to ensure a holistic approach to people's care and treatment. Effective collaborative working between professionals meant that people's received consistent and flexible care and treatment that met their needs and wishes.

People were supported to make decisions about how they wanted their end of life needs and wishes to be met and we saw the care people received reflected their wishes.

### Is the service well-led?

Good ●

The service was well led.

People and staff were positive about the leadership of the management team and staff were clear about their role and responsibilities.

There was an open and transparent culture in the service. Staff, people who used the service and relatives were encouraged to identify risks and to support the improvement of the service.

There were systems in place to monitor safety and drive improvements in the quality of the service. The management team learned from accidents, incidents and complaints. When the provider identified shortfalls in the service they took prompt action to review practice and make the required improvements

# Sam Beare Hospice

## Detailed findings

### Background to this inspection

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

This inspection was carried out on 11 and 12 July 2016 and was unannounced. The inspection team consisted of one inspector, a specialist nurse in end of life care, an expert by experience and a pharmacist inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. We previously inspected the service on 08 May 2013 and no concerns were found.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sent questionnaires to staff and people who used the service to gain their feedback. We reviewed the PIR, previous inspection reports, notifications and all contacts we had about the service. A notification is information about important events which the service is required to send us by law.

During the inspection we spent time with three people on the in-patient ward, two people at the day hospice and one relative. We also spoke with five people and one relative by phone who used the hospice at home service. We spoke with the registered manager (who is also the director of nursing), the chief executive officer, three nurses, the Practice Development Sister, the ward manager, the hospice at home team leader, two health care assistants, one of the doctors (specialist registrar in palliative care), the physiotherapy team leader, the cook, two cleaning staff, one student nurse and one clinical nurse specialist.

We attended the weekly multi- professional team (MDT) meeting, observed the doctor and nurse leading a handover meeting and observed one new admission assessment to the inpatient unit. We viewed a range of records including seven care documents for people who used the service, three people's medicine prescription and administration charts, five personnel files, and records relating to the running of the service.

## Is the service safe?

### Our findings

People and their relatives told us they had no safety concerns when people stayed at the hospice inpatient unit and when they received support in their own homes. They said they would be confident speaking to a member of staff or the registered manager if they had any concerns. Staff told us they had completed safeguarding training and records confirmed clinical and care staff were up to date with this training. Staff were able to identify the procedures they needed to follow should they suspect a person in their care had been or was at risk of abuse. Staff had access to safeguarding policies, procedures and telephone numbers in the event they were required to raise any concerns. One volunteer told us "I will not think twice about speaking to the nurse if I saw anything that concerned me or if I thought people were not safe here".

The registered manager was aware of their responsibility to report allegations or suspicions of abuse to the local authority. They told us they had not needed to report any safeguarding concerns to the local authority relating to the service since our previous inspection. However, they told us that staff had taken action to minimise the risks of avoidable harm to people when they became aware that people had experienced abuse or bad practice when accessing other services. Staff had referred these concerns to the local safeguarding team and had supported safeguarding investigations as required to ensure action would be taken to protect people from harm.

Staff knew how to follow whistleblowing procedures and raise concerns. They were confident that any issues they raised would be addressed and gave example of when they used this process effectively to improve the service people received.

Risks to people's safety and staff supporting them had been identified, effectively managed and reviewed. These areas of risk included any potential hazards in the environment, risks when people were supported by staff to move or transfer, risk of falls, weight loss, choking and the development of pressure sores. Staff demonstrated that they knew what action to take to keep people safe.

People at risk of falls had been assessed by the service's physiotherapist to ensure appropriate arrangements were put in place so staff would know how to support people to mobilise safely. The physiotherapist told us they took into account people's independence and their fluctuating strength when assessing their risks. They also identified if people required any equipment to enable their care to be provided safely or to remain safely independent at home such as grab rails, slide sheets, wheelchairs and hoists. People told us equipment was provided promptly at home when needed. One relative said "The physiotherapist came to the house and arranged for all the rails to be put in the bathroom so that I would not fall". Another relative told us "When we had to wait two days for my dad's new wheelchair, staff gave us one from the inpatient unit to use till his came and it meant he was safe and we did not have to worry about him falling". Staff had received training in safe moving and handling techniques and told us the physiotherapist supported them to ensure they knew how to use any new equipment safely.

People's changing health and fluctuating strength meant their risks could change rapidly. We found risks to people were reviewed continuously to ensure their risk management plans would remain effective. For

example, staff had received training to identify when people experienced swallowing difficulties and may be at risk of choking. One person told us "They pick things up straightaway. My voice went and they did some swallow tests". The hospice doctor told us staff alerted them promptly when people's risk of choking had increased and they agreed what adjustments were needed to people's food and fluids to keep them safe. There was a focus on positive risk taking so that people could manage their risks as they chose. Where people had indicated they did not want their food and fluid to be altered to manage their risk of choking the staff had agreed alternative plans with people and the health care professionals. These included sitting with people while they ate and offering people the low risk foods they liked.

Staff understood each person's vulnerability to infection and took action to protect people from the spread of infection. Records showed staff had received training in infection control. Staff washed their hands prior to undertaking any procedures and when delivering care to people. In the hospice inpatient unit staff had easy access to hand washing facilities. There were supplies of protective equipment such as gloves and aprons. The hospice was well maintained and clean throughout the inspection. People told us staff also followed good infection prevention practices when visiting them at home. One person said 'They always put their gloves on and their uniform is clean'.

Processes were in place to ensure that residents received their medicines as prescribed. Qualified nurses were responsible for looking after and giving people their medicines, and we observed good practice in the preparation of medicines. Some people's medicines were given through a syringe driver. A syringe driver is a small portable pump that can be used to give a continuous dose of a painkiller and other medicines through a syringe. The medicines for use in syringe drivers were appropriately and clearly prescribed, and we observed nurses safely and accurately setting up syringe drivers. Staff regularly checked syringe drivers to ensure people's effective treatment and safety.

Appropriate arrangements were in place for ordering and receiving medicines. We saw that people's medicines had been reconciled by the doctor or pharmacist; this involves reviewing and confirming the prescriptions for people on first admission to the hospice, to reduce the risk from discrepancies in medicines prescribed. Expired and unwanted medicines were stored securely and disposed of appropriately.

Prescribing was undertaken by in-house doctors along with an in-house consultant. A range of medicines were prescribed for people on admission to the hospice to ensure they always had access to appropriate medicines whenever they were needed. A clinical pharmacy service was provided by a pharmacist visiting the hospice once a week. Interventions by the pharmacist were recorded on the prescription charts to help guide staff in the safe use of medicines. We checked prescription and administration charts for three people, which were completed appropriately, indicating people had received their medicines as prescribed.

Medicines were stored securely in either a locked room or secured medicines trolley, and access to medicines was restricted appropriately. Medicines requiring refrigeration were stored in a lockable fridge, and temperatures were monitored and recorded daily to ensure these medicines were stored within the recommended temperature ranges to maintain their effectiveness.

All incidents and accidents were recorded and analysed to identify what had happened and actions the service could take in the future to reduce the risk of recurrences. For example, when a person developed a pressure area, the registered manager had reminded staff of the importance of supporting people to regularly change their position to relief pressure on their skin. They had reviewed the re-positioning recording system to make them easier for nurses to see from people's records that their risk of developing pressure ulcers had been managed. Medicines incidents were recorded and analysed within the service. We saw evidence of a robust process to report, investigate, review and learn from incidents. Staff described



examples of learning from incidents, and changes in practice to reduce the likelihood of a similar event occurring again.

Staff told us they had been required to undertake full pre-employment checks before they were offered employment and could work with people unsupervised. Staff files showed criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Nursing and Midwifery Council (NMC) checks had been completed to ensure health professionals were fit to practice. There were also copies of other relevant documentation including character references, interview notes, full employment history and proof of identification. The provider had used the interview process to demonstrate staff's relevant skills and experience and to support the registered manager to plan the induction for new staff. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to care for people safely and had taken into account all known risks relating to each candidate's suitability when making recruitment decisions.

There were enough staff on duty in the hospice inpatient unit to meet people's needs and keep them safe. Staff were deployed effectively on the two days of our inspection. We observed staff regularly checking on people who remained in their rooms. People were supported in the day service area throughout the day and people's requests for assistance were promptly responded to. Staff, relatives and people told us that there were enough staff to meet everyone's needs. One person said "The care here has been absolutely superb. There's no waiting, no faffing about" and another person said "They are usually on time, Things run like clockwork". A relative told us "The staff are patient and don't seem rushed. They are very attentive when we are not here and back off when we are here."

Staffing in the hospice inpatient unit was reviewed and adjusted daily to reflect the changing needs of the people using the service. For example, we saw additional staff had been deployed to provide one to one support for a person who was at high risk of falls. The service at times used agency staff when their permanent or bank staff could not complete overtime to cover sickness and annual leave. As the same agency staff were selected as much as possible, this promoted continuity of care for people as they were supported by staff who were familiar with their needs. One person who used the hospice at home service told us "It is always the same staff that come to see me at home. I like that I can get to know them and they know how my condition has changed because they have been with me from the start".

The provider operated health and safety systems effectively to protect all people from harm within the inpatient unit and day service outpatient unit. Regular audits and daily checks by nominated staff ensured that the environment and equipment used was safe and fit for purpose. The premises were secure and systems were in place to ensure that visitors to the service signed in on entry. The service had contingency plans to manage emergencies, for example; evacuation in relation to a fire or flood. This ensured the provider would prioritise people's care provision during such an event. Staff understood these plans and knew how to access them if required. People were protected as processes were in place to manage emergencies.

## Is the service effective?

### Our findings

People told us they received excellent care from skilled staff. Comments received included "They know how to change a morphine pad; everyone knows how to do it, so if one or two people are out it's taken care of", "The care here has been absolutely superb" and "The staff are excellent".

Staff had the skills and knowledge to meet people's needs. They had undergone an induction programme that met the requirements of the Care Certificate standards. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. There was an induction programme for newly appointed nurses that included an induction day and two weeks supernumerary practice. All new volunteers were provided with an orientation programme and mandatory training.

Staff were complementary of the training opportunities they were provided. Their comments included "There are many training opportunities here", "I had a good induction" and "I feel working here has improved my skills and understanding of people requiring end of life care". A programme of ongoing training for care and clinical staff covered health and safety related topics and also topics relevant to the support needs of the people staying in the inpatient unit. Clinical staff had completed specific clinical practice training such as the administration of medicines including intravenous drug administration and the use of syringe drivers, resuscitation and pressure ulcer training. The provider had developed a competency framework for the nursing and care team to evidence staff had all of the skills needed to meet the needs of people. The practice development sister told us the Practice Development team was working at ensuring records of competency assessments would be available for all staff as part of their improvement programme.

Nursing staff described excellent support for professional development. This included an active professional development team who supported staff with training and organised in-house education initiatives. Nurses are required by their regulatory body to have their practice re-validated every three years. They told us they were being supported to ensure they would be assessed and their NMC revalidation dates identified. The service was using the revalidation process as part of their appraisal of the nurses' competence to ensure their practice remained safe and current.

Staff told us they felt supported in their role and there were a variety of methods of keeping staff informed and updated of changes in practice. These included monthly staff meetings, regular supervision sessions and an annual appraisal. Staff told us supervision had been taking place regularly and their supervision gave them the opportunity to reflect on their practice, to identify their training needs and to contribute to the improvement of the service.

Staff gave us positive feedback about the skills and knowledge of the staff they worked with. Care staff told us the nurses were confident in making clinical decisions and always gave them support. One care worker told us "The nurses will always help, they will assist with care tasks and always keep us informed if there are any changes in people's needs". Nurses told us they had "no worries at all about the medical care people

received", commended the doctors and told us "they were professional and very thorough".

Some people did not have the mental capacity to independently make decisions about their care arrangements when staying at the hospice inpatient unit. 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 observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example when asking people if they wanted any pain relief. One relative told us "The staff are very good at explaining what they're doing". Staff told us how people's capacity to consent to their care, could at times fluctuate when they were in pain or taking medicine which made them drowsy. They could describe how they would ensure when people had to make important decisions about their care, that discussions would take place at a time when people were best able to understand the information.

The doctors were responsible for undertaking mental capacity assessments when people were deemed to lack the mental capacity to make decisions about their care and treatment. They had a good understanding of the legal process and the documentation they needed to complete. One of the doctors was able to describe the decisions they had made in people's best interest for example, when they could not consent to taking their medicine and how they had ensured these decisions were made in accordance with the principles of the MCA. They gave an example of an appropriate DoLS referral the hospice had made to ensure that restrictions to people's liberty had been legally authorised.

Everyone we spoke with in the hospice inpatient unit commended the quality, choice and availability of food provided. Comments received included "The food is really nice, it's always hot and tastes nice", "My mother told me that the chicken soup was the best she's ever had" and "The food is good". The chef told us that they were aware of people's dietary needs, allergies and preferences. We saw a list of people's dietary requirements within the kitchen to ensure kitchen staff remained up to date when preparing people's food.

Staff promoted the importance of good nutrition and hydration. They supported people to eat and drink foods they enjoyed and to maintain a balanced diet where possible. Some people who used the service had a reduced appetite or difficulty eating and drinking. Where concerns were identified with people's nutrition, relevant health care professionals were consulted and staff followed their advice and instructions where required. People using the hospice at home service told us the nurses would check whether they were eating well when they visited and provided nutritional advice when needed. This meant that people received nutrition and hydration that met people's needs and respected their preferences.

People's health needs were met by a range of health professionals during their stay, including a palliative care consultant, doctor and physiotherapists. People were supported to attend their hospital appointments whilst staying at the Inpatient Unit to ensure for example, their ongoing chemotherapy or kidney treatment would continue as prescribed by their health specialists. People told us they were supported to manage their pain. One person said "If you need a painkiller or anything needs attending to, they deal with it

straightaway." A relative told us that their loved one had a pain relieving patch administered to manage their pain and that they were satisfied that this effectively managed their pain.

## Is the service caring?

### Our findings

People and their relatives were complementary about staff working in the inpatient unit and the nurses supporting them at home. They described staff as "Very kind" and said, "The attitude of staff towards patients is just how it should be", "Staff work very hard, they're an excellent team working together.", "Staff are excellent. They are honest, punctual, and kind" and "The staff are excellent, charming, caring and attentive. We couldn't ask for a nicer team of nurses. The staff are cheerful, not doom and gloom".

We observed positive interactions between staff and people on the inpatient unit and the day hospice. People were greeted warmly and staff showed genuine interest and concern regarding people's care and welfare. We observed the admission assessment of a person to the inpatient unit who was very frail. The assessment was completed by the doctor and a nurse. The process was carried out warmly and with great empathy. The doctor had to ask some difficult questions. These included "Why have you come to the hospice? What are your hopes and wishes?" and enquired about their wishes regarding to resuscitation. We saw the doctor checked on numerous occasions that the person understood the questions and the implications of their questions. They used silence to allow the person to think and reply in their own time. The nurse came over to the person at one point and held their hand when they got upset to provide gentle reassurance. Staff were sensitive to people's experience and told us they admired people's strength and dignity when facing their uncertain future.

People told us staff made sure they were comfortable. One person told us they had been asked if the sound of the water fountain in the courtyard was disturbing them and that if it had, they would have given them another room. We saw when people could not remember what they had ordered for lunch that staff reassured them, telling them this was not a problem, politely offering them a choice of meals and ensuring they received their chosen meal promptly.

People's families were supported to visit the hospice at times to suit them and also the person receiving care. Several private seating areas were provided for people's visitors if they did not wish to visit people in their rooms. Relatives told us they could visit the inpatient unit throughout the day. The hospice acknowledged the importance of support provided to people by their social network and people were encouraged to stay in touch with those important to them.

The hospice understood the emotional needs of people and their families and provided opportunities for emotional support. A pre-bereavement, post-bereavement and counselling service was offered to all people and their families as appropriate. Bereavement support was provided initially for six weeks but could be extended for as long as needed. The counsellors were helping to run support groups and one to one sessions for family members whose loved ones had passed away in the hospice. The Hospice at Home staff also provided ongoing support for people and family members. Family members expressed positive views on the emotional support they received to overcome and manage difficult times. One relative told us "They understand that this is a very difficult time for me. I find it hard to talk about what is going to happen to my mum in the future and they respect the pace at which I can deal with things". We saw staff understood when people staying on the inpatient unit required emotional support and took practical action to relieve

people's distress or discomfort. We saw during the day staff were quick to recognise when people, became confused or anxious and responded to their calls for assistance. Staff sat with people to reassure them and distracted them with a chat when appropriate.

People and their representatives were consulted about their care and treatment and their views were respected and acted on. One relative told us the person's end of life care had been discussed with them and they were aware of the procedures going forward. Another person using the Hospice at Home service told us "I am in total control of my care, they always ask me what I want and ensure that things happen in the way I want. We discuss the plan of action, then they discuss it with my GP and they make sure it all happens as we agreed". Systems were in place to determine people's care and treatment in the event of their sudden collapse and for their end stage of life. These are known as advanced care plans. This meant that people were protected from receiving end of life care that did not meet their needs or wishes.

People were provided with information about the services provided by the hospice before they started using the service. People had access to the provider's website and told us the hospice at home and day service team also provided them with information about their illness and how they could be supported by the service. One person told us "Any questions you have they will answer or find the information for me" and another said "It is such a relief to know they will find me all the information I need to be able to make decisions about my care". People were supported to have access to information relevant to them to help them make decisions about their care.

People told us staff treated them with dignity and respect. When delivering personal care we saw staff adhering to standards which promoted dignity and respect. For example, doors were closed when people were receiving nursing and medical attention. Staff ensured people were not disturbed at this time and hung a sign on the outside of the door saying 'Personal care in progress' so that people would not be disturbed. We observed staff asking for people's consent before supporting them and waited for people to respond before proceeding. Staff took time to listen and did not leave the person until they were comfortable and settled. For a person who was feeling unwell, staff demonstrated an understanding of the symptoms they were experiencing, providing reassurance and comfort. When assessing pain, staff told us the importance of early intervention to ensure this was well managed and pain was assessed throughout the day to ensure people's pain relief remained effective.

The hospice had made adjustments to meet the needs of their local Muslim community. They had increased their contact with local community leaders and attended local events to promote the work of the hospice. Arrangements had been put in place so doctors would be able to verify death and sign death certificates promptly to ensure relatives could bury people without delay in accordance with their culture and religious requirements.

## Is the service responsive?

### Our findings

People told us they were satisfied that the service they received met their needs. The comments we received included "The day hospice is brilliant. I have made some friends and the staff are always at hand to answer any of my questions", "If I have any pain that makes me anxious I come to the day hospice or just give the hospice a call and they explain everything to me and tell me what I need to do. It has given me immense peace of mind and reassurance" and "The care is good". The feedback CQC received in response to questionnaires sent to people before the inspection was overwhelmingly positive. One person noted "Out of all the support services involved in my care, Sam Beare have by far been the most supportive, informative and empathetic to my needs".

People's care was planned and delivered to meet their health, social, emotional and spiritual needs. People received holistic care because staff understood the importance of working together as a team to provide seamless care for people. Weekly multi-disciplinary team (MDT) meetings were attended by medical and nursing staff, lead counsellor, occupational and physiotherapy staff and the chaplaincy volunteer. Comprehensive discussions took place about the care of each person and of close family members. A future plan of care was agreed which reflected people's views about how they wished to receive their end of life care and support. Multi-disciplinary decisions made about changes in people's care and pain management were appropriately documented in people's care records. We observed a person's initial admission assessment on the first day of our inspection and saw on the morning of the second day, when we attended the MDT meeting, that a comprehensive plan had been put in place to meet this person's needs. This meant people's needs and wishes were actively managed.

The day hospice was run once a week on a Tuesday. This provided people with an opportunity to participate in activities provided by the hospice for example, music, board games and arts and crafts. The day hospice was overseen by the physiotherapy team leader who told us people could also access complimentary therapies including reflexology, aromatherapy, relaxation and head massage at the day hospice. They said "The reflexology and other therapies are tailor made and adopted to ensure people who use wheelchairs or other equipment can also benefit". The day hospice also ran sessions to support people to learn to manage their symptoms and enhance their wellbeing. For example, we saw sessions were being offered to support people to manage breathlessness and maintain an appropriate level of exercise. People told us these sessions did not only meet their social needs but also provided emotional support and the opportunity to receive valuable support. One person said "They always included something to help you manage pain, relaxation, diet and if you have any questions about your medication they will discuss it with you." Another person told us "They always give you the opportunity to discuss your concerns in private so you get the opportunity to ask about any pain or things you are unsure about. And if you are feeling a bit low you can have someone to talk things through. My husband always says that he can see that I am happier when I come back from the day hospice."

Psychological support was available to people using the hospice services as well as their relatives, including for young children. This included bereavement support. One person told us "When my dad died I used the bereavement counselling for some years, you can use it as often or as little as you like. They make contact



with you and leave it to you to decide if you want to use it. It made such a difference to my life".

Staff told us about their active discharge planning arrangements, to support people in their end of life care who chose to go home; sometimes after a period of rehabilitation and symptom control. They could explain how they ensured care agencies, equipment, anticipatory medicines, home assessments and financial considerations were fully explored with people. These arrangements also helped to make sure that people received the support they needed after their discharge home. Anticipatory medicines were subject to people's assessed needs and could be administered out of hours by the district nurse if required, to help prevent the person being unnecessarily admitted to hospital. This meant that people's care and support was planned in a proactive way with people's involvement.

The service had developed the skills of staff to ensure more people could receive end of life care in their own homes if this was their wish. For example, due to the complexity of ventilator withdrawal with expected death, the option to die at home is not always available for people who are dependent on ventilators due to respiratory failure. The therapy team leader had received training in the process and symptom management surrounding ventilator withdrawal. They had been part of a working party to support LOROS, the Leicestershire and Rutland Hospice with their 'Development of National UK Guidance on Withdrawal of Assisted Ventilation at the Request of a Patient with Motor Neurone Disease'. The therapy team leader was also supporting other local palliative services to develop their skills in line with this national guidance. They told us "Having these skills in the team have enabled us to give people on ventilators the same choice as everybody else and we have supported several people on ventilators to fulfil their wish of dying at home".

We noted that the hospice inpatient unit was compliant with National Institute for Health and Care Excellence (NICE) guidance in relation to having a seven day per week community clinical nurse specialist service that could provide face to face contact at weekends. In addition, the unit had 24 hour telephone access for advice from nursing staff. The medical cover was provided through a partnership and collaboration arrangement with another hospice. The unit mainly admitted patients from Monday to Friday but could also admit emergency patients at weekends and in the evenings. People told us they were confident that support would be available when they needed it. The comments we received included "Doctors are on call all the time, and the physio is on call", "I know if I feel unwell any time of the day I can just call" and "They are always available". Staff were complementary of the out of hours support and told us the medical staff would regularly attend the hospice inpatient unit over the weekend to review people's treatment or meet with relatives.

People and relatives told us they would feel comfortable raising concerns with staff if they had any. The provider's complaints process was available to people and their representatives. This set out how people could make a verbal or written complaint and how their complaint would be dealt with.

The registered manager told us they had received one complaint since our previous inspection relating to the hospice care provided. There was a process for ensuring people's complaints were logged, investigated and responded to. The registered manager told us that they had used the information gained from the complaints investigations from both the provider's hospices to improve the service. For example, they had realised people at times raised concerns because they were not clear about the role of the hospice. They told us "We are working at improving our communication with people and their relatives so that they are clear about what to expect from us and what other agencies will be provided as part of their package of care and support". People's complaints had been dealt with in accordance with the provider's policy and action taken as a result was used as an opportunity to improve the service for people.



## Is the service well-led?

### Our findings

The hospice was experiencing a period of change as the service prepares to move location and merge with the provider's other hospice in the next year. The provider was aware of the uncertainty the upcoming location change could have on staff and people and was implementing a 'change management plan' to support staff and people through this process. Staff from both hospices had attended a joint workshop as part of the change programme. They were positive about the work done on the day to clarify the changes ahead and told us it had helped them to better manage their concerns. One staff member said, "It was good to meet the other staff we will be working with and realising everyone is feeling a bit unsettled. There will be opportunities for us to do some job swaps so we can work with the staff from Woking Hospice and get to know them better before we all move". People told us they were working with the day hospice staff to discuss transport arrangements to ensure they would be able to continue accessing the day hospice at the new location. The provider was also reviewing the location of the Hospice at Home service to ensure it would continue to be locally based so as to remain responsive to the needs of the local community.

People and their relatives told us they thought the hospice was well run. One person said "Contact with the manager is excellent". The registered manager and ward manager were responsible for the day to day running of the inpatient unit, the day hospice and the hospice at home service. They held management responsibility for both the Same Beare hospice and the provider's other service Woking Hospice. The registered manager visited the hospices two or three times a week. Staff told us there was good leadership in the service which supported them to understand what was expected of them and what their role and responsibilities were. Staff told us although they experienced the management team as approachable and supportive they welcomed the opportunity to have management present daily when the hospices merged. The chief executive officer told us they routinely visited the hospice to attend staff briefings and inform staff of service developments.

The registered manager and staff had promoted a culture that was person-centred. Every member of staff we spoke with was motivated, open and proud of the service they provided. The service's values focused on providing compassionate care and communicating with honesty and sensitivity to enable people's understanding and choice in the delivery of their care. Throughout our inspection, the registered manager and staff demonstrated they worked in a manner consistent with these values. People and relatives' comments about their satisfaction with the service supported our observations. One relative told us "It's been a pleasant experience. [My relative] has never been happier than here. The service here is superb. I couldn't fault it." And another person said "It is home from home here. It is a very comfortable place to be".

The registered manager understood the improvements that needed to be made across the hospice. There was a comprehensive programme of in-house regular audits, reviews and checks which identified shortfalls. These included, infection prevention and control, pressure ulcer management, falls risk management and safety engineered equipment, medicines, documentation checks, hand washing and recruitment. At the time of our inspection the provider was implementing an action plan to improve the service. The provider was taking action to improve the timely review of people's care plans to reflect people's changing needs, to record people's "when required medicines" consistently, a sedation framework was being developed and a

system introduced to ensure photographs of wounds would be available to support nurses to assess if their treatment plans were effective. There were quarterly clinical governance meetings, bi-monthly clinical services committee meetings and quarterly board of trustees meetings to discuss what went well and what they could improve. We saw action plans were put in place for any shortfalls identified and these were monitored and followed up by managers and the board of trustees.

The registered manager took prompt action to improve the management of people's medicines when they identified areas that required improvement. They had reviewed the medicine administration processes to ensure a clear and transparent process was in place for staff to follow when administering medicines through feeding tubes. A process was being developed to ensure staff would include information about people's unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms) when they were discharged from the inpatient unit. This would provide people or their carers with sufficient information to allow them to make informed decisions about their medicines. The provider had implemented additional checks to further improve the safe use of pain medicine patches following shared learning from the Control Drug Local Intelligence Network meetings of the risk of errors associated with patches. They were also working at reviewing the effectiveness of these pain patch checks in identifying medicine errors promptly. The registered manager was reviewing the medicine auditing process to ensure it would be sufficiently comprehensive to support staff to identify any concerns and action could be taken promptly to address shortfalls in accordance with current good practice guidance.

The provider had reviewed and improved the system for identifying, reporting and investigating safety incidents. The provider's Health and Safety Advisor showed us how the new electronic incident and accident reporting system worked. They told us the system had improved the safety culture in the hospice and enabled the registered manager to identify and investigate any trends that might indicate concerns in practice that might be putting people at risk. The Clinical Health and Safety group was led by the Health and Safety Advisor and the group scrutinised all safety incidents. They told us for example, investigations in falls and near misses relating to people's mobility had been reviewed and no pattern of concerns had been identified. The Clinical Health and Safety group also kept all medicine incidents under review. Safety alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) was acted on. When safety concerns had been identified, they had been reported and investigated to ensure lessons could be learnt to improve the safety of the service provided and prevent similar incidents from occurring.

The hospice reviewed its workforce and their training requirements to enable the service to remain responsive in meeting the diverse and changing care needs of the local population. For example, the hospice developed an assistant practitioner role, with a supporting education programme. This would give the hospice the opportunity to extend the role of care staff to improve the planning of people's non-medical end of life care arrangements. An assistant practitioner is, 'A worker who competently delivers health and social care and have a level of knowledge and skill beyond that of the traditional nursing auxiliary or support worker' according to Skills for Health. The first staff will be completing the programme by end of 2016. Staff were receiving additional dementia training and a social worker role has been created in partnership with another palliative care service. This role would support with the planning of care for people with dementia to ensure they could access appropriate dementia specialist services to provide their end of their life in partnership with the hospice in the near future.

People, relatives and staff were given the opportunity to provide feedback about the service and influence the improvement of the hospice. The service conducted formal 'patient surveys' with both people and their relatives. Every person was given service quality questionnaires upon their admission which asked them to provide feedback on the quality of care received, their involvement in decision making, counselling, complementary therapies and spiritual care. A service satisfaction survey completed early July 2016 showed

positive comments overall, with some areas relating to catering and food which required further work. The registered manager had a plan in place to address these concerns and people's recent feedback about the food and support they received during mealtimes confirmed that improvements had been made. A patient survey for the community team covering the period September 2014 to April 2015 had a 44% response rate. All respondents had indicated that the community team had met their expectations in regard to the care for the patient and support for their relatives.

There was an extensive range of meetings with other stakeholders to ensure that good practice developments were kept up to date and in line with current guidance. For example, the medical staff worked in collaboration with another local hospice, holding bi-monthly consultant meetings, which facilitated professional discussion and peer support. This collaboration had led to a weekly shared education meeting and a weekly shared journal club. The hospice participated in the North West Surrey End of Life Care Steering Group attended by the registered manager. This work had resulted in additional study days being introduced to support nurses to develop their skills in management of clinical emergencies, respiratory care skills and neurological conditions and end of life.

In addition, there was a regular programme of clinical supervision and accountability and responsibility training for all registered professionals. Learning was shared with staff at all levels of the organisation. We also heard of examples of where the hospice worked with other local palliative services and the local commissioning group to develop a strategy that could reduce inappropriate acute hospital admissions of people at the end of life or when requiring pain management. This resulted in the service having two designated beds for emergency admissions. The hospice palliative consultant worked closely with the local acute hospital to identify people whose care and treatment could effectively be managed in the hospice setting and ensure they were transferred to the hospice without delay.