

St. Luke's Hospice Plymouth

St Luke's Hospice - Turnchapel

Inspection report

St Luke's Hospice, Stamford Road
Turnchapel
Plymouth
Devon
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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

St Luke's Hospice, Turnchapel serves the people of Plymouth, South West Devon and East Cornwall. They provide palliative symptom control and end of life care, advice and clinical support for people with progressive, life limiting illnesses and their families and carers. They deliver physical, emotional and holistic care including bereavement counselling support, a lymphoedema service which provides advice and treatment (for people who experience swellings and inflammations usually of arms and legs) and an outpatient service. They offer occupational therapy, complementary therapies and physiotherapy, chaplaincy and spiritual support, as well as social workers, clinical nurse specialists and volunteer services. The hospice inpatient unit at Turnchapel was purpose built can care for up to 12 adults. The average length of stay is two weeks. The service provides acute specialist palliative care for people and does not provide a respite service or longer stay beds. The majority of people are cared for by hospice community specialist nurses in the community, currently around 300 people on the active caseload.

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. They held the post of head of quality and compliance and were supported by a leadership team that included the chief executive and directors and department managers.

The registered manager was open and transparent in their approach. They promoted the service mission of 'Hospice without walls' providing and promoting high quality end of life care accessible to anyone. Staff demonstrated this vision in their practice and gave person centred, individualised care. All staff felt valued by the leadership team and supported to provide high quality care throughout the service.

The service provided outstanding end of life care which enabled people to experience a comfortable, dignified and pain-free death. The environment was accessible for people with disabilities. It was welcoming, well maintained and suited people's needs. Clinics, therapies and support groups were held in the unit and people, in wheelchairs or beds could enjoy the view looking out over Plymouth Sound. There were well maintained grounds which were also accessible for people to enjoy.

The service continuously looked at the local community to see how best they could provide the service and had done excellent work in identifying the needs of the local population developing services to meet those needs. This had resulted in the provision of a Crisis Team service in 2014. It was identified that at times people experienced unnecessary hospital or hospice admissions when they would have preferred to remain at home. As part of the service mission to provide a "Hospice without Walls", the Crisis Team aimed to respond within an hour to provide a short 72 hour intervention to enable people to stabilise their symptoms and facilitate rapid discharge home from hospital or hospice.

The team of registered nurses and health care assistants operated 24 hours a day, 7 days a week. This

assisted and supported families and carers to respond to people's rapidly changing situations to enable them to continue supporting their loved one. The Crisis Team staff were employed by St Luke's and worked closely with other health care professionals in the community.

St Luke's Hospice staff also worked at Derriford Hospital, Plymouth where they provided a specialist palliative care service for any hospital patient with a progressive life limiting illness and working closely with an extended multidisciplinary team. Services included assisting hospital staff with people's complex discharge arrangements to their preferred place of care. The hospice had also set up their own domiciliary care agency in response to community need and we inspect this separately.

Staff were exceptionally well trained and had excellent knowledge of each person and of how to meet their specific support needs. Staff commented on the positive culture and idea of teaching and sharing skills within the service and in the wider community. Staff went that extra mile to ensure people's needs were met in a holistic way including support for people's loved ones. For example, a project was in place to ensure people identified as caring for their loved one at home were supported. For example, by a named hospice social care contact, signpost information and staff ensured carers received their entitled support through national statutory assessment. Attention was paid to people's individual social and psychological needs in a holistic way that included support pre and post bereavement for carers.

There was an excellent spiritual care service which was inclusive and their ethos was person centred regardless of belief. A spiritual care strategy was on-going to enhance the hospice spiritual chaplaincy team. This promoted spiritual wellbeing champions, specific training development and promoting the hospice vision that, "The spiritual wellbeing of St Luke's service users, staff, volunteers and those connected to the organisation is everyone's responsibility and is not the sole responsibility of the Champions." A dedicated space 'The Harbour' provided somewhere for quiet meditation and thought for all.

The hospice had a comprehensive training department. A specialist computer learning management system (LMS) was used to ensure staff were up to date and competent in their roles and all staff had a 'skills passport' of their knowledge and competencies. The department ran thorough orientation and mentorship programmes for new staff and focussed on personal development and quality. All members of care and support service staff received regular one to one or group supervision which ensured they were supported to work to the expected standards.

The service was particularly pro-active in offering training to a wide range of health professionals and those in contact with end of life care. For example, community specialist nurses and the education team had delivered training to hospice staff, school leavers, university, medical and paramedic students and community hospital staff. The service had also made links with projects supporting local homeless communities to ensure their staff were able to recognise end of life and so people accessed appropriate services.

An innovative project based on the nationally recognised 'Six Steps to Success' approach had delivered a programme of a series of workshops. These were tailored for care homes and domiciliary agencies in recognition of the challenges of providing high quality care. A 'train the trainer' approach was used to develop End of Life Care Champions in these settings along with a toolkit for learning and support. This programme also included additional workshops focussing on end of life care for people living with dementia and a learning disability focussed module. St Luke's supported vulnerable communities and had launched an easy read future and end of life care plan designed with people with a communication or learning disability in mind.

A compassionate community project at the hospice was already improving care for people in the community. This was based on the national Dying Matters Coalition, led by the National Council for Palliative Care whose mission is to 'support changing knowledge, attitudes and behaviours towards dying, death and bereavement, and through this to make living and dying the norm.' The project aimed to build compassionate communities to facilitate more conversations about death, dying and bereavement and provide effective practical community support. [National figures showed around 70 % of people would prefer to die at home, but around 60% die in hospital. We heard examples of how the hospice was working with people to ensure they were able to die in their preferred place].

Another project had facilitated end of life care through training senior healthcare practitioners as champions in the community- the 3R's project: Right place, right care, right time. A peer learning kit enabled these practitioners then cascade knowledge further. This project had directly led to service improvements, for example in the hospital, drug and alcohol team and prison, and was part of the hospice agenda of creating a 'compassionate community'.

The service had identified a lack of local access to end of life care for people in prison. The locality included a Dartmoor prison community of over 650. An effective collaboration was in place with the prison and a 'Living with and beyond Cancer' group. This had resulted in prisoners being able to access practical end of life care from hospice staff, access appropriate information and support, including personal care in Dartmoor prison.

People's feedback was actively sought, encouraged and acted on. People and relatives were overwhelmingly positive about the service they received. They told us they were extremely satisfied about the staff approach and about how their care and treatment was delivered. Staff approach was exceptionally kind and compassionate. Relatives stated on an independent online feedback website 'I want great care', "The care the patient received was above and beyond anything I could of expected, I am not good at asking for help or putting on people but I was made to feel we deserved the help unconditionally!" Relatives told us, "This hospice is outstanding, nothing is too much trouble." People's feedback about the caring approach of the service and staff was overwhelmingly positive and described it as, "It's like a 5 star hotel. There is a wonderful garden view" and "I loved seeing my dog, anyone is welcome at any time. They really care about you as a person." Clear information about the service, the facilities, and how to complain or comment was provided to people and visitors.

The hospice also spent time raising awareness of the importance of people discussing end of life care in the community. During a national 'Dying Matters' week the hospice had hosted promotional activities and a 'Big Conversation' emphasising the need for people to 'talk, plan, live', raising awareness of the importance of planning and making arrangements for end of life in advance. Awareness was further raised by a 'Hospice without walls' short film shown in the local 15 screen cinema.

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. This included during their work with other services. We saw an example where a safeguarding alert had been made and appropriate action taken as a result for the person's benefit to keep them safe. 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 make sure people were protected from harm. Accidents and incidents were recorded and monitored to 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 past conduct and suitability from previous employment to ensure staff were suitable to work with vulnerable people. The hospice was also supported by a large number of dedicated trained volunteers.

Staff knew each person well and understood how people may feel when they were unwell or approached the end of their life. They responded to people's communication needs. People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support as they wished. Plans in regard to all aspects of their medical, emotional and spiritual needs were personalised and written in partnership with people and/or their advocates. There were some limitations with the use of the computer patient electronic recording system but this had been identified by the service and was being addressed and managed by a working group. Staff delivered support to people according to their individual plans and provided outstanding care. A registered nurse said, "We involve patients and their relatives with care planning. We abide by what people want. We discuss patient preferences upon admission."

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered the requirements of the Mental Capacity Act 2005.

The staff provided meals that were in sufficient quantity and met people's individual needs and choices. People praised the food they received and they enjoyed their meal times with relatives able to join their loved ones for meals if appropriate. Staff knew about and provided for people's dietary preferences, restrictions and reduced appetite. One relative said how good the staff were saying, "My mother-in-law wanted a Jaffa orange once and they went to the shops and bought her one."

Staff communicated effectively with people, responded to their needs promptly, and treated them with genuine kindness and respect. People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent or refusal before they supported them. Staff pre-empted and responded to people's individual needs and requirements. People and their relatives told us, "They can't do enough for you here. I get frightened sometimes because I have no family and I talk to the nurse and she makes me feel better" and "All the staff are very kind. I should know, I've stayed in a few hospitals and care homes, they can't do enough for you here."

People were involved in the planning of activities that responded to their individual needs. One staff member said, "We are here to help people make positive lasting memories as long as they can." The hospice mainly cared for people with acute needs meaning they were unwell or at the end of their lives. Therefore, activities were more based on therapeutic methods such as therapies and spending time with people. The in-house occupational therapist also provided support with rehabilitation and we heard examples where this had made a difference to people's quality of life despite their life limiting illness. Attention was paid to people's individual social and psychological needs. This included supporting families with children, there was a play area and staff found ways to engage with young children such as providing a paddling pool.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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 on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

The environment was fit for purpose and well maintained.

Medicines were safely managed.

Good 

Is the service effective?

The service was very effective.

People told us staff had outstanding skills and knowledge. They told us that staff understood and anticipated their needs which enhanced the quality of their support.

Staff went that extra mile to ensure people's needs were met in a holistic way including support for people's loved ones.

People benefitted from high quality end of life care within the hospice service but also in the wider community because the service took a vital and key role in the local community. They also provided training to a wide range of health professionals and workers empowering them to share learning and maintain high quality end of life care for people outside the service.

Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation putting it into practice in a sensitive way.

People benefitted from a service which provided food and drink in an individualised way depending on people's end of life needs.

Outstanding 

People were referred to healthcare professionals promptly when needed. Staff worked in partnership with health professionals, sharing end of life expertise, to ensure processes benefitted people and supported their choices in a timely way.

Is the service caring?

The service was very caring.

People's feedback about the caring approach of the service and staff was overwhelmingly positive.

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. People valued their relationship with the staff team who often performed beyond the scope of their duties to meet people's needs.

The service was very flexible and responded quickly to individual's changing needs or wishes. Staff communicated effectively with people and treated them with utmost kindness, compassion and respect.

People were consulted about and fully involved in their care and treatment.

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

Outstanding 

Is the service responsive?

The service was responsive.

The hospice continually used knowledge of the local community to develop a service which best met local needs including vulnerable groups.

The service provided person-centred care based on best practice and focused on continuous improvement. People's care and support was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them.

People benefitted from a service where their experiences, concerns and complaints were routinely listened to and used to further improvement.

Outstanding 

Is the service well-led?

The service was exceptionally well led.

Outstanding 

The leadership team and registered manager provided outstanding and compassionate leadership and support to ensure people needs were met.

There was an open and collaborative culture within the team who worked effectively with people, relatives, volunteers and other professionals to shape the service on offer and ensure people's health social and wellbeing needs were met.

A committed and stable staff team showed willingness to learn from mistakes and improve because they felt supported and were well trained.

Information about the needs of the local population had been used to develop specialist support in innovative ways to further the mission of 'Hospice without Walls'. For example, crisis team, hospital team, prison, dementia, compassionate community and homeless programmes.

St Luke's Hospice - Turnchapel

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. At our last inspection in March 2014 the service was compliant with all the standards we looked at.

This inspection was carried out on 6 and 9 June and 1 August 2016 by a lead adult social care inspector, a pharmacist inspector, an expert by experience and two specialist advisors in palliative care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. It was an unannounced inspection on the first day.

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. The registered manager sent us a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We looked at the premises, spent time in the inpatient unit, the offices at 3-5 Brookland Campus, and in the clinics and went out on visits with the community nurse specialists. We were able to visit people in their own homes with their permission. We looked at six sets of records that related to people's care. We looked at the systems in place for managing medicines, spoke to two staff involved in the administration of medicines, and examined ten people's medicines charts. We looked at six people's assessments of needs and care plans. We consulted documentation that related to staff management and looked at four staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service. We observed a 'ward round' and the administration of medicines. We sampled the services' policies and procedures.

We spoke with four people who were receiving care in the inpatient unit and seven of their relatives to

obtain their feedback about their experience of the service.

We spoke with the registered manager/head of quality and compliance, clinical director, chief executive, head of education, development and research, head of social care, six volunteers, the cook and kitchen staff, a domestic, infection control lead and the inpatient unit manager. We also attended a community multidisciplinary team meeting (MDT), a strategic team meeting and inpatient unit meeting. We also spoke with two community nurse specialists, two team leaders and seven registered nurses, a nursing student, an occupational therapist and three health care workers on the inpatient unit. We had feedback from two community health professionals.

Is the service safe?

Our findings

People and relatives told us they felt safe receiving and visiting the service. They said, "I know I can ring at any time. They know how to keep me safe. I don't have to but I like my bed rail up, as I feel more secure." We saw staff ensuring this person's bed rail was up as they had requested. One person had sent the hospice a letter in which they stated, "There is a feeling of safety and security, knowing everyone is looking out for me, informing and directing me but not trying to control me as I make my way around."

There were robust systems in place to keep people safe and minimise risk. Staff knew how to identify potential abuse and how to respond and report internally and externally. Staff knew how to access the safeguarding of adults and whistle blowing policies. These policies were up to date and reflected the guidance provided by the local authority. Staff training records confirmed that training in the safeguarding of adults was part of the induction for all members of staff and volunteers. This was complemented by annual training and refresher courses which were up to date. ."

There were sufficient care staff on duty, to support and care for people in the inpatient unit, community, hospital, clinics and crisis team. The team of doctors worked across all services and visited people in the inpatient unit, at home, care homes, in out-patient clinics or hospitals. One of the doctors was always on call at weekends and overnight for advice, with a consultant in palliative medicine consistently available for further advice, if needed. The hospice employed their own occupational therapist and physiotherapist which enabled people to access this service without delay.

Staff told us there were enough staff to care in the way people needed and at times they preferred. People told us staff always had time to talk and they did not feel rushed or have to wait for assistance. One person said, "I called using my call bell last night and didn't wait long for a nurse, she helped me and gave me a drink afterwards. They always check that you have everything you need." A relative said, "You only have to ask, nothing is too much trouble". Staff also told us there was time to be with people which was seen as very important as part of the hospice ethos. Early shifts consisted of four registered nurses and two health care assistants and the same in the afternoon. Two registered nurses were on duty with two health care assistants at night. Additional staff were provided to respond to an increase in people's needs, which were calculated regularly using a dependency tool/risk assessment, such as to manage people at risk of increased falls. The hospice used their own bank staff if they needed to and tried to use staff that knew the hospice well for continuity.

Safe recruitment procedures were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established they were suitable to work with vulnerable people. Proof of identity and right to work and reside in the United Kingdom prior to starting to work at the service had been checked. References had been taken up before staff were appointed and were obtained from their most recent employer. Disciplinary procedures were in place to ensure staff respected their code of conduct. 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 and were reviewed and updated daily by nurses. Staff were aware of the risks that related to each person. For example, staff documented whether people could use their call bell and if not, staff ensured they did regular checks. One person required various methods of assistance with changing their position depending on how they were feeling. Staff knew to manage the person's pain and nausea before attempting to move them, which was reflected in their records.

People's individual risks were also communicated to the nursing team on handover, alerted through pop ups in the computer system and in the computer care records. Risks relating to pressure sore prevention were very well documented with clear actions and records and input from a tissue viability specialist. Thought was given to balance risk management and people's preferences and comfort when they were at the end of their lives. For example, when a risk assessment showed a high risk of pressure damage but the person did not want to move this was respected and gentler methods used or staff came back later. The pressure ulcer documentation was thorough and clear and included consent to photograph pressure ulcers and map wounds. Records showed clear involvement with people about safe management of risk that was also acceptable and proportionate to their needs. Therefore measures were in place to keep people as safe as possible depending on their needs and preferences.

Effective systems were in place for obtaining medicines. Staff ordered medicines from a community pharmacy. The service included the supply of stock for in-patient use and medicines when people went home. Medicines were available from the pharmacy when needed, including evenings and weekends. Staff told us the system worked well and they receive the medicines that they need in a timely manner. People could be confident their medicines would be available for them. The community pharmacist was available for support and staff told us they were also able to contact the hospital pharmacy for additional advice. This helped to ensure that staff managed medicines safely.

Staff told us doctors always checked people's medicines when they came to the hospice, to make sure that people continued to receive the medicines they needed. Nurses gave people a record of their medicines when they went home, along with advice and support. The setting had a dedicated telephone line that people or their families could use for advice, support and reassurance. Staff prescribed and administered people's medicines safely. Doctors prescribed people's medicines on prescription and administration charts. Staff recorded people's medicines allergies and sensitivities on every prescription chart and any medicines they had given or the reasons for any omitted doses. Staff assessed people who wanted to self-administer their medicines and made sure it was safe for them to do so. People were prescribed a number of medicines to be given 'when required'. It was clear to nurses when these medicines should be administered.

Medicines were stored safely. Prescription pads were stored securely and recorded when used. Up to date references were available with information for staff on the safe use of medicines. Comprehensive policies and procedures were in place. Staff reported any medicines errors and near misses, which the manager investigated. Staff changed processes following learning from medicines errors to make sure they did not happen again. Staff received and acted on medicines alerts. Nurses undertook annual medicines training and competency assessments, including medicines calculations.

People were cared for in a clean and hygienic environment. The premises were cleaned to a high standard and records were kept to evidence frequent cleaning throughout the day. Cleaning standards were monitored to ensure people remained as safe as possible from risk of cross infection. Systems were in place to make sure staff were aware when a person had an infection. People's rooms were deep-cleaned using steam cleaning equipment before any admission. Systems in place for the segregation of laundry and the management of waste were implemented appropriately. The ward appeared clean and was free from

unpleasant odours. Cloth notice/pin boards were in place above every bed. These were a potential infection control hazard as they could not be cleaned effectively and were removed and alternatives sought as soon as we identified the risk.

There were two infection control nurse leads. Infection control practices were evident, items such as commodes and trolleys were cleaned regularly. Infection controls audits were carried out regularly and included kitchen inspections. Detailed infection control policies were in place and had been reviewed to reflect current national guidance. These included a hand washing policy and standard precautions, such as instructions concerning how to deal with spills of bodily fluids. Hand washing audits had just been completed using a light box. Everybody entering the ward used hand cleansers each time they came in. Staff reported they would challenge others if they found that hand hygiene was not observed. Staff wore appropriate personal protective equipment (PPE) which was in ample supply. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe. Relevant staff had completed food hygiene training. The local environmental health food hygiene rating had awarded the hospice a '5 star' rating (the highest possible rating).

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks that included clear guidance for staff to follow such as a pandemic plan. 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. Fire safety equipment had been serviced and was regularly checked. For example, a record was kept of all incidents and near misses. When a fire alarm sounded it was found that not all doors were labelled so this was done and information shared. Staff also attended emergency training in managing anaphylaxis (shock), safe management of blood transfusions, and resuscitation. Throughout the service, fittings and equipment were regularly checked and serviced. Specialist bariatric equipment such as bed and hoist had been sourced to ensure safe and effective moving and handling and care for those with a higher weight range. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. Maintenance issues were dealt with in a timely manner by an in-house team.

Accidents and incidents were recorded and monitored using a computer system to identify how the risks of recurrence could be reduced. There were records showing external clinical incidents, internal and incidents relating to drugs, pressure sores or falls. For example, the computer system was being developed to include family involvement in minimising falls and included what coping mechanisms were already in place. Each person had a falls assessment plan and a named lead who monitored falls prevention documentation. Staff were clear about how to identify risk and minimise falls. A registered nurse said, "All patients assessed as 'high risk' of falls have 'intentional rounding' put in place. (Intentional rounding is a way of regularly checking that people are safe) I can call upon additional staff to undertake 1-1 supervision of high risk patients or ask relatives to supervise." A 'falls prevention in the community' group were developing cascade training in moving and handling in each staff team. A specific training module in ensuring safe discharges was also being implemented.

All incidents were reported and analysed to ensure appropriate actions were taken. An overall risk register ensured staff were aware and there was learning from events. For example, one family said they would have liked to have known about a person's fall sooner. Staff were given personal alarms for lone working and risk assessments were carried out to ensure staff safety. Risk was included within meeting agendas of all operational groups. Notifications required by CQC were sent.

Is the service effective?

Our findings

People consistently praised the excellent standards of care, treatment and support provided by hospice staff. People's comments included, "This hospice should be [seen as] outstanding, nothing is too much trouble" and "You'd be hard pushed to find better care. The team try their absolute best." Relatives told us, "I think my mother has improved since being in here, she wasn't eating before. They know what they are doing." In a letter a person said, "All of my needs have been met by caring, friendly, supportive individuals who have given me confidence in taking the next step into the community. I have been actively encouraged to ask for information as well as assistance." A GP told us, "I am very happy with [St Luke's] care. They...provide a significant amount of support for patients and families as well as liaising closely with us. We have regular meetings but they will also frequently call into the surgery as needed to discuss specific patient's face-face."

The hospice training department team, led by the head of education, training and research and overseen by an education programme board were passionate about providing high quality and innovative training, seeking out opportunities which benefitted people. For example, we attended the monthly strategic team meeting. They discussed progress of work relating to the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020. This national framework for action urges local leadership to be at forefront of improvement in end of life care. Part of this involved developing 'compassionate communities'. The chief executive said, "The time to develop compassionate communities is now" and the head of education, development and research added, "We want to grow a compassionate community, you have to change health professional attitudes".

A compassionate community project, the first in the south west, at the hospice was already improving care for people in the community. This was based on the national Dying Matters Coalition, led by the National Council for Palliative Care whose mission is to 'support changing knowledge, attitudes and behaviours towards dying, death and bereavement, and through this to make living and dying the norm.' The project aimed to build compassionate communities to facilitate more conversations about death, dying and bereavement and provide effective practical community support. National figures showed around 70 % of people would prefer to die at home, but around 60% die in hospital. We heard examples of how the hospice was working with people to ensure they were able to die in their preferred place. The project had already benefitted some people using network maps identifying their individual support systems, including named friends and neighbours and 'prison buddies', and encouraging other health professionals to recognise and share with the people in that system. A renowned professor from the University of Western Sydney with special interest in supportive networks at end of life had visited the hospice after hearing they were already doing compassionate community work. One hospice employee was a 'compassionate neighbour' for someone with no near family at end of life, living a more unconventional, rural lifestyle. This role focussed on patient ownership and promoted care as a privilege, not burden, for communities. This person now had a clear network of support with members sharing roles such as food provision, checks and managing the home environment in partnership with the person. This had meant they could continue to live where they wanted to, with full support from their community and community health professionals.

The hospice provided end of life care training to local health professionals working with the homeless in partnership with a drug and alcohol nurse in the community. They encouraged health workers to access and recognise end of life care needs and signpost to local services for the homeless population, which they were now doing. The education team were recruiting homeless ambassadors from partner organisations in the city to become end of life champions for the homeless, offering free training to those working or volunteering with the homeless community. This included practical care and holding supportive conversations. The hospice ensured learning was on-going and shared, influencing service improvement plans and providing resources. One attendee response stated, "We are now incorporating end of life discussions in our risk and needs assessments and early key-work sessions." Workers with the homeless were now using the hospice advice line to access specialist support to benefit homeless people in the community. For example, due to the homeless project, there was now a drop in health clinic session and multidisciplinary meetings which the palliative nurse attended. A homeless person was referred from there who was in considerable pain and breathless due to cancer, the palliative care nurse brought their symptoms under control and made urgent referral for housing as they assessed the person only had weeks to live, within 24 hours they had a flat with services going in supporting their end of life care.

The hospice had a community nurse specialist with a special interest in dementia and a dementia champion training package. There were plans in place to fund a formal dementia nurse specialist post looking at 'What does a dementia friendly St Luke's look like?' to further developing specialist end of life care for those living with dementia. Staff worked with Plymouth University to help deliver a dementia degree and masters programme. These conversations had also triggered use of a new icon within the hospice computer system to alert staff to people living with dementia. The hospice hosted regular Dementia Champions meetings to share information and drive improvement. The hospice was part of the Plymouth Dementia Action Alliance and had rolled out dementia friendly training to all staff including those in retail to promote dementia friendly shops. Sessions were advertised for other businesses, care homes or agencies to access.

An innovative project based on the nationally recognised 'Six Steps to Success' approach had delivered a series of workshops. These were tailored for care homes and domiciliary agencies in recognition of the challenges of providing high quality end of life care in those settings. A 'train the trainer' approach was used to develop 'End of Life Care Champions' with a toolkit for learning and support. Additional workshops focussed on people living with dementia and learning disability. St Luke's supported vulnerable communities and had launched an easy read future and end of life care plan designed with people with a communication or learning disability.

Another project had facilitated end of life care through training senior healthcare practitioners as champions in the community- the 3R's project: Right place, right care, right time. A peer learning kit enabled these practitioners cascade knowledge further. This project had directly led to service improvements, for example in the hospital, drug and alcohol team and prison, and was part of the hospice agenda of creating a 'compassionate community'. For example, one person had attended a coaching skills workshop. They said, "I have been able to implement what I have learnt and people are reaping the rewards. I have a more positive outlook on challenging situations." The education strategy stated, "Education is seen as everyone's business." A score was taken pre and post the course showing benefits to people in every area of learning such as more people enabled to complete advance care planning, peer teaching and increased respect, time and understanding of end of life care needs.

St Lukes's continued to host nursing and medical students from Plymouth university and worked in partnership to deliver degree level modules on communication and advance care planning, for example. One medical student said, "Excellent sessions. An interesting topic handled with care and passion rather than formality and procedure." Students accompanied community nurse specialists. One student said, "The

teaching has been very thorough and detailed. Fantastic introduction to new concepts and skills" and "The teaching and clinical opportunities are fantastic. I learnt a lot from it, especially pain management." An examiner module report stated, "A sound knowledge base was demonstrated by the students and learning was apparent, for example in understanding compassion and consideration for people's views and their families. GPs and paramedics also visited the hospice for one day interest observations and learning. St Luke's sent regular professional update newsletters detailing information such as drugs advice, myth busters, resources and policies. Feedback from a paramedic specific training session praised the local, hands-on knowledge of hospice staff and sharing of a gold standard framework tool to assist professionals in recognising dying.

All new staff had opportunity to work in all areas and the induction welcome day included sessions about each department highlighting core hospice principles and a passion for results. New staff had a thorough induction before they started work and worked in addition to staff numbers shadowing of more experienced staff for two weeks or until they could demonstrate they had attained the level of competency required for their role. The education programme board met quarterly to monitor personal development compliance and training. One student nurse told us, "It's been absolutely brilliant. Lots of support with my competencies, I don't want to leave." People said how knowledgeable staff were at all levels, which made them feel less anxious. A domestic told us, "I did a dementia course last summer, it was very informative so I feel happy to talk with people with dementia with more understanding." All staff showed excellent knowledge about people's holistic care, symptom control and information sharing. Staff shared information about people's care using a comprehensive computer system which enabled all staff to access all of the information about a person and their needs. There were regular multidisciplinary meetings where all staff roles had valued input, with the person and their family at the centre.

Staff were up to date with training. There was a wide range of training such as mandatory training, drug calculations, clinical human factors, anaphylaxis shock, and fire training delivered by an in-house clinical trainer. Staff were also encouraged to attend external conferences. All staff had a training framework and skills passport and competencies were monitored to ensure staff knew how to put their training into practice using a personal, interpersonal and clinical competency framework computer programme. Many staff had begun work in one role but had developed others. For example, moving from a care worker towards a registered nurse qualification, or supported to complete a higher academic qualification or to use their skills to train others. One manager at their leaving interview said, "The flexibility enabled me to complete my university course. I was able to demonstrate professional leadership and contribute to the development of St Luke's mandatory training." St Luke's held CQC training and carried hospice specific pocket guides encouraging staff to think about how they met legal standards of care. There were additional weekly ward based drop-in training sessions on relevant topics such as pain assessment, mouth care and CQC updates.

Staff did reflective learning logs detailing what they had learnt to enable them to meet professional re-validation expectations. Staff were able to influence their training. For example, the ward manager was introducing further intravenous antibiotic training in response to staff requests. There were opportunities for smaller, informal training sessions. A team leader organised 'mop up and mingle' sessions for staff. These were particularly useful for staff to discuss stressful events and enable them to channel emotions in a positive way. Staff were supported with regular group or one to one supervision sessions. All staff were consulted about how they would like support. The head of social care said, "Staff can tell us if they want a meeting or they can talk privately. I want them to feel they can approach me at any time so we can say 'I hear what you are saying'." A St Luke's Stories Steering Group shared 'real stories' throughout the organisation to give a personal feel to what the service did including for those staff who did not work in the clinical area or have direct patient contact. One person said, "Every staff member should attend a session to

show them what we are about" and praised how passionate staff were when speaking.

Staff sought and obtained people's consent before they supported them. One person said, "They always ask me if I'm happy with everything and I have all the information I need to make a choice." 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. 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 services are called the Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a good understanding of the processes to follow. Staff were trained in the principles of the MCA and the DoLS and these were applied in practice. Staff were able to discuss issues such as the appropriate use of restrictive safety bed rails and lap straps on wheelchairs. When people had been unable to leave unaccompanied and needed continuous supervision to ensure they remained safe, their mental capacity had been assessed appropriately. This ensured people's rights to make their own decisions were respected and promoted when applicable. Applications for the authorisation to restrict people's freedom in their best interest had been submitted to the DoLS office. Comprehensive records were made of how appropriate meetings had been held to discuss people's best interests and make a decision on their behalf. For example, we heard how a sensitive situation had been managed. A best interest meeting with the multidisciplinary team had been held with the person's loved ones to discuss the need to call emergency services to provide appropriate care for a distressed person. Following the incident the family were supported through the decision and staff included the event in learning logs, and set up as a resource for on-going learning and staff support.

There was a bespoke food service, available at any time like room service. People praised the food that was served; their comments included, "I can have anything I want and change my mind sometimes and it's never been a problem" and "The choice is very good and there's always something that I like, sometimes I'm not very hungry and I have jelly and ice cream", One person was very pleased to tell us, "I had cheese and biscuits last night and had a choice of four different cheeses! So many I've got some next to my bed. It's excellent, just like home cooking".

People were asked about their likes and dislikes, diets and allergies and how they preferred their food to be prepared. Relatives were able to eat with their loved ones or use the café area overlooking Plymouth Sound. Staff went that extra mile, and showed they knew exactly what people liked and when. A meal assistant popped into one person with an iced orange drink, they had known the person had missed it earlier as they were in the shower. One person said the hospice made their own soup which was very good. The seven week cycle menu plan was varied and appetising. Should there be something that someone wanted that was not on the menu or in the kitchen, a member of staff went locally and purchased it. One relative said how good the staff were saying, "My mother-in-law wanted a Jaffa orange once and they went to the shops and bought her one." People mostly preferred to eat at their bedside or use the café facilities nearby. Two people were enjoying lunch together by the window. People could access drinks at any time, and soft and alcoholic choices were available. One person happily said, "I had a gin from the trolley the other day, lovely although I was then a little light headed!" and another person said, "Look at me, I'm drinking a shandy!"

People were referred to healthcare professionals when necessary. For example, the service's clinical nurse specialists were 'attached' to GP practices in geographical areas and attended regular 'Gold Standards

Framework meetings'. All organisations providing end of life care are expected to adopt a co-ordinated process such as the Gold Standards Framework, which is a systematic, evidence based approach, developed to improve quality of care for patients with a life-limiting illness. For example, this had resulted in a co-ordinated approach to providing 'just in case' bags for people (emergency medication bags). People were referred appropriately and without delay to consultants such as neurologists and oncologists, to hospital specialist teams such as the chronic pain team and specialist nurses such as tissue viability nurses. Communication ensured that end of life care was provided in partnership with the wider community for the benefit of people. This ensured that staff responded effectively when people's health needs changed.

The service employed a specialist occupational therapist (OT) who worked collaboratively with the multidisciplinary team. The OT said on the hospice web blog, "We are professionals who optimise people's ability to undertake everyday activities, relating to self-care, independence and leisure." We heard many examples of how this was put into practice. The OT used Skype to attend multidisciplinary meetings. The hospice physiotherapist told us how they worked with people to achieve optimum movement and support for people in getting used to the role of being cared for. They provided a lot of rehabilitation work, for example to maximise what people could do despite requiring end of life care and one person benefitted hugely from passive movements enabling them to keep moving for longer. They visited people's homes before and after discharge to ensure they had the right equipment to facilitate effective discharge. For example, a person had been able to manage their dream of going to school with their children with a powered wheelchair and to move around their home because additional wheelchair ramps were fitted. The OT department had written a training guide and patient guide for those who become breathless, which helped the person and their families to self-manage their symptoms effectively.

The environment, care and wide information sharing approach in a holistic way by a knowledgeable workforce provided a very effective service. The environment was welcoming, well maintained and suited people's needs. The premises had been designed and decorated taking people's physical and psychological needs into consideration. During the inspection people were being wheeled on their beds outside or in the conservatory to take in the view of the beautiful Plymouth Sound. People said it was nice to feel the air and have a different view. There were areas for children to play and be supported away from clinical areas. The staff had set up a paddling pool for one person's small children to keep them occupied and often wheeled them out on their parent's bed, which made it into a fun thing to do.

Is the service caring?

Our findings

The service had a strong, visible, person-centred culture. Staff and management were fully committed to this approach and found innovative ways to make it a reality for each person using the service. The OT ethos, for example, was 'I'm dying, not dead' and 'Live until you die' and maintaining hope was seen as an important part of the process of care. They worked with a young person to create a short break at home. The OT provided specialist equipment and enabled them to be supported to go home. They said, "We are trying to make as many beautiful memories as possible." 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. Relatives told us, "They always ask me how I am. We are looked after as a whole family" and "Sometimes I get frightened about not having any family and a nurse will come and talk with me, I feel better then."

We looked at people's testimonies on the iWantGreatCare website. This is a national website which services can sign up to collect online feedback. The hospice had achieved a five star rating (the highest available). People's testimonies included, "Very prompt visit, great compassion showed, ensured everything understood. So caring, wonderful, warm staff showed just the right amount of empathy. Thank you. Cannot see what you could improve."

People all commented they felt they were getting the best possible care and that staff went that extra mile. One relative said in a recent survey response, "The community team stopped by to sing happy birthday and blow out candles with us. This was one of the last smiles she had and a memory we will all treasure." Another person said, "The most important and meaningful part about the care I received was the genuine listening. The caring face and tone of voice. The smiling face putting me at ease when I felt vulnerable, unable to help myself."

There was a homely feel to the service in the inpatient unit. There was 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 genuine interest. Their approach was kind, patient and respectful. 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 paid attention to the little things that mattered to people. For example, one care worker knew the family were anxious so rang them to let them know their loved one had settled after they had left.

The service had consistently overcome barriers to go the extra mile for people. One person's family had secretly restored a beloved vintage motorbike. The family and the hospice arranged a surprise unveiling and organised a celebratory afternoon tea for family and friends. Staff had organised a person's wedding on the inpatient unit in a matter of hours. The chief executive wrote in the newsletter, "I was so impressed seeing how everyone pulled together to make that happen." One couple had enjoyed a poignant stay at their holiday home thanks to the support of a community nurse specialist. They reviewed the person's medication and arranged an occupational therapist visit to ensure the right equipment was available at the

holiday home. The nurse said, "Having achieved this gives a sense of fulfilment and recognises that, no matter how big or small an achievement might be, the St Luke's community team will always try and go the extra mile for our patients and their families."

Visitors were welcome at any time. Pets were also welcome. A visitor had brought their dog into the unit and the person said how pleased they were to be able to spend time with the dog. They said, "I love seeing the dog, he really cheers me up." A care worker said, "I love that families can visit at any time. We respect patient's wishes and only allow visitors with a patient's agreement. We have 'pop up' beds available for families that want to stay with their relative too." A designated children's play area was available on the inpatient unit for children. The area was light, spacious and well equipped with toys and activities including computer games.

The hospice had developed a 'Carer's Strategy' pilot scheme. This aimed to provide a named point of contact for carers of people at end of life. Staff ensured carers knew their statutory rights to enable them to continue caring, signposted services and provided a direct emotional support service from St Luke's. Carers had already benefitted from being identified and valued enabling them to access carers assessments and receive a regular carers newsletter. Carers had fed back that, "It's good to talk about me!" The hospice had raised funds to offer complementary therapy to carers. One carer was the main carer for her mother, who had recently been diagnosed with cancer, and given a short prognosis of several months by the medical team. St Luke's received a referral and a carer's assessment was undertaken. This enabled the carer to take more control of their situation, and maintain their caring role. Initially, the worker was able to utilise specialist palliative care skills to address the emotional issues raised and maintained regular contact sessions either face to face or via phone. This gave the carer the opportunity to express feelings and talk through the issues most relevant to them such as 'fear of their mother dying, feelings of guilt of wanting their mother to pass away'.

St Luke's had recruited a Spiritual Care Consultant who was running a distinct project about 'Embedding spirituality in End of Life Care within the St Luke's Culture'. This was in response to a changing society and focussed on what "Spiritual Care" meant to St Luke's. The spiritual wellbeing of people using St Luke's, staff, volunteers and those connected to the organisation was seen as everyone's responsibility so people and their families could access spiritual support when they needed it in whatever form. A training programme across all areas of the clinical service was being developed. The project looked to attract 'spiritual staff champions' to take spiritual care forward in a sustainable way. People using the service will benefit from a more aware and empowered workforce who recognised opportunities to provide spiritual care feeling more able to do so themselves, at the right time. For example, one person had benefitted from the implementation of spiritual champions. A champion identified that the person wanted to have their partnership blessed using a Pagan ceremony the next afternoon at 2pm. The champion was unable to find an available Pagan within this time limit and therefore offered to lead the celebration. The person and their partner accepted this offer and a Pagan blessing was created by the champion. The service was held in front of 20 family members the following day. The person was so pleased with this service that they asked that the spiritual champion undertake their funeral as well.

Staff endeavoured to work closely with spiritual or religious faith leaders from people's communities. People were able to access religious services and communions if they wanted, often at short notice. A licenced lay minister worked with a volunteer spiritual support team including people from different religious denominations. The chaplain was completing an MA in Death, Religion and Culture to further their understanding of the needs of dying people across religions and cultures. One person had an unusual personal belief system and this was respected by the chaplain and discussed at length. Staff told us how they were able to call the chaplain who lived nearby at any time. One evening they were able to settle a very

distressed person who was anxious about their baptism status, they arranged for the person to be baptised. The person then slept and was able to die peacefully with their family and the chaplain officiated at the funeral.

The hospice had a calm, informal non-denominational sanctuary space, known as The Harbour. Previously a chapel it was now a space, not only one for religious purposes, but for reflection and contemplation. People and their families used The Harbour when they needed space and quiet time. They could write messages to their lost loved ones in a commemorative book. The space was obviously really valued as people returned up to 11 years later (often on the anniversary of the death) and left messages finding comfort in the connection to the hospice.

There was bereavement support for families and staff. The St Luke's Bereavement service was available at any time through the bereavement co-ordinator. The service was open to people affected by the diagnosis of a life-threatening illness and to the families and friends of anyone who had links with the hospice before the death. Services included: regular visits to provide company, reading with people, finding out information for you, assisting with practical tasks, writing letters and shopping, providing emotional support at times of change or difficulty and encouraging and enabling people to make a wider network of contacts. A helpful leaflet informed people what practical things to do when someone died. One person said they would not be here now without the support of wonderful St Luke's.

Staff were in turn supported by the management team if they experienced emotional difficulties due to the nature of their work and were also able to receive counselling. The last support session was on 'Why a person behaves in a certain way' which staff found very useful. Another was about 'Are men allowed to cry'. 'St Luke's stories' was set up so staff could attend a session in a culture of confidentiality and discuss how a situation affected them, which was open to the entire organisation. Reflective accounts were encouraged, one described how a community nurse had supported and arranged for appropriate childcare for a bereaved family at the person's time of death. This clearly showed how staff were enabled to discuss and work through emotions together after dealing professionally with very emotional issues. Staff were also supported to take time off and sabbaticals, one staff member having had the opportunity of going on a three month trip which was celebrated by the hospice.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. There was a comprehensive information booklet that included the service's mission statement, the range and nature of services available, the structure of the medical team, out-patient clinics, how to complain, and a list of information leaflets that were available such as strong medication and driving. The service had an updated website that contained clear, comprehensive information and that was user friendly. In response to a lack of accessible information for people with a learning disability St Luke's has launched a new easy read future and end of life care plan designed for people who have a communication difficulty or learning disability. The visually driven booklet supported people to think, talk about and write down how and where they would like to be cared for in the future while they could. The hospice worked with Plymouth People First, a self-advocacy organisation to develop the plan and included a guide for support workers. One person from the steering group had said, "I learnt I had choices around my care and how I want to be remembered. I also learnt that knowing peace is important." This plan was now available and used across Devon.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in '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. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. Staff said, "We involve patients and their relatives with care planning. We abide by what people want. We discuss patient preferences upon admission, it's very important but we talk when people want to talk, it's all about them as a person and who they want around them." A registered nurse said, "Care plans are kept by the patient's bedside. This works well because the plan is close to the patient."

All staff acted respectfully in the inpatient unit and in the community. They knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal needs in a dignified way. People were assisted with their personal care needs in a way that respected their dignity.

The staff we accompanied on community visits showed empathy and understanding of the whole family situation and were committed to deliver the best care they could provide. For example, we saw staff going the extra mile with someone who had very little in the way of basic provisions, heating, and lighting. There was excellent pulling together of resources between the district nurses and hospice team to provide the patient with the care they wished to receive in their own home.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. Each person had a pain management programme. Symptom control and pain management was discussed with people before any new medicines were administered. We saw staff at every opportunity ensuring that people were comfortable and discussing any changes in medication and also reassuring people about possible future options and that any pain could be managed. Some registered nurses had been trained in non-medical prescribing meaning that people could access medication without delay.

Staff were able to discuss difficult conversations with people and relatives and had a good understanding of individual patient needs. In the community, staff spent a lot of time talking to family members, there was good interaction and a trusting rapport. Staff said if they could alleviate some of family's anxiety it enabled them to support their loved ones at home and also helped to avoid hospital admissions based on fear. Many issues were discussed, the package of personal care, night sits, do not resuscitate forms (treatment escalation plans TEP) and how this could be changed at any time, pain levels, pressure care, fatigue levels, nutrition, why urine might be a certain hue, bowel care and medication to help and eye drops. One family told us it was an, "Amazing service, we can't wish for better" and "Fantastic advice. The nurse made one call and all equipment, the bed, commode, over-bed table, walking frame was delivered." The family told us there were also assisted with work & pensions entitlement to a higher rate attendance allowance to help provide for food/taxis/heating. The family were very happy to have the support to keep their loved one at home. Family members were involved in end of life planning care and treatment for their loved ones. Families were confident that staff explained everything to them clearly.

Another visit involved the CNS discussing death and dying in a calm, sensitive manner. The CNS showed the family how to alter a commode for comfort and discussed the use of a syringe driver device for administering pain relief. The CNS was very respectful and listened to the family with regard to the use of analgesia as the person had a needle phobia. Another person's relative had called and was very distressed

as their loved one was upset and asking to die as they felt they had no quality of life. The CNS visited as soon as they could and talked with them at length discussing various options to deal with symptoms. The person later told us, "[Nurse's name] is brilliant and has the patience of 'Job', she's so reassuring". The CNS discussed all the changes in medication and stayed with the family at their request to discuss issues further with the GP. We saw an excellent handover of information and the GP made no further changes to the medication. The GP said, "We are very blessed with regard to hospice nurses" and the relative thanked the CNS for the confidence they now felt, feeling reassured they would have another visit the next day.

Is the service responsive?

Our findings

People received exceptionally personalised care that was responsive to their needs. Relatives told us that the way staff responded to their needs was, "Amazing!" and "You can't find fault with anything, they are wonderful." People we visited couldn't believe they were able to access such good care and felt strengthened by the support and enabled to end their lives in a dignified way where they wanted to.

People could be referred to the service by a member of the St Luke's community specialist team, GP, hospital, district nurse and social care teams, care home manager or members of the out of hours healthcare teams. Referrals could be taken 24 hours a day, 7 days a week. The service aimed to respond to urgent referrals within 24 hours. All requests for routine admissions were considered at a daily admissions meeting. A GP told us, "They respond rapidly to phone calls, generally calling us back within a couple of hours if they can't take the call at the time, and offer helpful advice. They are willing to see patients urgently when needed."

There was excellent communication on a multidisciplinary level. The computer system contained a wealth of information that was able to be accessed by all staff, so they could follow people's journey from diagnosis to being provided care from hospice services. They were able to identify any issues with people attending and had a "toolkit" of support to offer. This meant they had a range of options to offer people that they may not have thought about such as dealing with fatigue, breathlessness, nutrition and discomfort. The system was constantly reviewed and additions made such as icons to alert people to cognitive difficulties. Alerts could be made to inform staff of particular issues such as if people requested not to receive named visitors. This was kept confidential. The handover sheets gave a high-level overview of each patient.

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Staff sat with people, enabling them to spend as much time as they needed and encouraged them to ask questions, discuss their options and reflect upon them. Ongoing communication and support was tailored to how people wanted it. For example, one person receiving bereavement support preferred to choose where they met. The community specialist nurse met with a person at a neutral location in the community, where the person felt more comfortable. The person said they couldn't praise the nurse enough as they were the only ones who really cared about them. People felt valued and understood because people and staff worked as a team to ensure each support plan was unique and responded to specific needs.

Hospice staff worked closely with external health professionals and services, providing access to end of life care in innovative ways to meet people's needs and co-ordinate best practice care. People were able to receive end of life care in accordance with national guidelines such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice. Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, major difficulties in adjusting to a terminal illness, or the need for in-patient end of life care. However, many people wished to be cared for in their own home, so the service set up a community Crisis Team to meet people's care needs when there was a crisis in the community. This innovative initiative provided people with

specialist care at home to stabilise symptoms, avoid unnecessary admissions to hospital where possible and to facilitate rapid discharge from hospital or hospice back home.

The crisis team supported families and carers at times of great pressure to respond to rapidly changing situations. One relative commented in the newsletter, "I cannot exaggerate how much difference [the team] made to the last few hours of life. Once the St Luke's team came it was absolutely wonderful. The crisis team made it possible for us to all be together at home surrounded by family." St Luke's offered a 'meet and greet' service to ensure patients had support when they arrived at home and staff worked alongside community health professionals and charities. Hospice staff provided verification of death by to avoid distressing delays for families after a person had died. Relatives said the presence of the hospice team had calmed situations and supported families enabling people to die at home as they wished. From August 2016 people in East Cornwall could also access this 24 hour specialist nursing service. The Director of Patient Services for Cornwall Hospice Care had told St Luke's, "We welcome this development and hope we can discuss our involvement in the development of similar services across the whole county in the future."

Inpatients at the local hospital benefitted from a St Luke's Hospice specialist palliative care team based at the hospital. The hospital had a contract with St Luke's Hospice to provide a 7 day 9-5pm hospital based specialist palliative care which enabled a collaborative approach to care. Advice was available from St Luke's Hospice during the evening/night time. The St Luke's hospital specialist palliative care team include two part time consultants, two part time associate specialists, two administrative staff and seven palliative care specialist nurses one of whom is the end of life facilitator. The team provide leadership, advice and support for patients with complex needs /symptom management to clinical teams across the whole trust. They received 1171 new referrals from April 15 – March 16 and audits showed how effective the service was. The end of life facilitator supported hospital inpatient end of life link nurses and champions within trust staff and also focussed on education and training; embedding the last days of life care plan fully within the trust. For example, the "last days of life" (LDOL) medical and nursing care plan had been revised following an audit and results of the national end of life care audit. The care plan provided guidance to hospital teams and enabled the development of individual plans of care focusing on the holistic needs of dying patients and their families before and after death. A 'Thinking Ahead' project was in place to improve advance care planning for people. The responsive nature of the team had enabled patients to be 'fast tracked' to either home or nursing home with 100% of referrals seen within 24 hours.

The locality included a Dartmoor prison community of over 650 people. An effective collaboration was in place with the prison and a 'Living with and beyond Cancer' group. This had resulted in prisoners being able to access practical end of life care from specialist hospice staff, access appropriate information and support, including personal care in Dartmoor prison, previously unavailable, and transitional support if they moved out of area. As a result of hospice input the prison was setting up a social inclusion unit where a palliative care suite would help prevent prisoners having to move to another prison to access additional health care facilities and end of life care. The hospice was now able to be responsive to the end of life needs for people in the prison through appropriate recognition and referrals and had effectively raised awareness of end of life care within the prison staff team. People were able to access monthly clinics at the prison and multidisciplinary meetings including liaison with the hospital. One person had been able to stay at the prison and the hospice had helped to arrange end of life personal care, which was previously being carried out by a fellow prison 'buddy'.

Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. Staff knew when a person might be too hot, recognised when they had breakthrough pain and knew what meals they fancied. A person asked for a particular burger and staff popped out to get them one. They also liked to go out into the sunshine and although very sleepy, staff enabled the person to enjoy some time outside as

they enjoyed the feel of the wind. A member of staff told us, "We try to do things the person wants. Every day is important and we aim for simple pleasures and comfort so they enjoy time with their loved ones."

Admission assessments to the inpatient unit ensured that people received a management plan of their symptoms, emotional and spiritual support, pain relief and specialist care. People's needs were discussed daily in a multi-disciplinary team meeting each morning. These discussions would be held with the patient and their families.

The hospice provided a chronic lymphoedema clinic service daily, Monday to Friday. The service aims to improve care for all people with chronic oedema by raising awareness of the condition, providing education, support and advice to health care professionals and managing people requiring specialist intervention. The clinics were nurse led. The nurses linked in with the referrers and the person's own GP for continuity of care. There was a lead nurse, registered nurse and a registered physiotherapist in the team. People could be referred to relevant groups such as a breast cancer support group at the hospital. Referrals were made when needed for people to access other services and support, for example psychological services and weight management. One team member was hoping to set up specialist exercise classes at St Luke's which helped to alleviate symptoms further for people living with lymphoedema.

People were involved in the planning of activities that responded to their individual needs. The hospice inpatient unit cared for people for short periods in an acute setting. There were no long stay beds (for example, some hospices have long stay beds funded by continuing NHS care). This meant that generally people were not well enough in the inpatient unit to be able to participate in organised activities. Attention was paid to people's individual social and psychological needs. A range of therapies were offered such as massage, aromatherapy, acupuncture, reflexology, reiki, relaxation techniques and mindfulness based stress management for patients, carers and bereaved relatives. The therapies were adapted to suit the needs of each individual. The team of therapists, which included paid staff and volunteers, worked across the whole service, the inpatient unit, outpatients, in the community and in outreach centres. Up to six therapy sessions were offered, free of charge, with the aim of enhancing relaxation and improving quality of life. These may aid symptom control and relieve stress and tension.

The service took a key role in the local community and was actively involved in building further links. The hospice maintained a high profile in the community and was regularly prominent in the local press through fundraising events. Volunteers and staff contributed to the planning of events. This raised awareness of the hospice services available, promoted donations to benefit people and helped to reduce any stigma. One staff member said in the newsletter following a 'Men's Day Out' charity walk, "I saw the husband of a lady I had cared for walking with my name on the back of his shirt [in thanks]. When I have little problems in my own life I think about that."

Additional feedback was actively sought about every aspect of the service and people, their visitors and staff were invited to make suggestions using a comments box displayed in the entrance. There was a notice board in reception called 'You said, we respond'. This assured people their views were taken seriously and examples of comments and responses were displayed. For example, "The water from the mains tap tastes awful". The response said, "We have added filters and provided bottled water." The hospice also encouraged people and staff to put forward any ideas. One person had suggested provision of two headphones for the TV to enable people and relatives to watch at the same time, this had been actioned.

Staff shared ideas through a 'Bright Ideas' scheme. For example, ideas had been put forward to try to reduce the noise of breaking ice at night to avoid disturbing people sleeping so a solution had been found. On-going satisfaction surveys were carried out and responsive action was taken to address shortfalls that were

identified as a result. One action resulted in a change to medication round timings to make them more effective and enable staff to be available at key times. 'Walkie talkies' were introduced to ensure access to breakthrough pain relief was not delayed for people. This meant when people required more powerful medication for pain which needed checking by two nurses, a nurse could easily call the second nurse. A summary of patient admission/discharge interviews showed how people felt the hospice was welcoming and everyone felt better when they arrived. A comment about the timing of discussing bad news was taken seriously and addressed.

Is the service well-led?

Our findings

There was an open and positive culture which focused on people. This was reflective of the outstanding leadership and management of this service. People received care and support by staff who upheld strong values about person-centred care, and positive connections were promoted that enhanced their experience of the service. People were placed at the heart of the service and the registered manager led by placing emphasis on continuous improvement in all aspects of their care. They had a plan to drive improvements in the service and worked in partnership with other organisations to that effect. This included other end of life support charities, retail, paramedics, universities and schools, specialist support groups, community health care professionals and the prison. People's feedback about the way the service was led said, "What an amazing service, they work with us to deliver outstanding care just for us." Relatives told us, "There are no improvements to be made. I don't know what we would do without the support of St Luke's, each and every-one there from top down" and "You cannot improve on perfection and that is what you get at St Luke's."

An effective leadership team oversaw the running of the service, and included a chief executive (the provider), the registered manager, who was the quality and compliance manager and clinical directors. They had particular experience and expertise in leadership, nursing and palliative care. The chief executive had a MA in leadership with others accessing further education in the palliative care field. They encouraged the staff to 'shout about it' recognising that awareness of the service was key to enable all to access the 'hospice without walls' ethos. The clinical director said, "It's important we all work together and value each other as a team. We have a lot of cross working between departments so we all understand what we do as a whole." A staff and volunteer newsletter 'Hospice Herald' informed staff what was happening monthly within the service. This included a one page profile about different staff members to encourage staff to reflect on what people said about them and encourage close working relationships.

The hospice took part in various research projects. For example, the project 'Occupational Therapist Led Rehabilitative Care in High Grade Malignant Brain Tumour Patients'. The project sought to identify early, people with brain tumours who currently present at a late stage to the palliative care service. The research project had specific aims around: improving and maintaining independent function through longer term active support and re-habilitative interventions: use of motivational interviewing techniques in order to achieve 'whole person' goals and promote client self- management. The project would then produce a best practice guide. A small aids and equipment proposal had resulted in filling the gap for accessing equipment not readily accessible from the Community Equipment Store. A delay in accessing special order items often meant people had died or were no longer able to take advantage of items to aid quality of life. Now the hospice directly issued small items of equipment. For example, a person with disturbed sleep due to a build-up of secretions was able to get a bed wedge to allow them to sleep more comfortably in an upright position.

There were many examples of partnership collaboration such as with homeless, drug and alcohol services, the prison and learning disability groups. These had resulted in real benefits for people in awareness, training, increased referrals from vulnerable groups and more people having access to end of life care. Further development of prison specialist nurse input was planned including joint education and clinics,

further literature and a South West prison palliative care forum. A conference, 'The Big Conversation' was delivered focussing on end of life conversations for those living with dementia aimed at health care providers, faith communities and patient support groups. Feedback showed how effective this had been in raising awareness of the need to talk about end of life. A new community development lead role was in place to strengthen networks and raise the end of life profile in the community, promoting the compassionate community for example. .

Best practice innovations and ideas to improve people's care were sought from staff. During our inspection staff were pitching ideas in a 'Dragon's Den' type setting. They pitched projects and the 'winner' (who proposed developing a spiritual care champion role) was able to attend a national conference if they could show how this would benefit people. Training and sharing information was not limited to the United Kingdom. One community nurse specialist attended a Palliative Care Works event. They had been invited to a hospital with basic end of life provision in the Seychelles with a palliative care consultant. They had provided a week long programme of training and developed a plan of end of life care. They will then follow this up later this year.

More sharing was promoted during national Dying Matters Week which encouraged the public to talk more openly about death, dying and bereavement. The week was officially launched by St Luke's Hospital Team with an information stand and a free make a will service in partnership with local solicitors. In addition a 'Hospice Without Walls' short film was shown locally in cinemas promoting the work of the hospice and raising awareness of the wide geographical area it serves and the variety of care settings. This had resulted in increased awareness and members of the public had contacted the hospice. For example, one person emailed to say, "I am requesting this information in advance of including a legacy to the hospice in my will. I have been aware of the raised profile of the hospice since you campaigned locally on billboards and in cinemas to create a hospice without walls. I would like to understand more about how this will be achieved." The hospice responded with the details.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. All the staff we spoke with told us they had confidence in the way the service was managed. Staff praised the provider and the leadership team for their approach and consistent, effective support. They said they could come to the registered manager, provider or any of the service managers for advice or help. All of the staff we spoke with told us they felt valued working in the service, and felt motivated to maintain high standards of care. The registered manager took an active part in monitoring standards of practice and staff said they were inspired by the registered manager's examples and values.

Staff commented on how well they felt valued, listened to and supported by management. They said, "I have never had this level of support before. Right from the top it comes down. The leadership team will have tea with us and we are all in it together." There was a culture of collective responsibility between teams and services, which was evidenced at the multidisciplinary meetings. For example, the hospice volunteer team was put forward for 'Volunteer Team of the year Inspiring Volunteers Award'. Assessors particularly noted, 'the warm welcome and hard work of the volunteers'. Volunteers from the community went to collect their Queen's Award for Voluntary Service. A named volunteer was also nominated by the hospice for a UK Honour stating, "I did a joint visit with [volunteer's name] and I was absolutely flabbergasted at their ability to just find that chink, that special personal connection with someone who had been very hard to engage."

Staff were able to raise concerns including whistle blowing through a range of channels. Coaching and leadership training was considered important in supporting staff. Staff representatives attended staff communication and consultation groups to share ideas, consult on changes and discuss challenging issues.

Staff could attend 'Mop up and Mingle' sessions, put forward 'Bright Ideas' and access personal support when it was needed. For example, following a stressful weekend. A head of department said, "We want to channel high emotion in a positive way and allow staff to talk when they need to."

Staff all spoke about how St Luke's was a wonderful place to work. Staff comments included, "I love working here considering it's a hospice it's a really nice place. The support from the team is really good they are friendly and the patients are lovely" and "I can't change the fact that patients have a life limiting illness. I want to make things as good as they can be for the patient. I don't just care for the patient; I get involved with the family. I see how anxious patients and their families can be when they first come into the inpatient unit. It is so satisfying to make it easier for them. We all deliver such good nursing care." Another said, "It's a wonderful place to work, everyone is so friendly. We have time to give good nursing care to all of our patients. The work is really rewarding and makes a vital difference to people's lives."

The service was forward thinking and constantly looking at ways to improve the service for the local community and in a wider sense improving end of life care as a whole. The chief executive and leadership team were clearly passionate about the work they did and proud of the staff team. This was evident throughout the service. For example, a new IT group in the community was working on making technology such as Skype and emails more available. A community team leader had academic work published in this area. A new staff intranet was set up to ensure close working across departments, including access to shared calendars and clinical documents. A new group was considering falls prevention in a community setting enabling referrals for falls prevention advice and moving and handling. Future plans for the lymphoedema service included supporting a registered link nurse role from the IPU to enable succession planning. The service was hoping to expand to more rural areas to minimise travel for people. Links were being made in community settings and clinics were held monthly in Kingsbridge and Tavistock].

St Luke's hosted a western locality end of life operational group and a forum including care providers which highlighted improvements needed in facilitating safe discharge and transfers. A training module was planned with the community and crisis team for inpatient staff so that people could go home quicker and further improve discharge planning. Referral criteria to the specialist community service included support for complex end of life discussions such as withdrawal of treatment. There were many examples of supportive work with community multidisciplinary teams. Clinical staff were regularly involved in 'horizon scanning' to identify new developments in clinical practice. A range of networks enabled staff to keep up to date with innovative practices. For example, Association of Hospice and Palliative Care Social Workers, South West Medical Consultants Forum, Centre for Faith and Cultural Diversity Hub, Motor Neurone Disease network, Plymouth Octopus Project and many others. These were used as forums for sharing expertise and discussion.

There were a number of situations where the operational group had helped with overall End of life 'systems' across the area, whether this was resolving access and availability of medication in the community, developing and understanding pathways of care, writing policies for the use of medication in the community. Writing prescribing guidelines for primary care/GPs for palliative and last days of life patients and joint work between hospital and community to understand the difficulties in discharging people at end of life from the acute hospitals. For example, a protocol was developed in order that a named person was able to receive a specialist drug in a syringe driver at home, an unusual medication that the community nurses were not familiar with and initially uncomfortable about using, this policy meant the person was able to die at home. Discussions around the ethics of withdrawal of ventilation for a patient with motor neurone disease (MND) were held in order that staff understood the ethics and legal framework that this procedure was occurring, reduced the distress amongst health care professionals in this procedure and ensured the patient was able to decline treatment with the appropriate support in his own home.

Sharing expertise was an important part of St Luke's work. This was seen across the service with staff working in all areas to maintain and develop their skills, and in innovative training projects which made a real difference to how care providers delivered end of life care. For example, the 3R's project (Right place, right care, right time) to recruit end of life champions, the Six Steps project to train and empower care home workers, and modules to develop clinical skills and knowledge for community teams including providing evening training sessions for health care providers. We saw how sharing had directly resulted in improvements in information sharing with local hospitals, other care providers and out of hours services. Also one person was dying in a care home. The staff had an end of life advance care plan conversation and ascertained that on her bucket list they wanted to sit on a Harley Davidson one more time. The care home staff contacted the Plymouth Chapters of Hells Angels who came to the care home and the person's wish came true. Another person was dying in care home who was a spiritual lady. The staff found out they wanted to die in the garden of the care home, surrounded by trees, flowers and hearing the birds. The care home staff enabled this to happen as it was a sunny day and they appreciated how important final moments are.

With the expansion and projected need for domiciliary care packages and crisis care the hospice had ensured they could meet this need in the community. Results showed that people were able to avoid hospital admissions and remain at home with care packages. The service had invested in training non-medical staff (nurses in the hospital) to prescribe medication which benefitted people by reducing delays in accessing medication to manage their symptoms. Hospital palliative care nurses now undertook writing prescriptions to manage symptoms for people at home, without the need to get a prescription from the GP, therefore saving time.

There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. Where appropriate, audits were discussed with the clinical management team, a clinical governance committee and the board of trustees. Audits of incidents were discussed at clinical governance committee meetings to explore how risks could be further managed. We saw the hospice annual audit programme. This was comprehensive and showed where lessons were learnt and acted upon. The quality and compliance department also carried out mock CQC inspections. One had resulted in a change in how staff recorded consent and best interests decisions in line with legislation.

The hospice used a UK wide hospice benchmarking system. The bench-marking process is hosted independently by Hospice UK who analyse the figures from all participating hospices comparing data analysed per 1000 occupied bed days for falls, drug errors and development of pressure ulcers. St Luke's were below the national average for a hospice of similar size, which was positive. Following an audit it was identified there was the potential to reduce the number of falls further by moving the nurses' bases into the four bedded wards which had been achieved and the number of falls had fallen further. Results were also monitored by the clinical review group and by organisational risk and internal audit committee. For example, an audit of on pressure care resulted in a detailed look at the effectiveness of specific specialist mattresses ensuring people benefitted from using most effective equipment.

In addition to the online survey, there were various other ways in which people could comment on the care provided. There were feedback forms for people to leave comments for the inpatient team, chronic oedema service and community team. Satisfaction surveys and complaints were scrutinised to identify whether people's experience of the service could be improved. There were clear examples of how this happened in practice effectively.

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. The policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated on a continuous basis. A computerised system

scheduled policies for regular reviews and these schedules were adhered to. Staff were made aware of the updates and knew where to locate the policies for guidance. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.