

Earl Mountbatten Hospice

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Inspection report

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

This inspection was carried out by four inspectors on 30 and 31 January 2017 and was announced to ensure the Hospice at Home staff we needed to speak with would be available.

Earl Mountbatten Hospice (EMH) serves the adult population of the Isle of Wight (IOW). Services are provided from the In-Patient Unit (IPU) and the local hospital. Day Services and Out-Patient appointments are provided from the John Cheverton Centre (JJC). People are supported in their own homes by the Rapid discharge and the Hospice Care at Home team. The hospice also offered a range of other bespoke services to people and their families including psychological support, creative and complementary therapies and a bereavement service. The hospice has a large multi-professional team consisting of medical staff, nurses, a psychologist, social worker, therapists and chaplaincy supported by people facing volunteers.

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

The Earl Mountbatten Hospice provided an outstanding service that creatively enabled people to choose where they wanted to receive end of life care (EOL) and responded promptly to clinical deterioration in times of need. People spoke of a service that was tailor-made for them, highly personalised and focussed on their individual needs and that of their families. EMH had developed their range of services innovatively with local agencies to ensure their local population would receive the support they needed at the time they needed it and in a way and place that best suited them.

The hospice worked innovatively with their local hospital and was highly responsive to ensure people were discharged from hospital in a timely manner so that they could receive EOL care at home when this was their preference. Through this joint working people who would not traditionally access hospice care had also been given the choice to receive their EOL care in a hospice. The various departments within this hospice worked well together so that people had a seamless experience of moving from one department to another as the need arose.

People, their relatives and staff spoke overwhelmingly of the positive support, guidance and healthcare interventions people had received. They were full of praise for the staff in terms of their exceptional kindness, compassion and knowledge about end of life matters. Staff went out of their way to support the needs of their wider community which included providing care and support to children and people living with dementia at the end of their life.

The Day Services used their Schools Project creatively to support people's desire to remain useful and contribute to society till the end of their lives. Through this project people had an open and honest dialogue with their local young people about palliative care and their end of life experiences. People told us this how

this had made them feel valued and they were proud to be able to teach others through their life stories.

Managers showed outstanding leadership and they recognised, promoted and implemented innovative ways of working in order to provide a high-quality service. This forward thinking approach had resulted in service commissioning arrangements that ensured people received high quality integrated community care to support their preference to receive end of their life care at home.

The management team promoted a culture of openness, reflection and excellence. Staff were involved in the development of the values and vision of the service. An outstanding example of enabling staff to contribute to personal and hospice development was the bespoke 'Well-led: Leading from the Middle' programme designed for middle managers across the organisation. We saw this project had empowered staff to work on operational challenges and creatively deliver tangible outcomes for the hospice. Governance of the service was of a high standard and robust quality assurance systems were in place that showed people were right to have confidence in this local hospice.

The hospice offered end of life care training opportunities for their staff and other health and social care professionals. Through this training and other service developments the hospice had enabled people to receive end of life care closer to home and reduced the need for hospital admissions. Staff were involved in the development of working practice, listened to and supported to offer high quality end of life healthcare and support.

People's informed consent was embodied into all work that was undertaken at the hospice and people who did not have capacity to consent to their care and treatment had their rights protected under the Mental Capacity Act (MCA) 2005.

People were protected from harm and abuse and robust staff recruitment procedures were followed to keep people safe. There were sufficient staff to meet people's individual needs and to respond flexibly to changes and unforeseen emergencies. Systems were effective to manage known risks associated with people's care and treatment needs such as falls, pressure sores, poor nutrition and hospice acquired infections.

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

The service listened to people, families and staff, involving them in the running and development of the service. They actively sought out their views and used feedback as an opportunity to improve and develop the service. There was a kindness and warmth about the management team that made them approachable to everyone and people knew them by their first names and told us they were visible and solved matters when they were raised.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People felt safe when supported by staff and staff understood their responsibilities to report abuse.

People's risks to their health and safety had been identified and staff knew how to protect people from the risks associated with their care and treatment.

There were enough suitably skilled staff deployed to meet the needs of people. Recruitment processes for new staff were robust to ensure they were suitable to work with vulnerable people.

The provider had appropriate arrangements in place to safely administer people's medicines when required and staff understood the risks associated with people's medicines.

Is the service effective?

Good ●

The service was effective.

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

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

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs, preferences and wishes. Professional advice was sought and followed for people's nutrition where required.

Is the service caring?

Outstanding 

The hospice was exceptionally caring.

People using the hospice, their families and the wider community were supported by kind and compassionate staff who went the extra mile to ensure people continued to have life enhancing experiences.

Staff had outstanding skills and an excellent understanding of the needs of people who may be vulnerable because of their circumstances. People who might be less likely to receive good care had received care from exceptional staff who through their compassion and understanding had enabled people to receive EOL care that was kind and sensitive to their needs.

The hospice focused on people's wellbeing and developed innovative ways to promote quality of life such as the Schools Project which gave people an opportunity to teach children through their experiences, to remain useful and to contribute to society until the end of their lives.

Is the service responsive?

Outstanding 

The hospice was outstandingly responsive to the needs of people using their service, their families and the wider community.

The hospice found creative ways to meet people's needs such as youngsters with life-limiting conditions. This meant that families did not need to travel from the IOW if they wished for their children to receive EOL care in a hospice setting.

The hospice worked pro-actively with their local acute hospital to ensure people who wanted and could safely receive EOL care at home or in the IPU were identified promptly and transferred from hospital without delay.

Complaints investigations were thorough and the hospice used complaints to challenge their practice and improve the service provided for people.

Is the service well-led?

Outstanding 

There was excellent leadership.

The registered manager had developed and sustained a positive culture encouraging staff and people to provide feedback about the hospice and to be actively involved in improving the hospice.

The values and aims of the hospice were visible throughout the service and were developed with the input of staff and volunteers.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high-quality service. They strived for excellence through consultation and reflective practice. We saw evidence of the hospice sustaining their outstanding practice and improvements over time.

Earl Mountbatten Hospice

Detailed findings

Background to this inspection

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

This inspection was carried out by three inspectors and a pharmacist inspector on 30 and 31 January 2017 and was unannounced. We had previously inspected the service in May 2013 and found no concerns.

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

During the inspection we spoke with nine people who used the service, five relatives and one visitor. We spoke with the registered manager (who is the Chief Executive and the Governance lead), the Head of clinical quality and patient experience and the Service development lead. We spoke with the head of housekeeping, the catering manager, a GP trainee, the Medical Director, the Care at Home team leader, a physiotherapist, the Social worker, the Admiral nurse, a Lymphoedema nurse, the Clinical Psychologist, nine nurses, a student nurse and eight health care assistants.

We attended the weekly multi- professional team (MDT) meeting and the Quality and Governance Committee. We viewed a range of records including care documents for eleven people who used the service, six personnel files and records relating to the running of the service

Is the service safe?

Our findings

People and their relatives told us they had no safety concerns when people received support in the Inpatient Unit (IPU), their own homes or attended the day service. One person told us "I feel very safe here" and another said "Staff always tell me how to stay safe". They said they would be confident speaking to any member of staff or the registered manager if they had any concerns. Staff and volunteers had completed adult and children safeguarding training as part of their induction and ongoing training. They were able to identify the procedures they needed to follow should they suspect a person in their care had been or was at risk of abuse. The registered manager was aware of their responsibility to report allegations or suspicions of abuse to the local authority and had not needed to report any safeguarding concerns relating to the hospice.

The service was aware of their wider safeguarding responsibility to keep people safe from abuse and discrimination. They had a dedicated safeguarding lead who received and reviewed all safeguarding concerns to ensure they were actioned in accordance with local safeguarding procedures. Staff gave examples of safeguarding alerts they had raised when people had been deemed as being at risk of avoidable harm at home. For example, when people lived alone and refused care, arrangements had been made to prevent self-neglect occurring. Staff had supported safeguarding investigations as required and were able to describe the positive outcomes these had brought for people.

Staff knew how to follow whistleblowing procedures and how to raise concerns anonymously if required. They told us they were confident that any issues they raised would be addressed to keep people safe and to improve the service people received. One staff member told us "If I suspected that someone had been mistreated I would always check they are ok and provide them with support and reassurance. I would report my concerns to the sister or deputy sister, I would be very confident that they would respond". Staff were also aware of other organisations with which they could share concerns about poor practice or abuse.

Risks to people's safety and staff supporting them had been identified using screening tools, effectively managed and reviewed. These areas of risk included any potential hazards in people's home environment, risks when people were supported by staff to move or transfer, risk of falls, weight loss, choking and the development of pressure ulcers. For example, one person preparing to return home from the IPU had a community risk assessment in place. This included what support and equipment would be needed on their return to keep them safe at home. Another person had turning charts in place which demonstrated that people at risk of developing pressure ulcers were having their position changed as highlighted in their risk assessment to relief the pressure on their skin. Staff demonstrated that they knew what action to take to keep people safe in accordance with their care plans.

People at risk of falls had been assessed to ensure appropriate arrangements were put in place so staff and relatives at home would know how to support people to mobilise safely. Where needed people were assessed by the hospice's physiotherapists and provided with the necessary equipment in the IPU and at home such as grab rails, slide sheets and wheelchairs. This meant their care could be provided safely and people could remain safely independent at home. Staff had received training in safe moving and handling

techniques and told us the hospice's physiotherapists would show them how to use any new equipment safely. Staff were provided with clear information on the daily handover sheet in the IPU about people's ability to mobilise and any equipment required.

People's changing health and fluctuating strength meant their risks could change rapidly. We found risks to people were reviewed continuously to ensure their risk management plans would remain effective. For example, one person's ability to eat independently fluctuated. We heard staff on the IPU offer this person support during meal time. Their food intake or lack of had been recorded within their nutritional assessment to ensure staff could assess if they were at risk of malnutrition and required increased support during meal times. Staff had a good understanding of people's risks and how to support them to remain safe.

Staff had been required to undertake full pre-employment checks before they were offered employment and could work with people unsupervised. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Nursing and Midwifery Council (NMC) checks had been completed to ensure health professionals were fit to practice. The provider had used the interview process to assess staff's relevant skills and experience and to support the registered manager to plan an induction for new staff. The provider had taken into account all known risks relating to each candidate's suitability when making recruitment decisions.

People, relatives and staff told us there were enough staff to meet people's needs and keep them safe. One person told us "The staff always comes quickly if I ring my bell". Relatives' comments included "There is enough staff, they are always there if we need them", "[Person] can be a bit unsteady, the staff never rush him" and "The staff have been very open and are always available to talk to". The provider used a systematic approach to determine how staff were to be deployed on a daily basis. New referrals to the service and the changing needs of people in receipt of a service were reviewed daily. This ensured that the available staff would be allocated to people with the highest need and risks. Staff worked flexibly across the different areas of the hospice to cover sickness. For example, the day before our inspection the community team was quiet and as a result two health care assistants came over to help in the busy IPU. We also saw additional staff were provided for one to one support to keeping people safe when they were at high risk of falling or becoming confused.

Staff understood each person's vulnerability to infection and took action to protect them from the spread of infection. We saw staff washed their hands prior to undertaking any procedures and when delivering care. Staff and visitors had easy access to hand washing facilities in the hospice. There were sufficient supplies of protective equipment such as gloves and aprons and staff used these appropriately. Records showed that regular cleaning and infection control audits had been undertaken to ensure staff complied with the hospice's infection control requirements. The hospice was well maintained and clean throughout the inspection.

Systems were in place to ensure people received their medicines safely as prescribed. Peoples' own medicines and stock medicines, including emergency medicines were stored safely. Medicines requiring refrigeration were monitored appropriately. Unwanted medicines were disposed of in line with waste regulations. Medicine safety alerts (alerts that are issued nationally regarding faulty products) were sent to relevant staff and records demonstrated that appropriate action had been taken to ensure people would receive their medicine safely.

Controlled drugs (CDs - medicines with potential for misuse, requiring special storage and closer monitoring) were stored securely. Nurses carried out weekly stock balance checks and pharmacy reviewed CD stock levels regularly. High strength injectable medicines were segregated from other strengths to

prevent selection errors. Unwanted CDs were destroyed and CD records were kept according to legislation. Medicine charts and blank prescriptions (FP10s) were stored securely and there was a system in place to prevent any misuse of prescriptions.

In-house doctors or nurses prescribed for people admitted to the hospice. We looked at peoples' medicines charts; these included details of peoples' allergies, there were no missed doses and all prescribed items were signed and dated by the prescriber. A pharmacist had checked that the prescribing was safe. People's medicines were administered safely.

We observed the morning medicines round. Registered nurses worked in pairs to administer peoples' medicines; student nurses were involved as part of their training at the hospice. Nurses completed annual medicines administration and drug calculation training online. Assessments were carried out to ensure they were competent to administer medicines safely. The hospice had some nurses who were trained to prescribe and we saw evidence that their practice was up to date.

Medicines errors and near misses (errors that are identified before the medicine reaches the patient) were reported, investigated and discussed by staff and we saw evidence of teaching sessions that included reflecting on medicines errors.

Is the service effective?

Our findings

People and their relatives told us people received high quality care from skilled staff. One person told us "Staff are well trained, they know what they are doing" and another said "They all know what they are doing, even the younger ones". Relatives told us "I am very confident in the staffs' abilities" and "They [staff] are excellent, I can assure you they are doing their jobs properly. They are all at the top of the class". Staff gave us positive feedback about the skills and knowledge of the staff they worked with. Care staff told us the nurses were confident in making clinical decisions and always gave them support. One staff member told us "I get supervision every six weeks, the sister's door is always open and they [sister and deputy sister] are really approachable. We are really lucky".

Staff had the skills and knowledge to meet people's needs. Care staff had undergone an induction programme that met the requirements of the Care Certificate standards. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. There was an induction programme for newly appointed nurses and the provider had developed a competency framework for the nursing and care team to evidence staff had all of the skills needed to meet the needs of people. All new volunteers were provided with an orientation programme and mandatory training.

Staff were complementary of the training opportunities they were provided. Their comments included "The best induction I have ever had, it covered everything and was enlightening", "We get lots of training and are given the opportunity to do extras if we have a particular interest in something" and "The dementia training was really good, it kept my attention and helped me to look at things at a different angle. It was really interesting hearing how dementia affected the whole family".

Nursing staff described good support for professional development. This included an active professional development team who supported staff with training and organised in-house education initiatives. Nurses are required by their regulatory body to have their practice re-validated every three years and nurses told us they had been supported to ensure they would be assessed and their NMC revalidation dates identified.

Staff told us they felt supported in their role. Their comments included "Everyone is thoughtful of each other and work as a team", "Staff look out for each other" and "I don't feel afraid to tell other staff how I am feeling or if I need support". There were a variety of methods for keeping staff informed and updated of changes in practice. These included monthly staff meetings, MDT education sessions, regular supervision sessions and an annual appraisal. Staff told us and records confirmed, supervision had been taking place regularly and their supervision gave them the opportunity to reflect on their practice, to identify their training needs and to contribute to the improvement of the service.

Some people did not have the mental capacity to independently make decisions about their care arrangements. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they

lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection no one was deprived of their liberty.

Staff showed a good understanding of the MCA and were able to tell us about their responsibilities under the MCA. One person told us "They [staff] will always asked my permission and get my consent, they will explain things and ask for my view". Staff could describe how they sought consent before carrying out care tasks and explaining the procedures they were about to carry out, for example, when asking people if they wanted any pain relief. One member of staff told us, "I wouldn't presume that a patient doesn't have capacity" and another said "If I give someone information I would give them time to digest this and check they have understood it". Staff told us how people's capacity to consent to their care, could at times fluctuate when they were in pain or taking medicine which made them drowsy. They could describe how they would ensure when people had to make important decisions about their care, that discussions would take place at a time when people were best able to understand the information.

All staff were responsible for undertaking mental capacity assessments when people were deemed to lack the mental capacity to make decisions about their care and treatment. They had received relevant training and records showed they had a good understanding of the legal process and the documentation they needed to complete. Staff had encouraged people to make decisions about their care, treatment and preferred place of death whilst they still had the mental capacity to make these decisions independently. Where people lacked capacity to make decisions about their care we saw these had been made in their best interests. For example, one person's swallowing ability had deteriorated and they did not have the capacity to decide whether a feeding tube should be inserting directly into their stomach to provide nutrition; this is called a percutaneous endoscopic gastrostomy (PEG). The medical director explained how they were considering whether inserting a PEG would be in the person's best interests through consultation with their family members and care staff.

People told us they had enough to eat and drink and were complementary of the food and choice available. Their comments included "The food is lovely and we get lots of choice", "The food is very good, I get loads of choice and whatever I want I can have" and "The ice cream is still solid when it gets to me". One relative told us "The food is excellent, nothing is too much trouble. They [staff] provide food little and often which is what [my loved one] needs."

Staff promoted the importance of good nutrition and hydration. People were given advice in relation to healthy eating and drinking. Some people who used the service had a reduced appetite or difficulty eating and drinking. Where concerns were identified with people's nutrition, nutritional assessments highlighted people's likes and dislikes, food consistency and support required with eating and drinking, including any equipment that would promote someone's independence. Staff and volunteers could describe how they supported people whose swallowing had diminished by encouraging small spoonfuls of food and ensuring food was of the correct thickness to prevent choking. The chef/catering manager was able to tell me us how they met the needs of a person in the IPU who followed a vegan diet and about another person who only liked very small portions. They said, "I am mindful of portion sizes, too much food can put people off".

Staff monitored people's health and wellbeing in the IPU, during home visits and when they came to the day

centre. Changes in people's health were identified promptly and records showed staff alerted the medical team when for example; concerns relating to people's skin, pain management, swallowing or mobility had been identified. Where people lived with chronic respiratory conditions staff monitored their general wellbeing and were prompt to discuss any increased breathless with the medical team. One person attending the day service told us "They always take my blood pressure and check my breathing when I come". Staff were familiar with people's pain management plans and the medical team prescribe additional pain relief if required at short notice. We attended the weekly case review meeting and saw any changes in people's health were discussed and management plans agreed, to ensure people would receive the support they needed to manage their symptoms and pain.

Is the service caring?

Our findings

People valued their relationships with staff and felt that they often went 'the extra mile' for them, when providing care and support. As a result they felt really cared for and that they mattered. People's comments included "I wouldn't ask for nicer staff, they go above and beyond", "The nurses are absolutely lovely", "They are brilliant, so kind", "The staff always have a smile on their faces" and "When they came to see me at home they could not do enough for me". People and relatives spoke overwhelmingly of the trust they had in staff and the comfort and peace of mind that gave them. One relative told us "'I can't fault it, [the care] it is a wonderful place and we [family] couldn't of got through this without them" and a person said "They really know what they are doing and I trust that they will tell me if I was not doing well and what to do".

People had been involved in making decisions about their care and choices about their symptom management and preferred place to die. One person said that they had been spoken to about the future and said, "My goal is to go home and they [staff] know that". A relative said, "It was [my loved one] decision to come here.

We heard numerous exceptional examples of staff having an in-depth appreciation of people's individual needs around the end of their lives or preferred place of death and how staff went out of their way to honour people's wishes. For example, this was evident in the pre-bereavement support and guidance staff provided to children's teachers and guardians so that people's wishes for their children to be supported after their death could be honoured. One person told us "I know when we need it there will be lots of support provided to all of us, this is really reassuring". Family support was seen as key to people's wellbeing and the needs of people's families were also supported.

Staff had outstanding skills and an excellent understanding of the needs of people who may be vulnerable because of their circumstances. Where for example, people without a fixed address were discharged from hospital into temporary accommodation staff ensured they had the support and equipment needed to receive EOL care out of hospital as they had wished. People in prison on the IOW were also supported to receive EOL care that reflected their wishes and preferences. This meant that people who might be less likely to receive EOL care had received care from exceptional staff who through their compassion and understanding had enabled these people to receive support that was kind and sensitive to their needs.

Staff viewed the hospice as belonging to the IOW and were highly motivated and inspired to offer support that was kind and compassionate to the community as a whole. We heard examples of staffs' commitment to go the extra mile for the community, creatively overcoming any obstacles to achieving this. For example, staff had made the hospice's cold room available to grieving parents in the community so that they could spend valuable time with their child after their death as part of their bereavement. Staff described how they would find out what the child liked and would decorate the cold room accordingly so that parents would be surrounded by familiar objects dear to them and the child. The hospice had also made their day service bathing facilities and sensory equipment available to the local children's team so that children could access specialist equipment required to develop their independence and participate in play. The hospice had also hosted a lunch at their Sunflower Café for older people in the community on Christmas day so that people

did not have to spend Christmas alone. One staff member told us "It is important that we give back to the community and support wherever we can, we are all like a big family in the island". The hospice focused on the IOW community's wellbeing and developed innovative ways to support and help them where they could.

The hospice focused on people's wellbeing and developed innovative ways to promote quality of life and support people's desire to remain useful and contribute to society till the end of their lives. An outstanding example was the Schools Project. These projects worked with people using the hospice, young people and schools to raise awareness of living with long term illness, palliative care and issues around death and dying. Under this project children visited the hospice and spent time listening to people's life stories and then gave these back as a play. People directed their own stories. One staff member told us "People were so excited on the night of the play; they were getting up and guided the children when they got some of the facts wrong. It was a lovely legacy for people and their families to cherish". People told us how this had created a sense of optimism, purpose and achievement for them. One person told us "I loved it when the children came in. They liked to listen to my stories and it was nice to teach them about the war and the jobs we did then".

One parent whose child was involved in the Schools Project noted in their feedback to the hospice "I think is really important for children to understand about illness and death, without being frightened, and you achieved that brilliantly". We heard how some of the children and people had developed friendships following this project. A parent whose child continued to visit a person till their death in the IPU told staff that this experience had supported their child to cope better with death and dying. This project had supported young people to demystify issues around death and dying in a caring manner and had invited open and honest dialogue between the generations about palliative care and end of life experiences. The hospice also worked with their local prison population on a project that saw prisoners sort donated clothing and produce crafts, including recycling furniture to sell in the hospice's shops. Staff told us how this was giving prisoners a sense of worth and an opportunity to contribute to the wider community.

People told us staff treated them with dignity. Their comments included "They told us staff adhered to standards which promoted dignity and respect when delivering personal care in people's homes. In the day service we observed staff asking for people's consent before supporting them and waited for people to respond before proceeding. Staff took time to listen and did not leave the person until they were comfortable and settled. For a person who was feeling unwell, staff demonstrated an understanding of the symptoms they were experiencing, providing reassurance and comfort. We heard many examples of how staff worked sensitively with people as they became increasingly frail and required more support to maintain their personal care to ensure their dignity was maintained.

We observed that people were treated with respect. Staff knelt down to people's eye level to communicate with them and we heard good-natured banter between people and staff when appropriate. People were given time to express themselves and not rushed during care tasks. People's privacy was respected at all times. Doors were closed during personal care, during private discussions about care needs and at patient's request. One person told us "I am treated in a dignified way by the staff here". Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered to promote their dignity. We observed staff knocking on doors, and asking people's permission before entering their bedrooms. Confidential care records were kept securely and only accessed by staff authorised to view them.

Is the service responsive?

Our findings

People, relatives and staff working closely with the hospice told us people received a service that was outstandingly responsive to their needs and wishes. One person told us "It is much different here than I expected, this is the first time I have been here and it is clearly not just a place to come and die, it offers so much more". Another person told us "The doctors are great and will always respond if I am in pain, the doctor comes straight away".

People's care was planned and delivered to meet their health, social, emotional and spiritual needs. People received holistic care because staff understood the importance of working together as a team to provide seamless care for people. Weekly multi-disciplinary team (MDT) meetings were attended by medical and nursing staff, therapy staff, social workers and the chaplain. Multi-disciplinary decisions made about changes in people's care and pain management were appropriately documented in people's care records.

A future plan of care (Anticipatory Care Plan) was agreed with each person which documented their wishes about their preferred pace of care and death and resuscitation wishes. People told us they had been involved in agreeing their Anticipatory Care Plan and they were satisfied that the service they received met their needs. Comprehensive discussions took place about the care of each person and of close family members. For some people with complex symptom management who wanted to receive EOL care at home a comprehensive second Anticipatory Care Plan had been developed in case they required to be admitted to the IPU if their symptoms could not be managed at home. This parallel care planning was outstanding practice and allowed for people to plan alternative EOL arrangements if their preferred place of death could not be achieved. The hospice was working with the ambulance service to further improve communication of people's parallel plans so that their wishes not to be hospitalised would be respected if their condition unexpectedly deteriorated.

When people were discharged from the IPU and required increased practical support to enable them to receive EOL care at home, staff worked creatively to ensure their rapid discharge. The hospice had an innovative working relationship with the local Adult Social Care team that enabled the hospice's social worker to assess people's eligibility for fast track continuing healthcare funding. This had enabled people to promptly receive the funding and care packages required to return home. The hospice also implemented a 'Mirroring Care Package scheme'. This involved the hospice's Care at Home Team providing some care sessions for people in the IPU that mirrored what they would be receiving at home prior to their discharge. This had enabled people to meet their support staff, build their confidence and for the physiotherapist to assess what equipment people would require at home before they left the IPU. For example, one patient who was planning to go home was receiving care in line with what would be provided at home and was being visited twice daily by staff from the Care at Home to meet their needs. This was reviewed throughout the day to ensure care on discharge would be appropriate. Additionally a settee had been put in their room at the hospice as they would be using a settee on their return home. This enabled them to practice with staff getting up from the settee without falling. This showed the hospice was flexible and responsive to people's individual needs and preferences, finding creative ways to enable people to live as full a life as possible.

The hospice was outstandingly responsive to the needs of their community. The provider continuously reviewed the needs of their local population and developed services in partnership with for example; the NHS England Area Team, local district nursing team and Clinical Commissioning Group (CCG) to better respond to the needs of their local population. This had ensured people promptly receive the appropriate care they needed at the end of their life. For example, the hospice had a 'pop up' suite for children. The brightly decorated rooms, furnished with specialist equipment, provided NHS staff with an alternative location to provide palliative care to youngsters with life-limiting conditions. This meant that families did not need to travel from the IOW if they wished for their children to receive EOL care in a hospice setting.

The hospice had also developed their service to ensure they could better meet the needs of people living with dementia. The hospice had a 'Pop up' dementia IPU room that could be refurbished with dementia friendly colours, bright eating utensils, reminiscence boxes were given to people and the nurse office's glass had been replaced to non-reflective glass which was more soothing to some people living with dementia. This had ensured if people living with dementia were admitted to the IPU the environment would better suit their needs.

All staff have received dementia training and the hospice had appointed an admiral nurse which is a specialist dementia nurse to provide practical, clinical and emotional support to people living with dementia, their families and staff to help plan their EOL care. The hospice provided training to local nursing and care homes and home care agencies to develop their knowledge and skills to more appropriately support elderly people at the end of their lives. The hospice worked creatively with home care agencies to enable their staff to attend training by swapping staff so that the Hospice Care at Home staff covered the agency's care calls whilst their staff attended training. We heard examples of how the hospice community staff had supported people living with dementia to plan their EOL care and worked with their care providers to prevent inappropriate hospital admissions. People living with dementia had been supported to die in familiar surroundings supported by staff that knew them.

The hospice worked pro-actively with their local acute hospital to ensure people who wanted and could safely receive EOL care at home or in the IPU were identified promptly and transferred from hospital without delay. A EMH team worked full time on the local hospital site, supplying training and advice to fellow professionals and supporting people through consultation. In this way the hospice enhanced the EOL care people received in the hospital and also responded more effectively to people's wishes about where they wish to be cared for. When people were waiting to be transported to the IPU from the hospital it was not always clear when transport would be available to take them to the IPU. There was a risk that if they were transported after hours a hospice doctor might not be at the IPU to admit them which would delay their admission. The hospice's doctors worked creatively to ensure people could be admitted to the IPU by visiting them at the hospital on the day of their discharge and completing all the required paperwork and informing the IPU staff of the person's symptom management plan. This meant that people's hospice transfers were not unduly delayed as they could be admitted to the IPU from the hospital any time of the day or night and their EOL wished could be honoured.

The hospice was also flexible with their admissions criteria and we heard examples of people presenting at A&E at the end of their life due to for example, septicaemia. Where these people had expressed a desire to receive their EOL care in a hospice setting the hospice had accommodated their request. By considering each person's needs individually the hospice had provided care to people at the end of their life who would not traditionally qualify for hospice care and thereby responded to the needs presented by their wider community.

People and relatives told us they would feel comfortable raising concerns with staff if they had any. The

provider's complaints process was available to people and their representatives. One person told us "I have never had any concerns but if I did I would just talk to the nurse immediately".

Records showed the hospice had received twelve complaints and 172 compliments in the past year. There was a process for ensuring people's complaints and concerns were logged, investigated and responded to. The registered manager had told us the hospice had actively worked on creating an open culture and opportunities for people and staff to raise concerns. This included updating the complaints policy and leaflet; introducing Lessons Learnt sessions to review complaints and incidents and 'Tell us your experience Just One Thing' forms to make it easier for people to provide feedback. We saw the provider had analysed the themes of the complaints and concerns received and used this information to improve the service. For example, they had improved the management of patient files and put systems in place to improve the service provided to people in the community when hospice staff and other care agencies both provided care to people. People's complaints had been dealt with in accordance with the provider's policy and action taken as a result was used as an opportunity to improve the service for people.

Is the service well-led?

Our findings

Staff, people and their relatives had high praise for the way the service was run. One person told us "This is the best thing that has ever happened to the IOW and it has really improved since the new manager came". Staff comments included; "The management is really inspiring. The registered manager has really good vision, we do things together and everyone is really involved", "The sister and deputy sister are really organised", "I am made to feel part of a team and really valued" and a student nurse said, "It's a real privilege to be here". Staff we spoke to understood the values of the hospice and were able to describe how these influenced their work. One person told us "Everybody that works here knows what it is like to be kind, compassionate and respectful".

The provider placed a strong emphasis on continually striving to improve the hospice with input from people who used the service, their relatives and staff. The hospice regularly evaluated their systems for gathering user feedback to ensure they would remain effective. They had identified that alongside their routine surveys and feedback cards, a system was also required that would encourage people to provide suggestions because it was easy and could be completed on the spot. The innovative "Tell us your experience – Just one thing" had been introduced across the IPU, JCC and in the EMH shops. It was available in paper copy and on the website. This form gave an opportunity for people to tell the hospice 'just one thing' that would have improved their stay or experience and to give feedback about a member of staff or volunteer who made a real difference. Following people's feedback additional hangers had been sourced for the IPU wardrobes, a baby changing facility had been installed, opening hours of the JCC had been extended and additional shower rails had been installed in four en-suite bathrooms.

The hospice also worked creatively to enable people to articulate their experiences about dying. A film had been created to provide a platform for people to address the positive need for different kinds of images to portray end of life, which reflect changing attitudes to death. One staff member told us "This film will be screened internationally and really gave people an opportunity to define death on their terms". People's stories had also been written up and put on display in the EMH shops. The registered manager told us "It is important that even in our retail section we put the experiences of people at the centre of what we do".

Staff told us that their views mattered and that they felt able to influence the service. An outstanding example of enabling staff to contribute to personal and hospice development was the bespoke 'Well-led: Leading from the Middle' programme designed for middle managers across the organisation. We saw this project had empowered staff to work on operational challenges and creatively deliver tangible outcomes for the hospice. Projects that were implemented following this project were for example, 'Reduce, Reuse, Recycle' which explored ways to create a revenue stream from recycling activities, '50 Shades of Volunteering' which developed a strategy for volunteer services at EMH including an innovative programme to expand the volunteer role to encompass the workforce available at the local prison and a project that developed closer community involvement with the JCC through the hosting of concerts, art groups and other community events. Staff told us how they had grown in confidence following this programme. One nurse told us "We would not have had the new re-enablement team if it was not for this programme. We were all able to make our suggestions and it is so satisfying to see these projects happening for people".

Staff and volunteers had also been involved in a project to develop the values of the service and agree the expectations and behaviours which underpin these values to be monitored during staff appraisals. The managers were forward thinking and worked creatively with local services to respond quickly and creatively to the changing needs of their community and to enable the implementation of national good practice guidelines. We saw many examples of how the hospice had put their values of being 'innovative and bold' and 'respecting our community' into action. For example, the hospice had created two more IPU beds to support more people to receive hospice care when the local hospital experienced bed pressures. They developed a Rapid Response Team so that people could be discharged home from hospital without delay and established the Care at Home team which meant that people living on all parts of the island could have access to a care service at home. The hospice implemented an innovative nurse-led approach for the IPU which saw five beds for people without complex symptoms being managed by the nursing staff. This enabled more medical time to be deployed in the community to keep people with more complex needs within their home if this is their preferred place of care. EMH had twinned with a hospice in Cyprus around education and best practice. Hospice staff from Cyprus had visited and EMH staff will be going over to train their staff. The hospice in Cyprus had a nursing home attached to their hospice and EMH were going to see how this was managed and whether a similar care arrangement would meet the needs of the IOW population.

The registered manager understood the improvements that needed to be made across the hospice. The provider had an array of systems for auditing and reporting to ensure a high quality service delivery. This included, but was not limited to, patient safety and quality, medicines management, reports to the board of trustees and Earl Mountbatten Hospice's Quality and Governance Committee. We had sight of a range of governance reports which demonstrated how the service was scrutinised and how safety was being monitored and reported effectively. This showed a transparent organisation that had clear links of accountability from the 'floor to the board'.

Information on matters such as infection control, falls prevention, medicines incidents, staff recruitment/competencies, complaint management, safeguarding and finances were known about by those responsible and accountable within the organisation. Effective methods of communication were in place as well as systems to address any matters arising. Medicine audit results were discussed at medicines optimisation team meetings and were reported to management. We saw minutes from meetings and action plans outlining projects to enhance patient care. For example, improving access to medicines for people cared for by the community team. Clinical staff had produced clinical guidelines to ensure the safe and effective use of medicines administered via syringe drivers (devices used to administer injectable medicines) and palliative medicine symptom advice guidelines.

Services provided by the hospice were continuously reviewed and improved to ensure they met the needs of the community as a whole. For example, EMH provided Lymphoedema Services across the whole of the IOW for palliative and non-palliative conditions. A full review was carried out and significant service developments and improvements have been implemented as a result. For example, regular Manual Lymphatic Drainage clinics had been set up to enable people to follow a six week course of treatment. Future developments include developing a proposal to fund enhanced staffing levels and training for the Lymphoedema Specialist to prescribe hosiery directly for patients.