

The Martlets Hospice Limited

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Inspection report

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Ratings

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

Summary of findings

Overall summary

The Martlets Hospice is a local charity that provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families in the Brighton, Hove and Havens area.

They deliver physical, emotional and holistic care through teams of doctors, nurses, counsellors, chaplains and other professionals including therapists and social workers. The service cares for people in two types of settings: at the hospice in an 18 beds 'In-Patient Unit', or in their 'Hospice at Home' service where a team of nurses and nursing auxiliaries offer specialist, short term end of life nursing care for people in the comfort of their own home. In addition, The Martlets Day Services provide therapeutic support for patients and their carers who are living at home, and aim to maximise their independence and quality of life. Services are free to people and the Martlets Hospice is largely dependent on donations and fund-raising by volunteers in the community.

This inspection was carried out on 21 and 22 December 2015 by three inspectors and two pharmacist inspectors. It was an unannounced inspection.

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

The services provided include counselling and bereavement support; outpatient clinics; occupational therapy, physiotherapy, chaplaincy and volunteer services that include approximately 500 volunteers.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or 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 references.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. Plans in regard to all aspects of their medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people according to their

individual plans.

The environment was well designed, welcoming, well maintained and suited people's needs.

Staff had received essential training including end of life care and were scheduled for refresher courses. Staff had received further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and an annual appraisal. This ensured they were supported to work to the expected standards.

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 as per the Mental Capacity Act 2005 requirements.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences, restrictions and reduced appetite.

People's feedback was actively sought and acted on. People and relatives were very positive about the quality of service they received. They told us they were very satisfied about the staff approach and about how their care and treatment was delivered.

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 individual communication needs and treated them with genuine kindness and respect.

Staff approach was kind, compassionate and pro-active. They often went beyond the scope of their duties to meet people and their families' needs. People's testimonies included, "Anything big or small they will do it for you" and, "Being here has been an enjoyable experience for me even in these circumstances because the staff are so fantastic". A relative said, "There are no adequate words to describe how wonderful all the staff are in this place, they have become our friends in times of great need."

Clear information about the service, the facilities, and how to complain was provided to people and visitors. 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.

The registered manager was open and transparent in their approach. They held a vision for the service that included, "Helping our patients make the most of whatever time they have left; providing person-centred care." They told us, "We are all very passionate about ensuring everyone has a dignified death, has their wishes respected and their families are well supported through the process."

Comprehensive audits were carried out about every aspect of the service to identify how it could improve. When needs for improvement were identified, remedial action was taken to improve the quality of the service and care. The service worked in partnership with other organisations to drive improvements.

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.

Practices regarding the storage and administration of medicines were in line with current controlled drug legislation.

Robust and safe recruitment procedures were followed in practice.

The environment was secure and well maintained.

Good 

Is the service effective?

The service was effective.

Staff were trained appropriately and had a good knowledge of each person and of how to meet their specific support needs.

The registered manager understood when an application for DoLS should be made and how to submit one. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

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

People were referred to healthcare professionals promptly when needed.

Good 

Is the service caring?

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

Outstanding 

They told us, "This is an outstanding place to be, absolutely exceptional staff" and, "The care is second to none, the staff go the extra mile as a matter of course".

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 and pre-empted people's emotional needs.

The service was very flexible and responded quickly to people'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.

Is the service responsive?

Good ●

The service was responsive to people's individual needs.

People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in line with people's care plans.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Good ●

The service was well-led by a management team who placed people and staff at the heart of the service. There was an open and positive culture which focussed on people.

The staff told us they felt supported and valued under the registered manager's leadership.

There was a robust system of quality assurance in place. Comprehensive audits were carried out to identify where improvements could be made and action was taken promptly as a result.

The Martlets 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 carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was carried out on 21 and 22 December 2015 and was unannounced. The inspection team consisted of three inspectors and two pharmacist inspectors.

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 had not been asked by the CQC to provide a current Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However we collected the relevant information which we looked at during our inspection.

We looked at the premises and equipment. We looked at 15 sets of records that related to people's care and examined three people's medicines charts. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff recruitment, training and management, and records relevant to the storage, ordering and administration of medicines. We looked at checks that were carried out concerning the monitoring of the 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 six people who stayed in the In-Patients Unit, eleven of their relatives and six volunteers. We also spoke with relatives of four people who received support from Hospice at Home in the community.

We spoke with the registered manager, the medical director, the nurse who was the development and quality lead, the counselling and bereavement manager, a social worker, six members of nursing staff, four care workers, the chef and kitchen staff, two members of learning and development staff, and a team leader in the Hospice at Home team. We spoke with the Partnership Service manager who was working in the service, employed by the NHS Community Trust. We also spoke with three managers of care homes where

the Hospice at Home team was providing support and advice, and three district nurses who oversaw people's care in the community. We obtained their feedback about their experience of the service.

At our last inspection on 25 September 2013 no concerns were found.

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "There is a good number of nurses", "This is where I can get the proper treatment and meds to manage my illness" and, "There is staff always at hand, ready to help, and this makes me feel safe and secure." Relatives told us, "I feel my mother will be completely safe here" and, "This is the safest place for our relative to be, we know there is an amazing team of staff ready to step in at any time and this is really comforting to us."

Staff knew how to identify 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. This was complemented by annual training and refresher courses which were up to date. Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. Two members of staff told us, "We discuss any concerns straight away within our team and will refer to the local authority if we have any doubt that abuse of any kind is taking place" and, "Our patients' safety is our priority."

There were sufficient care staff on duty, to support and care for people in the In-Patient Unit, and Hospice at Home Service. Staff told us there were enough staff to care for people in the way they needed and at their preferred times. Staffing rotas indicated that staffing levels met people's needs and staff confirmed that they were always able to have additional support if required. They told us, "We do not ask lightly but when we ask for additional support it is always given." Additional support was introduced when necessary, for example additional morning and evening shifts had been put in place due a patient's needs.

The team of doctors that included the medical director and four consultants in palliative care worked across all services and visited people in the In-Patient Unit, in the community, in out-patient clinics or in hospitals. There was a 24 hours support telephone line that was manned jointly by the clinical nurse specialists and the Hospice at Home nurses. This was used by people, their relatives, community nurses and other healthcare professionals. A consultant in palliative care was consistently available for further advice if needed.

Safe recruitment procedures were followed. Criminal records 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 that they were suitable to work with people. These checks also applied to volunteers and therapists. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and were obtained from their most recent employers. Regular checks of staff professional registration were carried out to ensure this did not expire.

Disciplinary procedures were in place to ensure staff respected their code of conduct. There was a detailed process in place to manage staff performance issues which was included in staff handbooks. Senior

members of nursing staff were knowledgeable of the procedures to follow and appropriate steps were taken by management to keep people safe and ensure good standards of practice were maintained. 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. These were reviewed daily by nurses and were updated appropriately. Staff were aware of the risks that related to each person. Risks associated with people's skin integrity and levels of mobility were assessed as soon as they came into the in-patient unit and no later than within six hours. There were risk assessments carried out for several people who were at risk of falls due to their health condition. These assessment contained guidance for staff about how to promote their safety and this was followed in practice. This included specific manual handling, angles at which limbs may be elevated, reviews of people's medicines or of their timing and placing pressure mats in their room to alert staff when they moved independently. Control measures to minimise risks to people included the provision of specialist equipment and instructions to staff to work in pairs when necessary.

Staff ensured that people had their call bells within easy reach so that staff could respond when they needed help. All the relatives we spoke with commented on the speedy response from the staff when people called for help. They told us, "My wife rings the buzzer and the staff are here in a flash", "They are so quick at answering the bells" and, "Within 20 seconds of pressing the buzzer someone is here to help." Therefore measures were in place to keep people as safe as possible.

We spoke with staff at the hospice about how medicines were managed. We saw patients' own medicines and stock medicines were kept securely. Appropriate arrangements were in place for ensuring medicines were not used past their expiry date. We saw detailed, clear records of medicines which had been ordered and received by the hospice. Emergency medicines and oxygen cylinders were available, in date and stored appropriately. Waste medicines were stored securely and disposed of appropriately.

Controlled drugs (CDs - medicines which are at higher risk of misuse and therefore need closer monitoring) were stored securely. Destruction of controlled drugs was undertaken and recorded appropriately. We saw written evidence that staff conducted balance checks of controlled drugs. High strength preparations of CDs were kept separately from other strengths to help prevent incorrect selection. Blank prescription forms (FP10s) were stored safely in two secure locations. A record of the number of pads that were stocked was kept, and there was a system in place to record their start and finish serial numbers to keep track of who prescribed the medicines and who they were issued to. Alerts that originated from The National Patient Safety Agency (NPSA), a special health authority that monitors patient safety incidents including medicines, were acted on.

We saw that temperatures for the fridge in the clinic room were regularly monitored and recorded. There was a new system in place to re-check temperatures after temperatures had altered every time the fridge had been opened. Prescribing was undertaken by in-house doctors with consultants also visiting the hospice to see patients three times per week. Processes were in place to ensure that medicines for management of pain were administered in a safe and timely manner. We observed a conversation between two staff nurses about the pain experienced by a patient and the action they planned to take to relieve this. We also saw two trained nurses safely prepare a syringe driver for a patient (a system which allows medicine to be administered by slow release over a period of 24 hours). Staff also had good access to up to date resources which they may need for medicines administration, including guidance on the use of a syringe drivers. Staff were able to clearly explain information patients are given about unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms).

We checked prescription and administration charts for three patients. We found that these were fully completed, inclusive of pain assessment charts and patients' allergies. The hospice had effective processes in place to allow patients to take out medicines safely when on day leave.

We spoke to staff about training and were able to view training records and assessments of medicines administration competencies. In addition to this, an up to date list of staff who were signed off as competent for administration of medicines was kept in the clinic room for a quick reference guide.

Prior to the inspection, the hospice had undertaken its own audit of medicines in November 2015. There was already evidence that the majority of suggested changes had already been actioned, and others were in process of being implemented. We also viewed a full audit cycle on medical gases which showed that improvements had been made as a result. Any medicines related issues were well communicated with staff, including oral briefings, through a medicines management group, bulletins and letters sent home.

There was an effective system in place to ensure people remained as safe as possible from the risk of acquiring an infection. Staff were trained in infection control and were aware of who the infection control lead was should they need further advice. There were robust infection control policies in place that included cleaning, staff protection and the management of infectious diseases. Regular infection control audits were carried out to monitor staff practice and ensure risks of infection were minimised. Staff were knowledgeable about how to manage a possible outbreak of infection and described the appropriate steps they had taken to prevent a person's infection from spreading to others.

The premises were cleaned to a high standard and records were kept to evidence frequent cleaning throughout the day. A relative told us, "This place is always absolutely spotless." . There was ample provision of personal protective equipment which the staff used throughout the day. Staff washed their hands appropriately, and guidance about hand washing was on display throughout the service. Alcohol gel was available outside every room and used by staff and visitors. Systems in place for the segregation of laundry and the management of waste were implemented appropriately. The kitchen was also cleaned to a high standard, and cleaning schedules were followed at the beginning and at the end of each staff shift. Food was appropriately stored in the fridges, freezers and pantry. The temperatures of served food, fridges and freezers were monitored and documented. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks, loss of electricity, severe weather and staff shortage. This included clear guidance for staff to follow. Staff understood how they should respond to a range of different emergencies including fire, and fire training was part of their induction. Staff took part in regular fire drills which helped them to remember the procedures and there was appropriate signage about exits and fire equipment throughout the home. Fire safety equipment had been serviced and was regularly checked. People had personal plans that included information about how they were to be supported by staff in the event of an evacuation of the premises. These plans were located in dedicated places and staff knew where to locate these plans in an emergency.

Throughout the service, fittings and equipment were regularly checked and serviced. 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 a maintenance manager, two staff and an apprentice. The premises were secure for people due to a robust security system in place. Visitors were signed in and out and their identity was checked. A close circuit camera system allowed staff to monitor who entered the premises. Key fobs were used to access different parts of the building. Staff monitored peoples'

whereabouts while maintaining their privacy, to ensure they were safe and able to call for help if needed.

Is the service effective?

Our findings

People said the staff gave them the care they needed. Three people who stayed in the In-Patient Unit said, "The nurses really know what they are doing" and, "The nurses communicate in plain and clear English" and, "Every member of staff, whether it be the nurses, the assistants, the ward clerk, the kitchen and the housekeeping staff are so efficient at their job." Relatives told us, "The staff are well trained, they appear to be very confident and competent" and, "The communication here is very good, we are kept well informed." People commented positively on the quality of food that was provided, they described it as "Very good indeed", "Well presented and hot". The feedback that had been collected from people in the last food satisfaction survey was very complimentary and included, "Exceptional" and "Excellent." Two district nurses who oversaw people's care in the community told us, "The Hospice at Home team are very effective, they provide consistent specialist care and communicate well with the person in their home and all other parties involved" and, "We work well together."

Staff knew how to communicate with each person and understood their individual needs. A person was not able to communicate verbally and was not fluent in English. Their relative had been able to interpret. The service had access to an interpreting service should there be no relatives to help. Staff talked with people ensuring they were positioned at eye level to facilitate effective communication. When people were feeling unwell, staff used a gentle tone when they spoke and appropriate touch to communicate their empathy. We observed how staff communicated with a person whose speech was impaired and noted how staff allowed plenty of time for the person to express themselves and checked that they understood them correctly. One person told us, "I got to know the nurses well; we have a good connection and we have a laugh together, sometimes laughter is the best medicine."

Staff shared information about people's care following a 'ward round' in the In-patient Unit. The medical director talked with each person on the In-Patient Unit and discussed their options with them. They then reported their findings with a team of doctors and ascertained the best way forward to manage people's symptoms. There was a system of frequent and scheduled staff handovers throughout the day to ensure continuity of care between staff shifts. Additionally there were weekly multi-disciplinary meetings to review each person's care and treatment to ensure it remained appropriate and discuss how to ensure people were safely discharged when they wished to return home, or access other residential services. This system ensured effective continuity of care and that staff were knowledgeable about people's individual care, treatment and relevant updates. Staff also used a communication board in the meeting room to remind each other about particular tasks, for example about hearing aids checks and supporting people to attend a weekly drop-in hearing aid clinic run by volunteers.

New care and nursing staff had a thorough induction before they started working at the service. A suitable induction programme was used and a booklet was available for nurses that included information about relevant practical skills such as catheterisation. The induction included the shadowing of more experienced staff until they could demonstrate they had attained the level of competency required for their role. Competency checks were carried out to ensure that staff were competent to manage and administer medicines.

The Learning and Development team had implemented ways to render their system of induction and training more effective. For example, they had filmed the induction programme to ensure this could be made available to new recruits at short notice. They were exploring how to make their online portal available to new recruits as soon as their position was confirmed. This would provide instant access to staff handbook that contained comprehensive information about the code of conduct and standards they were expected to uphold and make a start on their online training. The learning and development team had worked effectively to improve the computer literacy skills of their staff through the use of a dedicated website.

Staff had appropriate training and experience to support people with their individual needs. Staff were provided with essential training that was up to date, and an effective training matrix system identified whose training was due to be renewed so staff were scheduled for refresher courses. There was a 'blended model' in place, such as a mix of online training and face to face training. Training included training on bereavement and palliative care.

Staff were supported to complete appropriate vocational qualifications. Records indicated 98% of staff had completed relevant qualifications while in employment and other staff were enrolled to start their studies. Five members of staff were studying to gain a degree in palliative care at the local university.

The Learning and Development team collected feedback from staff about their training to ensure this was meeting their needs and identified any improvement needed. The staff we spoke with were enthusiastic and positive about the range of training courses and study opportunities available to them. They told us, "The training is really, really good; it covers what we need to know and we are encouraged to ask for extra training on anything", "We are given opportunities to progress", "We get so much support here, we learn loads from the doctors and the training." An annual appraisal of staff performance was scheduled for all staff to ensure expected standards of practice were maintained.

One to one supervision sessions for staff were regularly carried out in accordance with the supervision policy. Staff training and support needs were discussed at supervision. A member of staff said, "I have never had clinical supervision like it, it is very thorough." Every other day, opportunities for reflection were provided so staff could reflect with their team any practical or emotional issues they had encountered and share their experience to learn from each other. A member of staff told us, "We have time for reflection at the end of each handover; this is built into the daily practice." A staff counselling service was available to provide support when required. This ensured that staff were appropriately supported to carry out their role and care effectively for people.

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.

The registered manager demonstrated a good understanding of the processes to follow. Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. When people had been unable to leave unaccompanied and needed continuous supervision to ensure they

remained safe, their mental capacity had been assessed appropriately. When applicable, authorisation to restrict their freedom in their best interest had been sought with the DoLS office. The registered manager had considered the least restrictive options for each individual.

Consent was sought, obtained and recorded before any aspect of people's care and treatment was carried out. When people declined, this was respected. A person told us, "Everyone always asks me if I consent before they do anything." When people were unable to express their consent or refusal, their mental capacity was assessed appropriately and meetings were held to discuss people's best interest with legal representatives and other parties involved with their care. The purpose of such meetings is to explore options and make a decision on the person's behalf as per the requirements of the MCA. All documentation relevant to people's mental capacity was appropriately completed to evidence in detail the decisions that had been reached. With such system in place, people could be confident that correct processes were followed by staff to protect their rights and act in their best interest.

People told us they were very satisfied with the quality of the food. Their comments included, "They pay attention to how it is presented on the plate and it is always nice and hot", "Always very good" and, "They know I have problems with certain food and they avoid it." People who remained in bed had a jug of water or juice of their choice that was within reach and replenished throughout the day and night. Meals were prepared using fresh ingredients and included plenty of fresh fruit and vegetables. Menus were planned with the input from a nutrition group that was led by a ward nurse. They were presented to people every day to allow them to choose their preferred meal. They always included a vegetarian option and desserts were served with both lunch and supper. Staff in the kitchen told us there were choices available outside of the menus. A person had changed their mind about their lunch and had been presented with alternative options. Food was available in the communal kitchen overnight and staff confirmed that additional food was readily available. One member of staff said, "Patients could eat or 'graze' all day if they wanted."

Recommendations from the speech and language therapists were followed and the chef was knowledgeable about people's individual dietary requirements, preparing soft diet food or pureed meals when people had difficulties with swallowing. Staff had time to help people to eat and drink effectively and people were supported with eating and drinking when they needed encouragement.

The premises had been designed and decorated taking people's physical and psychological needs into consideration. They were spacious, well-lit, and decorated in calming tones. Corridors were wide, with handrails to help people move around when necessary. All doors had been designed for easy access by people in wheelchairs. The reception was welcoming with a café area and facilities for refreshments. The attractive gardens that surrounded the premises were maintained to high standards by volunteers. It included ample seating areas for people to relax in. All bedrooms in the In-Patients Unit were spacious, had attractive views, were well equipped and specifically designed to provide a calming environment. There was communal space available where families could spend time together. There was a shop within the building and we were told by staff that this was popular with patients. There were single rooms available when needed although people had the option to share a bay with three other people if they preferred company. The registered manager told us how people were accommodated in single rooms when their needs were complex and/or when they needed more privacy and one to one nursing support. Facilities were available for family members to stay overnight if they wished. Such an environment had been designed to promote an atmosphere of calm and comfort where people may be able to unwind and relax effectively.

People were referred to healthcare professionals when necessary. For example, before a person had returned home, the service's occupational therapist and physiotherapist had visited their home to assess what equipment and adaptations may be required and ensure this was provided. People were referred

appropriately and without delay to consultants such as neurologists and oncologists, to hospital specialist teams such as chronic pain team and a fall prevention team. This ensured that staff responded effectively when people's health needs changed.

Is the service caring?

Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were overwhelmingly positive. People told us, "This is an outstanding place to be, absolutely exceptional staff", "The care is second to none, the staff go the extra mile as a matter of course", and, "I could not be in a better place, the staff are simply sensational." People's testimonies included, "Anything big or small they will do it for you" and, "Being here has been an enjoyable experience for me even in these circumstances because the staff are so fantastic". Relatives told us, "The staff have supported our whole family with great understanding and compassion through the difficult times and long afterwards, and have made our grieving process much more manageable than I ever expected" and, "There are no adequate words to describe how wonderful all the staff are in this place, they have become our friends in times of great need." A specialist nurse, external to the service, who visited the service regularly told us, "All the staff in this hospice have the right skills and they genuinely care, it is not just a job for them."

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

Staff were given enough time to get to know people who were new to the service, and read through their care plans that included risk assessments and a spiritual and psychological care plan. All the staff we spoke with were knowledgeable and understanding about each person's individual history, likes, preferences and needs. Staff were attentive to people's individual needs, focussed on what was important to people and paid attention to their emotional state. Care plans included recommendations to staff to practise active listening, identify cause of spiritual distress or psychological problems and offer a range of interventions. These were applied in practice. A person told us, "The staff realise straight away if I get anxious, and we do breathing and relaxation techniques." A person had formed a deep attachment to their pet goldfish and had expressed their concerns about what would happen to the pet after they had passed away. The staff had written an individualised care plan for the pet that covered all its needs and had presented the person with options about the pet's safety and relocation in the future. Information about how important this was for the person had been discussed at multi-disciplinary team meetings. A relative told us how staff always ensured that linen was matching in people's rooms. They said, "Little touches like that shows they realise how details are important when you are feeling ill."

People valued their relationships with the staff team and told us that they often went 'the extra mile' for them, when providing care and support. As a result people felt really cared for and that they mattered. A person told us how a bed was purchased specifically so they could sleep close to their loved one in the same room while they approached the end of their life. A person's beloved dog was allowed to remain sleeping on their bed over the fortnight that preceded the end of the person's life. The staff had accommodated their routine to include meeting the pet's needs. Another person had requested their two dogs to stay with them over the Christmas period and this has been accommodated. The staff told us, "Whatever it is that people wish for, we do everything we can to make it happen."

The relationships between staff and people receiving support consistently demonstrated dignity and respect at all times. A nursing assistant had stayed with a person who had no family, and additional staffing was put on shift to allow this to happen. The nursing assistant told us, "I made a promise to this person that we would be there with him until the end; it was important to him that a familiar face stayed with him therefore it was important for me to be there and support him; I stayed, gently talking or stroking his arm so he knew he wasn't alone; I stayed as long as was needed, and it was peaceful; we respect patients' wish to die as they wish to and we maintain their dignity to the end; it is why I do this job." With such caring approach from staff, people could be confident that staff spent time with them when needed and had genuine concern for their wellbeing.

Family support was recognised by staff as vital to people's wellbeing and staff strived to meet the emotional needs of people's relatives and families. A nurse told us, "We look at the whole person, not just the illness, and do not just focus on the person but also on all their family as one unit; we understand how they feel because we are very experienced with the process of death and all the associated feelings, our job is all about providing a dignified and peaceful death and make the journey easier for the person and their family." A member of staff had ensured a person was wearing a shirt that their spouse had purchased when they approached the end of their life, as this was important for the relative.

Where necessary, staff supported people and their relatives to regain their personal strengths, to help them cope and come to terms with illness or death. A family support team comprised of a chaplain, a counselling and bereavement service manager, a social worker for the In-Patients Unit and the community, three counsellors who worked part-time, an administrator and several trained bereavement volunteers. This support was provided in house as well as in the community. On-going support was tailored to individual needs and was provided before and at least six weeks after people's death. This period could be extended if support was needed for a longer time. The counselling therapy that was offered extended to people's relatives including children, to help them come to terms with loss and bereavement. A bereavement meeting was organised within 48 hours after a person's death for families, providing an opportunity to pass on practical information, address concerns and assess coping mechanisms. Therefore the service provided emotional support for families that was continual, beyond the provision of care for people.

People's relatives were invited to 'a time to remember' meeting six months after the death of their loved ones for a remembrance service. One person told us, "This was really appreciated, we looked forward to that specific time where it was all about remembering our relative." At Christmas, gatherings were organised by the service in local venues where families could light a candle, reflect, and find comfort from others. Attention was paid to people's spiritual needs and chaplaincy support was available to people 'of all faith and no faith', which means that it was accessible to all. There was a dedicated room titled 'The Sanctuary' where relatives could pin stars on a tree where they could leave messages for their departed relatives, and write in a memorial book. Religious services were held there and a member of staff told us this was a quiet place where relatives could pray, reflect and reminisce in peace.

Reading material was recommended to parents to use with children, to promote their involvement in the therapy process. The counselling and bereavement manager showed us a booklet that was provided to parents when they needed help with managing their children's emotions. It included 'balancing hope and honesty'; 'riding the emotional rollercoaster'; 'preparing for change'; 'living for today' and 'practical ways to support children' about expressing emotions, coping with separation and night-time worries. This enabled parents to appraise situations through a child's perspective. Testimonies from relatives who had received support from the staff included, "They gave me strength to cope and the opportunity for me and my children to attend counselling sessions which was invaluable" and, "All the staff showed empathy beyond kindness, we felt they were with us all the way through and remained with us long afterwards until we felt we could manage by ourselves."

The service also focused on people's wellbeing and had developed innovative ways to support and help them practically. It recognised that people and relatives may face practical problems as well as emotional distress such as financial difficulties, or concerns about children's wellbeing. As a response, the service employed a registered social worker who visited people in the community and provided practical support and information. This included housing support, accessing care services, making wills and testaments, how to 'get affairs in order' and how to support children. The social worker also acted as an advocate when necessary and had helped arrange for a visa application when a family member had wanted to come from overseas to visit their loved one. In certain cases the social worker also referred people or their relatives to specialised therapists in a local county hospital. They told us, "Sometimes families are overwhelmed with the steps that need to be taken, the forms to be filled, which authorities to contact, and we take them through all this step by step and help" and, "We offer psycho-social support and help people address any worries they may have and plan for the future, practically and emotionally". The service also provided welfare clinics where people could access advice about specific welfare benefits.

Visitors were welcome at any time and relatives were able to bring people's pets to visit their owners in the service, to bring them comfort and lift their spirit. Such measures ensured that people could retain and find comfort in routines that were familiar to them.

The service took account of people's cultural and religious needs. In the Hospice at Home team, care workers took care to remove their shoes before they entered the home where a person of Muslim faith lived. The service had understood the importance for a burial to be carried out within 24 hours for a person of Jewish faith.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. This included a 'Patient information guide', the range and nature of services available, and how the service had formed a partnership with the local NHS Trust to provide a 24 hour telephone advice line and visiting service in the community. A wide range of leaflets was displayed in the service that included how to complain, information about spiritual care, coping with loss, living through bereavement and controlling chronic pain. A booklet was available about 'preparing to say Goodbye' that outlined what to expect when someone was dying so that families and carers could be as informed as possible and better prepared to cope. All information was available in larger format upon request to help people who may have visual impairment. The service produced a seasonal newsletter 'Martlets Mail: care, compassion and support' that included news relating to the service, accounts of fund raising events, personal stories and an events diary. The service had an updated website that contained clear, comprehensive information and that was user-friendly.

Staff and management ensured that people had individual and inclusive methods of communication. Staff communicated effectively with every person using the service, no matter how complex their needs were. A

person had great difficulties conversing due to their illness and during the ward round, the medical director and doctors spent the necessary time to ensure they understood clearly the person's wishes and statements, and checked that they were understood in return. All staff ensured they were positioned so that good eye contact could be maintained when they addressed people and used appropriate positive body language to convey their empathy.

People were proactively supported to express their views and staff were skilled at giving people face to face information and explanations they needed and the time to make decisions. A person had wished to be discharged to their home and the service's occupational therapist and physiotherapist had gone to the home to assess the environment, the alterations and aids that would be needed and to check whether their return would be possible and safe. The doctors then had held a frank discussion with the person and had tactfully presented a range of options to the person outlining the positive and negative aspects of each option. As a result, the person and the doctors had reached a compromise that was satisfactory to the person whose ultimate decision was respected and facilitated. Staff liaised with other supporting services such as the Community palliative Care Team who are clinical nurses specialists in the care of people with life-limiting illness. These nurses were located on the premises so people could access this support quickly.

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. They often performed beyond the scope of their duties, pre-empted people's emotional needs and supported each other as well as people and their families. For example, when a nurse had remained with a person overnight to support them in their last moments, another member of staff had volunteered to work the next shift so that the nurse was enabled to rest and reflect afterwards. 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. One member of staff told us, "We get affected because we create real connections with people and their families".

People were given support when making decisions about their care and treatment and were fully involved with all relevant planning, from symptom and pain management to their end of life care. People were supported at the end of their life to have a comfortable, dignified and pain-free death and their wishes were at the centre of the service. 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. As staff demonstrated great understanding and empathy, people could be confident that their individual needs were met and responded to in a way that may exceed their expectations.

Each person in the In-Patient Unit had a symptom management action plan. Symptoms control and pain management were discussed with people before any new medicines were administered. During a 'ward round', a person had expressed the wish to be provided with a particular type of medicine to regain energy and the medical director and doctors had explored this possibility with the person.

All staff 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.

People were assisted with their personal care needs in a way that respected their dignity. A person told us, "Staff are ever so respectful." When people had physical examinations, the medical staff maintained eye contact with the person to assess whether they were in discomfort and responded to them accordingly. During handovers, 'ward rounds', and at staff meetings, staff spoke about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality.

Is the service responsive?

Our findings

People and their relatives told us that staff responded very well to their needs. People told us, "The nurses know me well and know all my history so they understand what I need", "I enjoyed the tea dances they organise; people dress up in period clothing and last time it was the 1950's, it was also a reminiscence session" and, "99% of the time there are enough staff to occupy us, we do not get bored because they do activities like crafts which is lovely."

People referred to the service had their needs assessed as soon as they came into the service for respite of for a longer stay. Newly referred people met with a member of the clinical team so that their individual needs could be understood. Personalised goals, frequency and length of their attendance were discussed and agreed on. Admissions to the In-Patient Unit ensured that people received a management plan of their symptoms, emotional and spiritual support, pain relief and specialist care. Comprehensive assessments of people's pain were carried out. This identified the pain's site, character, intensity, and what increased or relieved it. A relative told us, "It was such a relief to get the proper pain relief for X."

There were honest discussions with people about what they could expect and how the services available may support them. A person in the In-Patient Unit had planned to visit a friend in a town that was several hours drive away. Staff had enquired about the length of the drive, the comfort of the car passenger seat, where the person would be staying and had checked that they would be known to the local hospital should they need to be seen. They had prepared a cover letter that explained to the local palliative team the history and how to care for this person according to his specific needs. They had provided the person with contact details to use in an emergency. The person told us, "They thought of everything, they make sure that I am covered."

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the In-Patient Unit, and when people received support from the Hospice at Home service, 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. As people and staff worked as a team to ensure each support plan was unique and responded to specific needs, people felt valued and understood.

People were encouraged and helped to complete advance care plans to record their wishes regarding how and where they wanted their end of life care to be managed. People's care plans included strategies in regard to their pain and symptom management that were updated on a continual basis. For example during ward rounds, doctors updated the care plans on a laptop computer to ensure nothing was missed. The updates included changes in people's health and about how to respond when people experienced changes in their symptoms or pain levels. Discussions with people about their wishes and their consent about any changes in their treatment were recorded. A person was offered different options of pain relief and was supported to make an informed decision. They told us, "In the end it is always my choice and my decision." This meant that when people's pain increased they could be confident that responsive action of their choice was taken.

People's wishes were at the centre of their care planning. Staff were aware of people's care plans that clearly outline people's likes, dislikes and preferences. For example, they knew when a person preferred male or female care workers, a late breakfast, to wash in bed, or a specific routine. A person liked to have their curtains slightly drawn, another person had changed their mind and had requested to try a particular therapy, and these wishes were respected. People were offered the options to have a bath, a Jacuzzi or a shower every day and were able to request these at any times including at night time. A room was dedicated for smokers' use. Nurses visited people to find out about their choice of food for the day. People were able to eat in the communal areas or in their rooms if they preferred. One staff member told us, "Their wish is our command, anything we can provide, anything at all, we do it." As the staff approach responded to people's needs, they could be confident that staff understood what was important to them.

There were additional care plans that were updated hourly when people approached the end of their life, to monitor closely their comfort and respond to their changing needs. The care plans were centred on the individual, included food and drink, symptom control and psychological, social and spiritual support. Sensitive communication took place between staff and the person, and those identified as important to them. Therefore people's needs in the last hours of their life were met by well-informed staff who were knowledgeable about people's individual requirements.

People were consulted about what they enjoyed doing and were encouraged to get involved in the activities programme. Activities and therapeutic support was provided by the Martlets Day Services for people and their carers who were living at home with a serious life limiting illness. These free services were flexible and offered throughout the week. People could self-refer and attend clinics for acupuncture, physiotherapy and occupational Therapy. Light touch aromatherapy massage and reflexology were also available. The service had formed its own choir, titled 'Good Vibrations Community Choir' and people were encouraged to join workshops and weekly rehearsals. Activities were provided in the In-Patient Unit such as art therapy, a visiting pet dogs service, reminiscence sessions and listening to music. People could join the day services activities if they wished and when people did not wish to join activities and preferred to read, watch television or listen to music, this was respected. A shop was available at day time where people could purchase diverse items. A café where people could congregate and have hot drinks and snacks was open throughout the day. An Art Therapy Group ran courses of six weeks and provided an opportunity for people to paint, work with clay and make memory boxes. Events were celebrated by staff, such as birthdays, the Jubilee, Olympics, and staff dressed up occasionally to mark an occasion, such as wearing yellow at Easter time. A person told us how they had enjoyed a tea dance where people and staff had dressed up in 1950's and had reminisced.

The registered manager told us how people's families and friends were invited to visit them at any time. A relative told us, "I can come and visit my wife when I like; my son works night shifts and he can come around work." As visitors were welcome at any time of day or night, and as they were enabled to remain overnight with their family members if they wished, social isolation was reduced.

Links with the community were actively sought and maintained through a series of fundraising events. These included theatre productions, Zumba events, sponsored dog walks, memorial walks, midnight walks, and challenge events for people who were interested in cycling, trekking, running or swimming to raise funds. There were approximately 500 volunteers supporting the service. A volunteer told us, "This hospice brings everyone together, when we help or raise funds, there is a real feeling of us being a big united family." Such events improved people's experiences as they were actively included and connected with their local community. People were invited to subscribe to the service newsletter via the website and people could buy books or vintage items via the service's online shop.

Regular surveys were used to gather stakeholders' views of the service. The last survey had been carried out over a six months period and had a 42% response rate. The results showed consistently high levels of satisfaction with the service, the staff and the environment, and did not highlight any shortfalls. Staff were able to provide their feedback during involvement groups, and plans were in place to introduce a more effective survey system to obtain and collect their response. Some of people's stories and testimonials were displayed on the service's website.

Minor complaints had been received by the service since our last inspection. The complaints had been addressed promptly according to the service's policy and to a satisfactory outcome. One relative who needed to gain information and a better understanding of how their loved one had died had been invited to visit the service, speak with the staff, consult relevant documentation and obtain a sense of closure. The registered manager told us, "This was not just about responding to the complaint but also to meet this relative's needs."

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. People's feedback about the way the service was led described it as "Very well managed" and "It is obviously well managed because the staff seem happy and this hospice has such a good reputation." A relative told us, "We got to meet the manager who made us feel at ease straight away."

The registered manager was also the Director of Clinical Services and was part of a leadership team headed by the Chief executive (the provider). The leadership team also included a medical director, and three other directors in charge of finances, income generation and human resource.

We spoke with the provider and the registered manager about their vision and values about the service. The provider told us, "Our core belief is that everybody should be entitled to a dignified and pain-free death; We develop a strategy based on what patients and families want and need, with consistent high standards to ensure we provide the best care and support we can within a robust framework." The registered manager told us, "About 85% of our patients have Cancer and we work towards widening our reach to include 'non Cancer patients'; we help our patients make the most of whatever time they left; the care we provide is person-centred and we have a very cohesive team, we are all very passionate about ensuring everyone has a dignified death, has their wishes respected and their families supported through the process." From what people told us and our observations, these principles were implemented by all staff throughout the service.

Staff praised the provider and the leadership team for their approach and consistent, effective support. They said they could come to the provider or any of the directors for advice or help and that the directors welcomed their comments. One member of staff told us, "There is an open door policy, we are able to pop in any of the directors' offices at any time and we will be listened to." All of the staff we spoke with spoke very positively about the registered manager's style of leadership and told us they led by example. They described them as, "Really hands-on", "A problem solver" and, "Firm and fair but also very caring." They told us that they felt valued working in the service, and felt motivated to maintain high standards of care.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. The registered manager and medical director were very visible in the service and knew each person who used the service by name. The registered manager worked shifts in the In-Patient Unit and stepped in to deliver nursing care to people when there were unexpected shortages of staff. Members of the leadership team ensured continuity of management when this occurred. The registered manager and medical director took an active part in monitoring standards of staff practice.

The registered manager kept themselves updated with latest research that related to hospice care. They visited relevant websites daily and closely followed guidance from 'Hospice UK' regular e-newsletters. Hospice UK is a national charity for hospice care that produces a range of briefings for hospices on key policy developments, and works with them to make sure the voice of hospice care is reflected in policies and laws. As a member of this charity, the service had easy access to the latest information and intelligence

relevant to the hospice world. The service participated in joint research such as a research on patient outcome with the Sussex Community NHS Trust. They shared knowledge with other organisations, for example the local falls prevention team had been invited to spend a day in the service to exchange views on best practice.

The service worked in partnership with other organisations to ensure they provided a high quality service. The service had formed a partnership with the Sussex Community NHS Trust to form a joint service titled 'Palliative Care Partnership', which offered three types of services to people in the community when they had a life limiting illness and when they were on the Golden Standards Framework register. All organisations providing end of life care are expected to adopt a coordinated 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.

The Palliative Care Partnership offered a respite service, a 'Hospice at Home' service, and a community palliative care team service. This partnership meant that staff from the Martlets Hospice and from the NHS were working side by side and liaised effectively to provide the best care for people, in the right place, at the right time and by the right person.

Within the partnership, the staff used the same care records to avoid duplication of assessments and make sure information was shared by nurses and care workers as soon as it was updated. The partnership provided a single point of contact for people, 24 hour advice and support service through a manned telephone line, and a home-visiting service seven days a week. A Partnership Service Manager, employed by the NHS Community Trust, told us, "We work very well together, our collaboration ensure a 'seamless journey' for people." A team leader in the Hospice at Home service, employed by the Hospice, told us, "We have had this partnership now for two years and it is a great success." As a consequence of this partnership, people who received care and support in in their home could be confident that staff practice was cohesive and effective.

The registered manager involved the staff with the running of the service. Staff forum meetings called 'Involvement Group meetings' were held every two months. The meeting included staff representatives from each department of the service and managers attended upon invitation. All staff were encouraged to contribute to the agenda and comment about how the service was run. Any suggestions for improvement were communicated to the registered manager. No staff satisfaction survey had been carried out for the past two years; however there was a comments and suggestions box in the dining room that staff could use. The registered manager was looking into further formats to collect staff feedback.

There was a robust system to monitor the quality of the service. Monthly management meetings took place to discuss every aspect of the service, including staff training and policy and guidelines reviews. The policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated on a continuous basis. They were clear, specific to the service and updated on an on-going basis. A computerised system managed by the assistant to the Leadership Team 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.

There was a recording system concerning accidents and incidents that ensured relevant information was considered and analysed without delay. The registered manager was informed after these happened and action was taken to minimise risks of recurrence. Monthly and quarterly reports of accidents and incidents, and of near misses, were written and scrutinised at meetings that included the registered manager and senior nurses. There were meetings held every two months with a health and safety team and a clinical governance group to discuss each occurrence and other issues that may affect people in the service. The

nurse who was the development and quality lead was also the 'lead for falls' had organised a learning set for staff to improve their knowledge about falls.

Robust systems to identify how to monitor and improve the quality of the service were in place.

The Nurse development and quality lead monitored a comprehensive range of audits and reported to the registered manager. There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. These included audits on blood transfusion, medicines, dignity in care, health and safety, housekeeping, medical gases equipment, record keeping and infection control. There was an effective system to monitor the audits and ensure they were completed within a set time frame. Each audit included a recommendation when a need for improvement had been identified. For example, an infection control audit had highlighted the need for signage in relation to the segregation of waste and the cleaning of phones, computers and keyboards. Action had been taken to implement the recommendations.

Satisfaction surveys had indicated that people in the community were confused about who came into their home. As a result, a clear leaflet had been designed that will be provided to GPs, people and their families that explained staff roles, identity and responsibilities. A person had wished to go home for the last days of their life and was unable to eat or drink but wished to remain hydrated. This had led to a new policy being written, that provided guidance and procedure for staff to follow in relation to the administration of fluids through injections. The Nurse development and quality lead met other quality managers from other services quarterly to exchange views and discuss best practice. They told us, "I come back from these meetings 'buzzing' with new ideas; this is a great way to share knowledge and discuss what works."

All records relevant to the running of the service that we saw were well organised and reviewed regularly. All records were kept securely and confidentially. An electronic record system was in place to store and update data about people's care. A monthly group had been set up to communicate to each department how the system could be used to its potential. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.