St. Margaret's Somerset Hospice

St Margaret's Somerset Hospice -Yeovil

Inspection report

St Margaret's Somerset Hospice
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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?	Good
Is the service well-led?	Outstanding

Summary of findings

Overall summary

This comprehensive inspection took place on 9, 10 and 12 April 2018. The first day was unannounced.

We previously inspected the service on 22 August; 5 and 7 September 2016 and 6 October 2016. At the last inspection the service was rated as 'requires improvement' overall and requires improvement in three key questions; safe; effective and well-led. One breach of regulation was found at the last inspection relating to regulation 12, safe care and treatment. This was because people who used the service and others were not always protected against the risks associated with smoking and oxygen use.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe; effective and well-led to at least good." At this inspection we found the provider had followed their action plan and improvements had been made to ensure people were safe when using oxygen.

St Margaret's Somerset Hospice is a charity which provides a range of hospice services for adult patients with life-limiting illnesses or advanced progressive conditions and support for their families and carers. They provide a service for people with a range of conditions including cancer. Services include an inpatient unit (IPU) with 12 beds in Yeovil. This means the hospice are able to prioritise beds for those people with more complex symptom control or end of life care needs.

Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, physical, psychological and spiritual or complex end of life care needs or referral to other hospice services. The average length of stay was two weeks with some people being discharged home or to a local care home.

Most people are able to remain in their own home, supported by the community services. There are five community teams supporting people across Somerset, bringing the benefits of hospice care to those who can remain at home. 3800 people are supported across the Somerset community per year with an average of 300 on the community caseload at any one time.

The Sunflower Centre provides support for people who are well enough to live at home but would like the specialist support that St. Margaret's can offer during the day. The centre at Yeovil is open Monday to Wednesday from 9.30am to 4.30pm and provides emotional, spiritual and social support, symptom control and management, as well as a range of complementary therapies. Practical advice on nutrition, rehabilitation, finance and benefits is also available. Carers are welcome to attend as well.

Other services include physiotherapy and lymphoedema clinics. (Lymphoedema is a chronic long term condition that causes swelling in body tissues. It can be a primary or secondary condition). Bereavement and counselling service were also offered to people and their relatives or friends.

The service provides specialist advice and input, symptom control and liaison with healthcare professionals. The hospice has a 24 hour out of hour's advice line and central referral centre (CRC). One person reported , "It has been a great support to me…"

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

There is a second St Margaret's Hospice in Taunton which is rated outstanding. The two services work very closely together. Services are free to people, with St Margaret's receiving some NHS funding and the remaining funds are achieved through fundraising and charitable donations. The hospices are largely dependent on donations and fund-raising and are assisted by over 1200 volunteers.

The service was clear about their local demographic meaning they had an understanding of the community they served and continuously monitored how best the service could meet their needs. They followed national guidelines such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice and this was the aim of St Margaret's as much as possible.

People, relatives and healthcare professionals consistently praised the high standards of care, treatment and support provided by the hospice. Comments included, "We have had invaluable support from wonderful staff" and "All the staff I saw were highly experienced, extremely kind and gave me excellent advice; I couldn't ask for more".

The service was well managed. There was an open and transparent culture. This was evident from the incident reporting process and complaints process and how the service had responded to serious incidents. The senior management team demonstrated an excellent knowledge of the duty of candour. This was also evident when reviewing complaints and concerns.

There were robust systems in place to obtain feedback from people, their families and friends, staff and other health and social care professionals about the hospice. Feedback was overwhelmingly positive about this service.

The hospice played a leading role in promoting end of life care within the local community and developed strong links with many community groups. The service worked collaboratively with other professionals and organisations to improve end of life care within the county. Hospice staff worked closely with the local NHS Trust, GP's and community nurses when people moved between different services to ensure the transition was as seamless as possible.

Over the last two years, the provider has conducted a 'Fit for Future' review to help identify and plan a sustainable model for the future provision of services provided by St. Margaret's Hospice across Somerset. They engaged with the local community to improve public understanding and the ongoing development of the hospice.

The hospice participated with various research projects and used evidence-based practice and nationally recognised benchmarking tools to promote and sustain outstanding care.

Staff worked in a highly personalised and holistic way to deliver outstanding care to people. Staff had developed exceptionally positive caring and compassionate relationships with people. People were treated with sensitivity, dignity and respect. People said the staff were exceptionally compassionate, meeting their physical, emotional and spiritual needs. People's comments included, "The place is fantastic. Not at all how I imagined a hospice to be…" and "The staff are outstanding in every way. We trust them…." The occupational therapists and social workers at the hospice had won the Somerset County Council 'Care and Respect' team award for their contribution to excellent patient care.

Support for relatives and friends was an important part of the service provided. Relatives and friends had access to complimentary therapy, counselling and bereavement services. Relatives reported the positive benefits of these services. Comments included, "I received excellent bereavement counselling….very sensitive and understanding. My sessions were very enjoyable as it helped me to become strong inside…"

The service had a strong person centred culture and staff went the 'extra mile' for the people and families they supported. The whole team worked to fulfil people's last wishes where possible. For example, arranging weddings and blessings at the hospice; and special celebrations and outings.

People's emotional and spiritual needs were met by the excellent spiritual care, led by a spiritual care co-ordinator. The spiritual care co-ordinator explained the holistic model of spirituality which was not based on religion alone, but included the philosophy of mind, body and spirit. A 'sanctuary space' offered a neutral spiritual space, which was open to all. This quiet, peaceful space had small multi-faith symbols discreetly available to those who wished to use them for prayer or worship.

People were remembered and celebrated. An ornate celebration tree had been installed in the reception area which enabled relatives and friends to remember and celebrate their loved one. Each leaf had the name of a person cared for by the hospice team or the celebration of a special event for someone. One relative said, "I think this is a lovely touch and a way to remember people."

Without exception, the people we spoke with said they felt safe at the hospice or when using the community services at home. One person said, "I feel absolutely safe here. They attend to every detail…" and "The Staff make me feel very safe here, they spend time with me without rushing me…"

People received effective care and treatment based on best practice delivered by a highly skilled multi-disciplinary team. Staff received excellent training and support to ensure they had the knowledge, skills and competencies needed to support people's complex needs. Without exception, people and their relatives spoke very highly of staff and their experiences of the care and treatment they received, both on the in-patient unit and in the community.

Supportive suggestions and interventions by staff enhanced people's sense of wellbeing and quality of life. People had access to the multidisciplinary team in order to meet their health and care needs. For example, occupational therapists, physiotherapists, counsellors, nurse specialists, clinicians and spiritual support. There was a focus on people's rehabilitation and the promotion of their independence, led by the therapy team. People, including those living in their own home, were provided with equipment and adaptations in a timely way and taught techniques to help manage their symptoms to make life easier. People valued this support and described positive outcomes, leading to increased ability, confidence and wellbeing.

The hospice had improved end of life care for people living with dementia through staff training and by making improvements to the environment. Specialist crockery and cutlery assisted people with cognitive difficulties to eat and drink independently.

The catering service was provided ensuring people's nutritional needs and preferences were met. People had access to high quality food and drink, for as long as they were able and wished to. People were highly complimentary about the food; comments included, "The food is brilliant, I can have what I want and at any time…" and "The food here is very good, they give me anything that I fancy…"

The hospice provided valuable training and support to staff working with people with cancer and life limiting illness in various settings to promote knowledge and implement the principles of palliative care. Training and support was provided to local care home and nursing home staff. This meant people could receive high quality end of life care at the home. This helped to avoid admissions to hospital or the hospice and meant people could stay in their preferred place safely. A member of the local Clinical Commissioning Group (CCG) reported, "The Hospice have shown a real willingness to support nursing homes in delivering the best possible care by supporting them with education, resources, verbal and physical support." Feedback from the registered managers of these homes demonstrated a positive impact, with improved confidence and competency of their staff. One told us, "We have a valuable working relationship with them which benefits our residents…" Two hospice community staff had been awarded the certificate for 'outstanding commitment to practice based learning' by Plymouth University in recognition of their commitment to nursing students on placement with the community team.

The premises had been purpose built and the environment was light and airy with excellent facilities for patients and their relatives and friends. This included a spacious well equipped flat, which relatives could use for overnight stays. There was also a 'children's corner' with toys and books to entertain any children visiting the service.

People were protected against the risks of potential abuse because staff were trained in the principles of safeguarding. Risks associated with people's care and treatment were managed to reduce the risk of avoidable harm. The provider ensured there were sufficient staff available to deliver care and treatment in an unhurried and calm manner. People explained staff always had time for them. Staff were recruited robustly to ensure they were suitable to work with people. People's medicines were managed safely.

Accidents and incidents were reported, and actions taken to minimise risks for people. Environmental risks were assessed with actions taken to improve safety. Equipment, gas and electrical appliances were regularly serviced and there was an ongoing programme of repairs and maintenance. Reliable and effective systems were in place to prevent and protect people from avoidable infections.

People's human and legal rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People benefitted from person-centred care based on best practice. People's care and support was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them. There were some limitations with the use of the electronic recording system but continual improvements were being made.

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.

Improvements had been made to ensure the service was safe. Following a serious incident a robust investigation had taken place and new policies and procedures and staff training had been introduced to reduce the risk.

People were safe because individual and environmental risks were assessed and steps taken to reduce them. Risks were managed positively and did not restrict people's lifestyle choices unnecessarily.

The service had robust procedures in place to protect people from potential abuse and unsafe care.

There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet people's needs and preference.

People received their medicines on time and in a safe way.

Recruitment checks were undertaken before staff and volunteers began working at the service to ensure they were suitable to work with people.

The environment was safe and very well maintained. Excellent levels of infection prevention and control were maintained throughout the hospice.

Is the service effective?

Good

The service was effective.

Staff worked collaboratively as part of a multi-professional team to meet people's needs. The team provided care and treatment based on national guidance and evidenced its effectiveness.

The provider ensured staff were competent for their roles through access to training, support, mentoring and appraisal.

Staff morale was high and they described the service as a 'great' place to work.

People received an excellent catering service. People had access to a variety of high quality foods and drink when they wanted them.

Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and demonstrated an effective knowledge of the consent
Process.

The environment provided facilities to meet the needs of people using the service and their relatives. Improvements had been made to provide a 'dementia friendly' environment.

Is the service caring?

The service was exceptionally caring.

People were treated with the utmost dignity, respect and compassion. This was reflected in the feedback received from people who said staff were exceptionally caring.

People were supported by staff that were committed to providing high quality care and treatment. Staff had an excellent understanding of people's needs. They had a holistic approach, providing emotional, spiritual and psychological support for people using the service and those close to them.

Staff went that extra mile for people by organising weddings, blessings and outings to events meaningful to them.

People were supported to maintain their independence with the use of aids and adaptations, and taught techniques to help manage their symptoms. People valued this support and described positive outcomes, leading to increased confidence and wellbeing.

Support for relatives and friends was an important part of the service provided. Relatives and friends had access to complimentary therapy, counselling and bereavement services.

Is the service responsive?

The service was responsive.

People received person-centred care. Systems were in place to ensure that people's physical, social and psychological needs

and wishes were comprehensibly assessed. Detailed and current information about people's needs and wishes was available to staff to ensure people received the supported they required.

The service ensured people experienced a comfortable, dignified and pain-free death, according to their wishes and preferences.

The hospice board and senior management team had worked with the local community and local commissioning groups to plan and deliver services to meet the needs of local people into the future.

People benefitted from a highly effective multidisciplinary team. A 24 hour, seven day a week advice line provided support for people, their carers and other health professionals.

People knew how to raise a concern or complaint. The registered manager and senior management were open and honest with people when things went wrong. Complaints were investigated thoroughly, and analysed for trends and themes. Learning was identified and shared to improve people's experience of the service.

Is the service well-led?

The service was well led.

Feedback from people, staff and external professionals was exceptionally positive about the quality of end of life care provided by the hospice. The board and senior management team had a clear vision and strategy to ensure the delivery of high quality care and treatment.

There was an open culture of incident reporting within the service and learning from incidents was key to providing a safe and effective service. Strong emphasis was placed on continuous improvement of the service and best practice.

The service monitored the effectiveness of care and treatment through participation in national and local audits, research and national and regional projects. They used the findings to improve outcomes for people. People's views were sought and valued.

The hospice played a leading role in promoting end of life care within the local community and developed strong links with many community groups. The service worked in partnership with other organisations and professionals to ensure they followed best practice and provided a high quality service and supported

other services to do the same.

Care Quality Commission

St Margaret's Somerset Hospice -Yeovil

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 took place on 9, 10 and 12 April 2018. The first day of the inspection was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector, two specialist advisors in palliative care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we looked at records that were sent to us by the registered manager to inform us of significant changes and events. We reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

During the inspection we spent time on the inpatient unit (IPU), the day centre and we visited two people receiving support in their own home. We spoke with five people on the IPU; two people using the day centre and two people receiving support at home. We also spoke with two people by telephone following the site visit. We spoke with 10 relatives either within the IPU or in their own home during visits or by phone. We also spoke with 31 members of staff and two volunteers. This included the registered manager, clinical director, consultant, two doctors, eight nursing staff, two Clinical Nurse Specialist (CNS), the lead IPU nurse infection control lead, tissue viability lead, the human resources coordinator, two learning and development leads, the head chef, cleaning staff, volunteer coordinator, lead therapist; occupational therapist, members of the spiritual care team, the estates manager and maintenance personnel.

We looked at six sets of records that related to people's care on the IPU. We also attended a

multidisciplinary team meeting (MDT). We sampled the services' policies and procedures; quality audits, quality assurance reports and minutes of meetings.

We contacted commissioners and other professionals who worked with the hospice. We received a response from one commissioner and five community partners. For example, community nurses, care home managers, community health and wellbeing lead and palliative care nurse specialist.

Good

Is the service safe?

Our findings

Following the last inspection this domain was rated 'requires improvement'. This was because people using the service and staff were not always protected from the risks arising in relation to oxygen therapy and smoking materials.

Improvements had been made to ensure the service was safe.

A serious incident occurred in September 2016. A person using the service died as a result of fatal injuries sustained during a fire when the person was smoking whilst using an oxygen cylinder. As a result of the incident, the 'smoking room' on the inpatient unit (IPU) was closed. The hospice became a smoke free environment and patients have to go off site to smoke. However, staff and trustees recognised this introduced a number of new risks for people receiving palliative care particularly in cold weather. The Trustees supported the decision to provide a safe smoking location on site for people in the future. This had not been established at the time of the inspection. The registered manager confirmed there would be a review of all policies, procedures, e-learning modules, staff training packages, leaflets and all material prior to opening of an on-site smoking facility for people.

In addition to introducing smoking restrictions within the premises, specific risk assessments had been introduced for people who smoke and/or use oxygen. None of the people using the service at the time of the inspection were smokers using oxygen therapy. A leaflet had been developed and was distributed to people to highlight the risks of using oxygen while smoking. The hospice promoted the smoking cessation programme to people and carers where appropriate.

The service used safety precaution notices on oxygen cylinders to remind people and staff of the dangers of using oxygen. Staff had received training about the risks of smoking and oxygen including oxygen saturation considerations. This means they understood how oxygen could linger on clothes for example for some time after use and remain a high fire hazard. All staff were clear about the potential risks and how to reduce them. The registered manager and clinical director had taken every opportunity to inform other health care professionals and hospice services about the incident. They had candidly spoken about the experience at a national conference to highlight and reduce the risk of a similar incident occurring again. They had shared any resources that would be of benefit to other services. For example, the Dangers of Using Oxygen Therapy leaflet, which had been shared with and adopted by other hospices.

Without exception, the people we spoke with said they felt safe at the hospice or when using the community services at home. One person said, "I feel absolutely safe here. They attend to every detail. The staff are all very kind nothing is too much trouble. My possessions are safe no problem; keys, money all intact". Other comments from people included, "I am well looked after…I have no worries…" and "The Staff make me feel very safe here, they spend time with me without rushing me…" Relatives visiting the IPU expressed their confidence in the staff's ability to keep people safe. One explained, "They (staff) are always thinking about how they can make things easier for (person's name). Safety is very important here. I feel (person) is 100% safe and I have no worries in that respect. It is a blessing to know (person's name) is so well cared for…" A

health professional said, "This is an excellent service. We are happy to work with them…"

Risks associated with people's health and well-being had been identified, monitored and managed to ensure they were safe and their freedom respected. Individual risk assessments were completed, in relation to people's risk of falling, skin damage, malnutrition and dehydration, and about moving and handling risks. Where people were at risk of developing pressure ulcers, the correct pressure relieving equipment was in place and records showed people were re-positioned regularly. The lead staff member for tissue viability (skin care) regularly checked pressure mattresses to ensure they were set correctly in order to work effectively. They confirmed that no avoidable pressure ulcers had been developed on the IPU in the past 18 months. This showed the care and treatment provided was effective.

Systems were in place to monitor and manage accidents and incidents to maintain people's safety. Staff were aware of the process to report any incidents and accidents and all were recorded. No reportable serious injuries had been sustained as a result of an accident since the last inspection. The registered manager audited incidents and accidents to analyse any trends or to identify where improvements could be made to minimise their reoccurrence. Lessons were learnt and improvements made when things went wrong. For example, significant improvements were made to reduce risks, incidents and accidents relating to oxygen use. Quality markers of safe care were measured relating to falls, medical errors and pressure ulcers and these were monitored through the Hospice UK national inpatient benchmarking project. This helped the service to compare with similar services, and to highlight any areas of concern within the hospice community.

We checked the arrangements for managing medicines, and found that there were safe systems in place. Medicines were supplied through an agreement with the pharmacy department of the local NHS hospital trust, including medicines for the in-patient unit and for people to take home with them. They also supplied a clinical pharmacy service to the hospice, and pharmacy staff visited weekly to review prescription charts and check that people's medicines had been prescribed correctly on admission.

An out of hour's service was also available if needed, and medicines information was provided for hospice staff. Hospice medical staff prescribed people's medicines on prescription charts, and nursing staff recorded when these medicines were given. We checked the charts and records for seven people and found that these were clearly prescribed and recorded, showing that people received their medicines safely in the way prescribed for them. Separate charts were used for medicines given in a syringe pump and there were safe systems for prescribing, recording and checking these (a syringe pump is a way of giving medicines continuously through the skin). People's medicines were reviewed regularly, including any medicines prescribed to be given 'when required', and medical staff were always available for advice.

People were supported to look after their own medicines if this was safe and appropriate for them. We saw one person receiving their medicines at lunchtime and saw that they were given safely and in a kind and caring way at the person's own pace. Nursing staff could give a range of discretionary medicines, (meaning some medicines could be given by a nurse without a doctor's prescription) following clear policies so that nursing staff could respond quickly to some symptoms safely and appropriately.

There were systems in place to check people's medicines when they were admitted to the hospice and make sure that these had been correctly recorded and prescribed. Staff explained the information given to people taking their medicines home. The supplying pharmacy dispensed these into compliance aids if necessary to support people to take their medicines correctly at home. Compliance aids are simple devices to help people to remember to take their medication. They also act as a visual prompt for carers that people have taken their medication

People's current medicines were stored in secure bedside lockers. Other medicines were stored securely in a locked clinical room, and there were appropriate arrangements for storing, and recording medicines needing extra security. Staff regularly checked these medicines and were aware of who to report to if there were any issues. There were appropriate systems in place for ordering, receiving, and disposal of medicines. Temperatures in the clinical room and refrigerator were monitored and recorded to ensure that medicines were stored at suitable temperatures so they would be safe and effective. There was an emergency trolley with medicines, oxygen and equipment and this was checked regularly to make sure it would be suitable for use if needed.

People living in their own homes managed their own medicines. However 'nurse prescribers' within the community nurse team offered advice about medicines and were able to adjust medicines where necessary.

Staff had detailed policies and procedures available for guidance. Regular medicines audits and reviews of any incidents took place. We saw that some systems had been changed and new processes introduced in response to learning from these audits. For example there were safer systems for storing and recording medicines brought into the hospice when people were admitted.

Nursing staff received training on giving medicines intravenously and in syringe drivers, and had checks to make sure they could give these medicines safely. Pharmacy staff from the local hospital trust were also involved with medicines training on staff study days.

People were protected from potential abuse by staff and volunteers who were knowledgeable and understood how to keep people safe. All staff and volunteers received safeguarding training as part of the core and refresher training programme. Appropriate safeguarding policies were available for additional guidance. Staff were confident any concerns raised about people's well-being would be dealt with appropriately by the registered manager and senior staff. No safeguarding alerts had been made since the last inspection. No concerns were raised with us during the inspection.

People said there were enough staff to meet their needs in an unhurried way. One person said, "They (staff) have time for you…they don't rush me…I can talk to them." The IPU was calm and staff answered calls bells quickly. Staff reported staffing levels enabled them to support people appropriately. One staff member said, "The staff to patient ratio is very good. We have time to spend with people; take them outside or speak with relatives. I never feel that we don't have enough time for people."

Sufficient numbers of suitably qualified staff were available on the IPU, the Central Referral Centre at Taunton and community services to support people to stay safe and meet their needs and preferences. The PIR stated staffing levels on the IPU exceeded the required national NHS guidelines for 'Safer Staffing'. A minimum of six staff worked on the early shift; five on late shift and three overnight. There were at least two or three registered nurses on each shift, supported by health care assistants or assistant practitioners (This role was a level above a health care assistant and under a registered nurse. This enabled them to have a higher level of skills to assist the nurses.)

Staffing levels were reviewed on a daily basis by the lead nurse or head of inpatient services taking dependency levels into account. Staffing was increased where necessary. For example during the inspection one person required one to one support. Additional staff were used to ensure the person received the care and support required. A trained team of volunteers supported staff. Volunteers spent one to one time with people; delivered meals, drinks and snacks and constantly replenished the flower arrangements around the building.

A team of doctors worked across all services and visited people in all areas including the community. A doctor was on call at weekends and overnight for advice with a consultant in palliative medicine available for further advice if needed. A team of therapists also worked across all services, providing physiotherapy; occupational therapy and complementary therapists. A spiritual care co-ordinator was supported by spiritual care volunteers.

Staff within the community team confirmed there were enough community staff to enable them to provide the necessary visits, which depended on people's needs. Staff said they had time with people to explore their needs; assess for equipment and provide advice and support in an unhurried way.

Safe recruitment procedures were in place to ensure new staff and volunteers were of suitable character to work at the service. New staff and volunteers were required to complete an application form and attend an interview. Disclosure and Baring Service (DBS) checks and references had been obtained prior to their employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

People were cared for in a clean and hygienic environment. Excellent practice ensured people were protected by the prevention and control of infection. People spoke highly of the housekeeping team. Comments included, "The hospice is always being cleaned and the cleaners are so cheerful"; "I see the cleaners all the time, it is kept clean" and "…they keep the place very clean".

There was a housekeeping team and an infection control lead. The housekeeping team ensured all areas of the service were clean. There were a number of cleaning schedules in place to ensure daily cleaning and deep cleaning was undertaken. A member of the housekeeping team confirmed they had received training to enable them to work safely and they had all the necessary equipment. The hospice kitchen was awarded the top rating of five following a visit from environmental health.

The laundry was secure, well equipped, clean and organised. The majority of the laundry (bed linen and towels) was sent to an external laundry service. Systems were in place to ensure laundry was segregated and managed safely. There were arrangements for the safe management of waste.

The infection control lead worked across both Taunton and Yeovil sites. They kept up to date with national guidelines and research to ensure people were receiving safe care. The infection control lead chaired the national Hospice Infection Control Forum, as well as chairing the South West Infection Control Forum. They also worked with the Lead Health Protection Practitioner for Public Health England South West to share best practice through a formal document agreement. The PIR stated there had been no episodes of hospice acquired infections in the past five years.

Clinical staff received annual mandatory infection control training and used the appropriate protective equipment, such as gloves and aprons. All visitors were asked to use hand sanitising gel when they arrived at reception.

The infection control lead carried out regular audits. For example, compliance with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infection; hand hygiene and care following death. Where improvements were identified, action was taken. For example, where taps were causing concern a meeting was arrange with the head of estates to ensure the problem was addressed. In-house overall compliance scores were good. There was a pet policy ensuring people could have visits from animals safely.

The provider and registered manager had ensured people were cared for in a safe environment. The premises were very well maintained and there were systems in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. An estates team carried out an ongoing planned programme of repairs and maintenance. Contracts were in place with specialist companies to service and maintain medical equipment. Records showed gas, and electrical equipment was regularly tested and serviced.

Fire safety was well managed. Regular checks of the fire alarm and fire safety equipment were undertaken. A comprehensive fire risk assessment was in place which showed there was a good provision of fire safety equipment. All staff undertook annual fire training and twice-yearly fire drills to ensure they knew what to do in such an emergency.

Contingency plans were in place to ensure continuity of the service for people, for example, in the event of staff sickness or the loss of utilities such as water, gas and electricity.

Good

Is the service effective?

Our findings

Following the last inspection this domain was rated 'requires improvement'. This was because staff were not knowledgeable in relation to the use of oxygen therapy and smoking materials.

Improvements had been made to ensure the service was effective. All staff had received training about the risks of smoking and oxygen use including oxygen saturation considerations. All staff were clear about the potential risks and how to reduce them. A short video had also been used by the service to help staff understand the dangers. This was available on line for any interested party to access.

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. People, their relatives and professionals unanimously confirmed staff were well trained to be able to deliver effective care. Comments included, "We have had invaluable support from wonderful staff. It is clear to us staff are very well trained and know exactly what they are doing"; "The staff seem very well trained. If they are unsure of anything they find out for us. I have total confidence in them (staff)"; "All the staff I saw were highly experienced, extremely kind and gave me excellent advice; I couldn't ask for more" and "There is not much the staff can't answer…it is a brilliant service, which has helped me a great deal…" Professionals described a skilled and knowledgeable workforce. Comments included, "This is an invaluable service. The staff are definitely skilled and knowledgeable…" and "The hospice has well trained and competent staff. They provide excellent support and advice."

There was an excellent training and development programme run by the hospice academy led by the learning and development team. A wide range of training was delivered, both internally and to external organisations. Training included – a six day palliative and end of life care course; six day spiritual care at the end of life course; dementia friends; supporting people in loss and bereavement; syringe pump use; and tissue viability (skin care). Other specialist training was also provided. For example, feedback from staff who provided a telephone advice/support service identified the need for training on various aspects such as coping with suicidal calls and closing down conversations. Training was provided by the Samaritans and was extremely well evaluated.

In addition, training was in place to ensure staff worked safely with people. This included, safeguarding; infection control; fire safety; moving and handling and food safety. Compliance with this mandatory training was 95 percent overall. Where there were deficits this was due to staff absence, for example maternity leave or long term sick leave. There was a system in place to monitor when training was required and staff were alerted when refresher training was due. There was a 'rolling' training programme with course offered monthly or bi-monthly to accommodate staff availability. Staff had opportunities for ongoing professional development. For example a member of staff had been supported to complete a Masters in tissue viability and they took the lead role for this area, providing support and advice to staff.   Their work with the staff team on improving pressure ulcer care had a positive outcome resulting in reducing pressure ulcer incidence on the units by 81% between 2012 and 2017. Registered nurses were supported with training and development to help them meet the requirements of revalidation with the Nursing and Midwifery Council.

The hospice supported staff and volunteers to ensure people living with dementia experienced good quality end of life care. There was a dementia care lead/champion and staff had completed dementia care training and were dementia friends. A dementia friend learns a little bit more about what it's like to live with dementia and then turns that understanding into action. For example, staff and volunteers were able to provide one to one support for people living dementia, providing reassurance and company to reduce confusion and anxiety.

There was a comprehensive programme of training for the team of volunteers who supported people and staff in the in-patient unit (IPU). One volunteer explained, "I had a brilliant induction and welcome…"

Newly recruited care and nursing staff received a thorough induction before they started working at the service. This included shadowing more experienced staff until they could demonstrate they had attained the level of competency required for their role. New staff also completed training to ensure they worked safely as well as additional training related to their specific role. Competency checks were completed to ensure staff were safe and confident when caring for people.

The senior management team within the IPU ensured staff worked safely by completing competency tests regularly with staff. Staff received regular supervision and annual appraisals, providing feedback about their learning and development and performance. Supervision was a one-to-one support meeting between individual staff and the management team to review their role and responsibilities.

Staff spoke very positively about the support, and training and development they received. Comments included, "Great place to work, we are well supported by management"; "We are able to access training… there are always course available…" and "The hospice provides very good training for staff. They have funded Diplomas and a Masters. Makes you feel valued…"

The hospice was a member of the National Association of Palliative Care Educators, which aimed to advance education and research in palliative care. The hospice aimed to promote knowledge and implement the principles of palliative care among those staff working with people with cancer and life limiting illness in various settings. Staff worked closely with local NHS trusts, care homes and nursing homes and Plymouth University to provide a programme of education and training for health and social professionals in palliative care and end of life care. Two community staff had been awarded the certificate for 'outstanding commitment to practice based learning' by Plymouth University in recognition of their commitment to nursing students on placement with the community team.

The training and support to care home and nursing home staff meant people could receive high quality end of life care at the home. This avoided people being admitted to hospital or the hospice and meant they could stay in the preferred place safely. A member of the local Clinical Commissioning Group (CCG) reported, "The Hospice have shown a real willingness to support Nursing homes in delivering the best possible care by supporting them with education, resources, verbal and physical support." Two registered managers of local care homes provided very positive feedback about the support and training the hospice provided. One said, "We can't speak highly enough of the support…the training and support has improved our staff's confidence and competence…" Another reported, "We have a valuable working relationship with them which benefits our residents. The training they deliver has made sure there is consistency in care when people are transferred to us…"

Each person admitted to the hospice had a full individual assessment of their current needs, for example, personal care, level of pain, nutrition, moving and handling, and pressure area care.

The service used nationally recognised 'patient' outcome measures (Outcome Assessment and Complexity Collaborative (OACC) and The Integrated Palliative care Outcome Scale (IPOS)). These evidence based assessment tools helped people to report their physical, emotional, social and spiritual needs. This enabled people to identify their main concerns, symptoms or worries so staff could address and monitor needs. The tool was completed at regular intervals to ensure outcomes that mattered to people were met. For example, one person had rated their anxiety very high initially. Information within the records and a review of the regularly completed IPOS tool showed this had reduced significantly with interventions from the multidisciplinary team. The tool also showed a reduction in the person's pain. This demonstrated that concerns and issues identified by the person were effectively managed.

People's health and wellbeing needs were met to a high standard. People's feedback was positive about the care and support provided. Comments included, "All the staff I saw were highly experienced, extremely kind and gave me excellent advice. I couldn't ask for more" and "Time taken to understand current needs, past medical needs and treatments, and possible future support and needs if required…" A relative reported, "(Person's name) was so well supported and felt relaxed and happy being there. Before that (person's name) was becoming very unwell but St. Margaret's managed to get on top of their symptoms so they could enjoy their time. As a family we are so very grateful."

People had access to the full multidisciplinary team in order to meet their health and care needs. For example, occupational therapists, physiotherapists, counsellors, nurse specialists, clinicians and spiritual support. People could access therapists on the IPU; in their own home; at the day centre or at an outpatient appointment. Physiotherapists and occupational therapists supported people, to maintain their health and retain their independence for as long as possible.

A weekly multidisciplinary team (MDT) meeting provided an opportunity for the team to discuss each person in detail and helped make decisions about on-going interventions to improve outcomes for people. For example, whether a person would benefit from assessment and additional equipment provided by the occupational therapist. The MDT meeting also discussed advanced care planning and arrangements for people's discharge to ensure this was successful. Staff responded effectively when people's health needs changed. For example, staff worked closely with other health professionals and ensured appropriate referrals were made to consultants and other specialist teams. A hospital based specialist reported, "They are an invaluable partner in palliative care…" A dedicated discharge co-ordinator ensured that people were discharged to their preferred place of care if at all possible, with the right support available to them.

People received effective care based on best practice evidence. Staff had various lead roles to promote and champion best practice. For example, in prevention of pressure ulcers and skin care; infection control and dementia care. Staff had completed additional training in their area of interest. The champions provided educational sessions and resources for staff; shared information at staff meetings and supported and monitored skin care and infection control within the unit. This ensured staff were using best practice which minimised the risk of people developing pressure ulcers or acquiring avoidable infections. Information provided by the service showed no avoidable pressure ulcers had been developed during a hospice stay in the past 18 months. Similarly no hospice acquired infections had been developed in the past five years.

People were supported to live as well as possible. For example, one person had been admitted with a history of an abdominal wound that experienced repeated infections and bleeding. This resulted in the person becoming socially isolated due to the odour and bleeding. It also impacted on their sleep. Whilst in the hospice several treatments were trialled culminating the use of an effective but expensive wound treatment. This resulted in significant healing. The person's life improved considerably; their confidence grew and they were able to socialise again. This significantly increased their quality of life.

A detailed pain assessment was used to assess and record people's pain where present and what made it better or worse. Staff continually checked and adjusted people's pain relief to ensure it was meeting their needs. Care and treatment was considered in a holistic way. Staff used alternative non pharmacological methods of pain and anxiety relief with some success. For example heat pads, acupuncture, guided imagery (guided imagery means that people were supported with a method of relaxation which concentrates the mind on positive images in an attempt to reduce pain, anxiety and stress) and psychological interventions. Complementary therapists completed an outcomes questionnaire with people between January and March 2017. People rated their symptoms (tension, anxiety, pain, sleeping digestion and breathing). The data was collated looking at the impact of complementary therapy with positive benefits noted.

A regular lymphoedema clinic was run to support people living with this condition. (Lymphoedema is the collection of fluid in the tissues of the body causing swelling and discomfort.) People were supported with skin care; exercises and simple drainage.

The community team supported people and their relatives/carers whose preferred place of care was in their own home. The team offered support with symptom control, psychological support, and practical help. People and their relatives explained the positive impact of the service. One person reported, "The support is working very well. It has been great support for (person's name) confidence". Other comments included, "It is a brilliant service. The service has helped me a great deal" and "They certainly do a very good job, which gives us additional layers of comfort…" One person wrote, "I have been completely happy with the care I have received especially with the liaison between myself, doctors and nurses… All medications have been sorted for something I would have struggled to manage myself. Excellent care all round."

Staff understood the importance of working together with other professionals to provide seamless care for people. Staff worked in close partnership with people's GPs and district nurses when they supported people in the community. The hospice community nurse specialists (CNS) undertook regular home visits with GPs and district nurses to assess and monitor people's health needs. A district nurse manager described an excellent working relationship with the hospice staff. They added, "They [hospice staff] are always looking for solutions, even little things that can make a difference for people."

Across the Taunton and Yeovil sites four registered nurses were qualified as 'nurse prescribers' in the community. This meant they were able to adjust people's medication, such as pain relief, without delay to ensure people's symptoms were controlled effectively. GPs were always advised of any changes made.

The catering service was tailored around the nutritional needs and preferences of each person. People were supported to eat and drink what they wanted, when they wanted it. The focus of meal planning and preparation was on each individual. There was a flexible approach to meal times and the hospice was able to meet people's special dietary requirements as well as likes and dislikes. The chef explained, "The menus are a guide for patients and us…but they can eat what they want, when they want it…" People could 'graze' throughout the day if they wished. People could order favourite foods that may not be on the menu. Menus were prepared in pictures form as well as words, which helped people with cognitive impairment to make informed choices.

The chef and catering staff knew people's likes and dislikes and met with people on the IPU daily to offer a variety of tempting meals. For example, one person admitted to the IPU had preferred to eat organic food at home. The chef immediately sourced a variety of local organic foods within two hours for the person. The chef said, "Anything we haven't got we get…" The person was so touched they took the time to write a thank you card to the chef and catering staff. They commented on the wonderful food and staff and added, "You have helped me back to eating again and enjoying it…" Other people's comments about the food included,

"The food is brilliant, I can have what I want and at any time, I can get a snack at any time, day or night, drinks are also available day or night" and "The food here is very good, they give me anything that I fancy…"

Care records contained nutritional risk assessments and control measures to minimise the risk of malnutrition. The chef explained how they fortified food with additional calories to avoid the risk of malnutrition. Staff had time to assist people to eat and drink where required. Mealtimes were unhurried and made as sociable and pleasurable as possible. The service considered the needs of family and friends and they could join people for meals on the IPU for a small charge. One relative said, "They look after us too. Always a tray of drinks and snacks offered when we are here. We can have a meal, which is welcome when spending long days here…"

The service was mindful of the needs of people living with dementia. There were special coloured plates/bowls to promote independence. There was a full range of adapted crockery and cutlery to support people's independence.

The premises had been purpose built and the environment was light and airy with excellent facilities for people and their relatives. There were rooms for complementary therapy and counselling, outpatient clinics and lymphedema clinics. A spacious day centre was accommodated within the building.

The in-patient unit (IPU) provided a calm, peaceful environment. There were two three bedded single sex bays and eight single en-suite rooms on the IPU. All bedrooms were spacious, well equipped and with attractive views of the well maintained gardens. Several people commented on the grounds. One person said, "The gardens are beautiful. A welcome tranquil space…" Other people commented on the general environment saying, "The whole environment is beautiful with a wonderful atmosphere…" and, "We have been made so comfortable here…"

The hospice worked to improved end of life care for people living with dementia. There were dementia friendly facilities within the hospice. Since the last inspection one bay had been refurbished to provide a 'dementia friendly' space. The flooring, curtains, wall protection and signage was changed/updated to meet with dementia friendly requirements. A dining room table had been placed in the bay to create a more homely environment for people.

There was a flat people could use prior to discharge to help build their confidence. The flat provided similar accommodation to that found in most homes and allowed therapists to assess the needs of people and their carers in a domestic setting rather than a clinical one. It allowed people to become familiar with living independently before they went home but with the reassurance that hospice staff were available if they were needed.

Consideration had been given to the space needed by relatives and visitors. There was a spacious well equipped flat, which relatives could use for overnight stays. There were also private and quiet areas around the IPU for people and families to have time together. There was a 'children's corner' with toys and books to entertain any children visiting the service.

The 'sanctuary space' offered a neutral spiritual space, which was open to all. This quiet, peaceful space had small multi-faith symbols discreetly available to those who wished to use them for prayer or worship. The reception was welcoming with a pleasant seating area, a shop and facilities for refreshments.

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's ability to make decisions for themselves was assessed throughout their care. Staff received training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and understood the principles of the legislation. They understood the implications for their day to day practice. From our observations and from records, we saw people and their relatives, where appropriate, were involved in all decisions about the care and support individuals received. People were given information to help them make decisions, for example information leaflets. Staff also discussed the risks and benefits of treatment options and explored any practical, psychological and spiritual support the person needed. People could discuss any concerns or worries about decisions with clinical staff, counsellors or the spiritual team.

Outstanding ☆

Is the service caring?

Our findings

The service had a strong person centred ethos and people received outstanding care from compassionate, caring staff, who had developed positive relationships with them and their families.

People, their relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff. People said the staff were exceptionally compassionate, meeting their physical, emotional and spiritual needs. People's comments included, "The place is fantastic. Not at all how I imagined a hospice to be. Staff are so kind and caring and reassuring. They always have time for you. I feel I can speak with them about my worries and concerns"; "The staff are outstanding in every way. We trust them. I have been most impressed with this service" and "Communication was very good. Nothing was ever too much trouble. Very caring with great empathy." A relative reported, "Wonderful place, care is great, staff are so very cheerful, so very kind, they go the extra mile". Another said, "The thing about this place is that staff treat everyone with such kindness. They have time to answer any questions and have difficult conversations with us. We will be eternally grateful for all their help and support…"

Staff cared for people with compassion and consideration. We saw several examples of staff from all disciplines being supportive and kind to people and their relatives. For example, during a home visit one person was very tearful and distressed. Staff took time to speak with the person and calm them; providing reassurance and advice. The person and their relative felt more settled following the visit. One relative visiting the IPU was distressed and upset. Staff approached and immediately comforted the person, allowing them to talk about their concerns and worries. They arranged for the relative to have a massage to help reduce their distress. The relative told us, "The care is really fantastic, not just for (person's name) but for us (relatives) too. Already I feel my more relaxed and able to cope again…" Staff's approach was gentle and sensitive; they used gentle touch to comfort and reassure people and their relatives.

The service provided excellent spiritual care led by a spiritual care co-ordinator, who was ordained in the Church of England. Spiritual care at St. Margaret's recognised each person as an individual. The spiritual care co-ordinator explained the holistic model of spirituality which was not based on religion alone, but included the philosophy of mind, body and spirit. Staff had attended a six day course relating to spiritual care at the end of life and knew how to respond to each person's diverse cultural and spiritual needs in a caring and compassionate way. The hospice cared for people from diverse cultures and religions at times. The spiritual care co-ordinator explained they had contact with other spiritual leaders within the local community, including a local Imam, to ensure people's spiritual needs were met.

A wide range of religious services and funerals could be carried out by the hospice spiritual co-ordinator. The hospice has a licence to arrange weddings on the premises. The spiritual care coordinator had conducted weddings, renewal of vows and special blessings to which family and friends were invited. One relative shared their experience of their special ceremony with us. They said, "All the staff rallied around. The volunteers made posies; staff helped (person's name) to get ready and with their vows; the chef made wonderful food. They (staff) were just marvellous. It made (person's name) very happy before they died…"

A small team of spiritual care volunteers who had a wide range and diverse set of faith/non-faith backgrounds were being supported and empowered to gain skills to be able to support people through difficult experiences. The team provided a responsive service in the community as well as on the inpatient unit. A volunteer explained, "We work with our patients in a totally non-denominational way and do our very best to support their spiritual needs and the needs of their family members".

The whole team worked to support people to fulfil their last wishes. The team co-ordinated a trip to a local concert for one person whose wish was to see Status Quo one last time before they died. They enabled another person to get to the Colston Hall for a Michael McIntyre concert. Their relative told us how much this had meant to them both. They described how the occupational therapists and physiotherapist had worked to improve the person's mobility and clinical staff had worked with the person to reduce their pain so they could enjoy the trip. They added, "They were so marvellous here…I would rate it 10 out of 10. Staff tried to do things to make (person's name) feel better and give them something to look forward to…it felt like a second home…" One person in the IPU was supported to visit a film character and the local football team. Recently a person who was approaching the end of life wished to have a last swim in a local pool. Members of the clinical team worked with the person and family to co-ordinate transport, medication requirements and comfort measures to facilitate the trip. A risk assessment was completed and the trip took place very successfully just hours before the person died.

People were able to have visits from much loved family pets, which comforted them. During the inspection a Pets as Therapy dog was visiting people on the IPU. Staff explained how much people enjoyed and benefitted from these visits.

The occupational therapists and social workers at the hospice had won the Somerset County Council 'Care and Respect' team award for their contribution to excellent patient care.

Bereavement and counselling services were available for people to access specialist support. Support included telephone support, individual appointments, counselling, group therapy and family support. This enabled people and their relatives/carers to explore their feelings and manage any distress. Feedback from relatives about this service was particularly positive. One wrote, "My husband received excellent end of life care and I received excellent bereavement counselling. (Counsellor) was the best counsellor I could have wished for. The right person at the right time. Very sensitive and understanding…My sessions were very enjoyable as it helped me to become strong inside being shown so many tools for survival and self-care in a kind, compassionate and fun loving way. Many thanks!"

People were remembered and celebrated. An ornate memory tree had been installed in the reception area which enabled relatives and friends to remember and celebrate their loved one. Each leaf had the name of a person cared for by the hospice team. One relative say, "I think this is a lovely touch and a way to remember people…" A book of condolence was kept with comments from relatives and friends about the individual and the care provided. Six months after a death a remembrance service was held for family friends – up to eight services were held each year providing an opportunity for friends and family to come together to remember the person.

Staff demonstrated excellent communication skills when dealing with difficult issues and had established a very good rapport with people. People said they were able to discuss anything with staff. One person said they had been able to speak about their funeral plans and other arrangements they may not have thought of. One person said, "I trust staff completely. They are delightful and always there when you need them." A person using the community service said, "Staff come and let us talk. The service has helped me a great deal. The thing I notice is that everyone smiles. That makes such a difference." A relative explained, "We look

forward to their visits. We fell in love with them straight away…Without them I wouldn't cope…"

Staff demonstrated an in-depth understanding of people, their needs and preferences. Care and support was provided with great sensitivity and staff spoke about people with genuine kindness. Staff were friendly, courteous and mindful of people's privacy and dignity. All personal care was delivered in private. There were privacy curtains in the three bedded bays. One person said, "They (staff) make sure of that (privacy and dignity)…they are very helpful and sweet with me…" A relative remarked that people always looked clean and comfortable when they visited. The added, "(Person's name) always looks presentable and tidy, just as she would wish…"

There was a focus on people's rehabilitation and the promotion of their independence, led by the therapy team. People, including those living in their own home, were provided with equipment and adaptations in a timely way to make life easier. For example mobility aids, shower and baths aids and handrails. One person was given a wheeled trolley to assist with their mobility and independence. This meant the person could still lay the table at mealtimes, which made them feel useful. Their relative said, "The service has been a complete boon to us. The assistance has helped their confidence greatly." During a home visit with the multidisciplinary team assistant (MDTA), we observed how they skilfully identified equipment and aids to assist the person, without overwhelming them with information. The MDTA put the family at ease; listened to their concerns and made positive suggestions. The person told us, "They certainly do a very good job…" The innovative suggestions and interventions by staff enhanced people's sense of wellbeing and quality of life.

Staff supported people with techniques to manage breathlessness and fatigue management, which helped them control their symptoms and aided independence. One person said how successful the techniques had been for them, which had improved their breathless and mobility. A relative said, "They (staff) are always trying to think of something different to increase (person's name) enjoyment of life."

Staff understood the importance of family and other significant relationships. Relatives and friends could visit at any time. People and their families and friends were encouraged to eat together particularly to celebrate important events such as birthdays and anniversaries. Special meals were prepared for these events reflecting people's preferences. The hospice had arranged a visit to a reindeer farm for a group of children who had lost a parent. As a result, the surviving parents had set up their own self facilitated support group.

A volunteer in the Sunflower Centre (day centre) was undertaking a 'Life Story' project for people. They were training staff and volunteers to support people and their families to take time to capture memories, reflections and thoughts and what was important to them. This was done through writing, recordings, photos and videos. Life story work with people approaching end of life offered time to reflect, make sense, and reframe. The project aimed to create a lasting, audible and visual archive of people's life providing thoughts and memories for families to share

Staff knew how to respond to each person's diverse cultural needs. Staff had access to a translation service and advocacy service to support people who need it. Staff said in the past they had accessed Russian and Polish speaking translation for people using the IPU.

Staff worked collaboratively with people and their family when planning their care. A member of staff said, "The essence is knowing each person's agenda, their aspirations, hopes and dreams. We assume nothing…" Clear and detailed information about the service and its facilities was provided to people and their relatives.

There was a range of comprehensive information leaflets that included in patient stay, last days of life, integrated palliative care, consent, and bereavement support. People were involved in conversations about their care with clinical staff; therapists; counsellors and spiritual care co-ordinator, where required. The service also had a useful website.

Other testimonies from the 'I want great care' website about the service included, "All the staff are extremely polite and caring. I couldn't ask for anything better. So thank you from the bottom of my heart"; "Everything was excellent…. Absolutely beyond all expectations" and "The wonderful peaceful feeling of optimism and fun which the care gives…Total dedication of the staff."

The caring ethos and philosophy of the hospice extended to staff well-being. Staff were supported where necessary to cope with difficult working situations. Regular de-briefs were held to enable staff to reflect and discuss what went well and what they do differently. Counselling opportunities, and access to complementary therapies and employee assist service were provided to support staff. Staff said unanimously how much they enjoyed their work at the hospice. Comments included, "This is a special place to work. It is very humbling at times. We have a great team and great support" and "We have all we need to do the best possible job; good training and support; enough staff; the best equipment…I really enjoy my work…"

Good

Is the service responsive?

Our findings

People received outstanding personalised care tailored to their individual needs, wishes and preferences. People and relatives highly praised all aspects of the care and support provided. Their comments included, "I really couldn't fault anything. The care and attention is exceptional…"; "They have made my stay very comfortable. I am feeling better and might be able to go home…" and "The staff, all of them, couldn't have done more to help Mum…"

There was an extensive collection of testimonies and feedback from people, friends and relatives who expressed how responsive the staff had been to people's needs. Feedback from the 'I want great care' website included, "I have been very impressed with the care and kindness I have received. All the staff are very supportive and it's very comforting to know that if I have a problem and not feeling too well there is always someone there to talk to" and "My husband had excellent care from health care assistants (HCAs) right through to doctors. They managed his pain successfully which in turn meant he ate the excellent food. Thanks to all the staff who are outstanding and I am taking the patient home a much happier pain free person."

The service was exceptionally effective and responsive. People were supported to have a comfortable, dignified and pain free death. Each person's wishes were at the centre of the delivery of care.

People's care and support needs were continually assessed and their plan of care adjusted. People admitted to the IPU were assessed by doctors and nurses, who gathered as much information as possible from people and their family and friends as well as relevant health and social care professionals. The electronic care planning system was used to record relevant details about the person's care and support needs and how they wanted to be looked after. An assistant practitioner at the hospice had designed the 'All About Me' document specifically for hospice use. It was completed for people on the IPU to give staff a greater understanding of what was important to each person so that the care delivered met their individual needs. For example, one person's religious beliefs were described in their own words along with the information for staff to follow to ensure these needs were met. This included catering staff, who were aware of the person's preference for mealtimes. This person confirmed their religious and dietary needs were being met. They added, "I really couldn't ask for better care. It is very reassuring to be here…"

All staff had access to information about people's needs using the computer system, which was used regionally by most hospices. Staff on the IPU were able to tell us in great detail the correct, up to date information about people's care but were not always able to find the record or guidance on the computer system. For example, guidance relating to catheter care. However, the combined nursing and medical records provided comprehensive information about people's needs and how they were being met. Although the computer system had some identified limitations, this was being addressed with a working group of various staff to improve the detail of information held on the system.

Staff used detailed handover sheets which highlighted diagnosis, active problems and daily updates. This ensured all staff were aware of any changes to people's condition or emerging needs. A handover meeting

was held for each shift to ensure any changes in people's care or treatment was communicated to all staff in the IPU. This helped to ensure people continued to receive the appropriate care and treatment. A multidisciplinary team meeting, chaired by a consultant in palliative care, was held weekly to review people's care and treatment and discuss any emerging problems. The meeting also assessed any new referrals received and discussed those people who were moving between different parts of the service.

People and their families were given every opportunity to discuss their needs and wishes and staff ensured people received the right treatment and support. National benchmarking tools were used to assess the effectiveness of interventions. One person who used the IPU explained their experience, "Time given to involve close family members and their support if needed. Time taken in explaining a care plan, who is involved and why and the needs, care worries, anxieties of the individual. Access to information and support." They scored the service five out of five in all areas.

People were supported to 'plan ahead' with their families. Staff worked in a sensitive way help people plan for the future so their wishes and preferences at the end of life were known, understood, respected and met where possible. People were supported to make decisions about withdrawing treatment and resuscitation. The last days of life care plan was activated when it was recognised that a person was dying to ensure their wishes were adhered to and that interventions continued to be appropriate.

A wide range of therapies were on offer to promote people's wellbeing. Volunteer complementary therapists provided aromatherapy, massage, reflexology, reiki and music therapy. People were able to try a variety of options and choose the therapies they preferred and when they wished to have them.

The service offered a 24 hour palliative care advice and support line for people and their relatives and for health professionals such as GP's, district nurses, hospital and care home staff. Staff provided advice on symptom control, management of pain relief and access to services. The advice line had seen an increase in calls of 32 per cent since the last inspection, showing it was a much needed and used service.

The service was aware of the local demographic and the needs of the local community. The senior management team had commissioned a 'Fit for Future Review' to assess the current services provided and consider how the service might best meet people's needs in the future. The aims of the service followed national guidelines such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice, whenever possible. The vast majority of people received care and support in their own home.

The community nurse specialist team provided an excellent, responsive service. The community service was provided seven days a week and consisted of a varied skill mix with nurses and health care assistants working alongside the CNS team. They provided advice, support, signposting and symptom control to enable people to stay in their preferred place at home. Visits were prioritised and managed depending on people's needs. Staff worked together with primary care teams, care homes and hospital teams to ensure appropriate access to specialist palliative medical and nursing services when required. Feedback from professionals confirmed the service was valued and highly thought of. People using the service commented, "It is working very well for us. They (staff) couldn't be more helpful and friendly. Their help has made a huge difference" and "The service supports us very well…the staff are wonderful…"

The hospice day centre was open on a Monday, Tuesday and Wednesday by referral. Referrals could be for six or 12 weeks initially and were reviewed regularly. The day service also offered 'drop in' sessions for people and their carers. This ensured staff could respond to people's needs or concerns when they arose. The service continued to develop new ways of helping people live with life limiting illnesses and complex

needs. For example, they were developing a provision of exercise and the 'pop up gym' concept for people based in the Sunflower Centre. The aim was to improve and maximise strength, balance, and stamina of people and an awareness of the benefits of exercise.

The service responded effectively when they became aware of a number of deaths in the community whereby verification of death by GPs and DNs had taken some time to occur. This had impacted on the complexity of grief and in some cases resulted in anger. The lead palliative care consultant facilitated verification of death and competency training for the hospice community teams so they could verify appropriate deaths in the community. The aim was to "enhance the responsive, effective and caring element to their role and improve family support."

Recognising and responding to the needs of relatives/carers was an important element the work of the hospice. Implementing family and friends forums to capture feedback to improve and develop services had not been fully successful due to low attendance. However, the registered manager and staff planned to improve contact with family friends over the next 12 months. There were plans to develop links with village and community agents, health coaches, talking cafes, and outreaching support to areas of the county where transport links were poor. Providing cookery classes for primary carers was also being introduced this incoming year to assist people who had not previously cooked, following the installation of appropriate cooking facilities.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 which requires the service to identify; record and meet communication and support needs of people with a disability, impairment or sensory loss. Care plans provided information about people's sensory or hearing impairment. Staff were aware of those people who relied upon hearing aids or glasses to enhance communication. We saw people's glasses and hearing aids were in use where needed to enhance communication, with the person's consent.

There were arrangements in place to manage complaints and concerns. Information was provided for people about how to make a complaint. The registered manager maintained a clear process for each complaint, from an initial acknowledgement to its conclusion. Where appropriate they met with the complainant to discuss their concerns and assure the individual concerns would be investigated. The registered manager and senior staff demonstrated a positive attitude towards complaints, and welcomed feedback from people as a way of improving the service.

Three complaints had been received in the past 12 months. All had been resolved. Responses showed the provider and registered manager had carried out their duty of candour with a transparent approach. They acknowledged where things could have been better and apologised in these cases. A relative said any minor concerns or suggestions they had made were responded to and actioned. For example, their relative preferred female members of staff to deliver personal care. The person's preference was being met.

The service had received 357 compliments in the past 12 months. They categorised compliments into the five Care Quality Commission (CQC) domains. A review of all compliments received over the past 12 months showed in almost all instances, there was an overwhelming theme of thanks, caring, love, support, and of the kindness shown to people and relatives by staff across the clinical services.

Outstanding ☆

Is the service well-led?

Our findings

Following the last inspection this domain was rated 'requires improvement'. This was because there were failings in the management of oxygen therapy use in relation to smoking materials.

Improvements had been made to ensure the service was well led.

A serious incident occurred in September 2016. A person using the service died as a result of fatal injuries sustained during a fire when the person was smoking whilst using an oxygen cylinder. Following the incident, the service had developed a comprehensive action plan and conducted an internal investigation led by an external senior executive clinician to establish the root cause of the incident. The service introduced a no smoking policy and improved staff training to ensure they were aware of the dangers of oxygen therapy and smoking.

There was an open and positive culture which focused on people, quality and safety. This was reflective of the outstanding leadership and management within the service. The service demonstrated a strong duty of candour by acting in an open and transparent way in relation to a serious incident. The registered manager and clinical director had informed other health care professionals and hospice services about the incident. They had spoken about the experience at a national conference to highlight and reduce the risk of a similar incident occurring and shared their learning. They had also shared any resources that would be of benefit to other services in a range of accessible ways to help avoid a similar incident.

The registered manager led the drive for continuous improvement in all aspects of the service. Staff and Trustees were committed to providing a safe service and had engaged in a number of initiatives to support a safe culture since the last inspection. The hospice had pledged to improve patient safety by signing up to the national NHS 'Sign up to Safety' campaign. This national campaign was designed to help organisations address the problem of unsafe care and avoidable harm. The hospice had made five key pledges which outlined what they were doing currently and what plans they had to improve safety measures over the next 12 months.

The hospice was taking part in a 'Safety Culture: The Score Survey' run by the South West Patient Safety Collaborative in conjunction with the South West Academic Science Network. The survey is an internationally recognised way of measuring and understanding the safety culture that exists within organisations and teams. The ethos within the senior management team was to encourage and empower the organisation and staff to acknowledge mistakes, learn from them, and take action to put things right. The PIR showed the results of the survey were due and once received the senior management team would use the results to improve patient safety culture.

People using the service, their relatives and friends, and health and social care professional said the hospice was very well managed. People expressed their complete confidence in the service provided. Comments from people using the service included, "Yes I do think it is well led, it must be brilliant management, the staff get on well together and the atmosphere is very good and cheerful"; "From my point of view it seems to

be well led, there is always a good atmosphere here and they are always smiling and have a good banter" and "I can't fault one thing here so it must be well managed. Staff are wonderful, first class; the food is very good indeed and the place is kept immaculately clean. I have enjoyed my stay and will be leaving feeling much better. I can't thank them all enough…"

The service had managers at all levels with the right skills and abilities to run a service which provided high quality sustainable care. The registered manager, who was the director of governance, worked closed with the clinical director and other senior managers to ensure effective clinical governance. The service was managed by a board of trustees. The senior management team met regularly with the board of trustees. Quarterly reports were shared with the board which included an overview of complaints and concerns, pressure ulcer management, feedback from 'I want great care', bench marking data and accidents, incidents and near misses. This ensured information was escalated from local level governance meetings and information was shared from top-level governance.

The provider had a clear vision and strategy to continue to deliver high quality care and support. The trustees and senior staff were constantly looking at how funds could be best used to meet the needs of the local area in the best way. Over the last two years, St. Margaret's had conducted a 'Fit for Future' review to help identify and plan a sustainable model for the future provision of services provided by St. Margaret's Hospice across Somerset. An independent, comprehensive and evidence based analysis was commissioned. Stakeholders including people using the service; carers; staff and the wider community, such as partners from Somerset health and social care commissioners and providers, were consulted with. Following the 'Fit for Future' project the board of Trustees were in the final stages of deciding how St Margaret's will deliver services in the future to meet the needs of the local community.

The hospice played a leading role in promoting end of life care within the local community and had developed strong links with many community groups. For example Public Health, Somerset Health Watch, Somerset County Council, Somerset CCG, Somerset Partnership, Acute hospital trusts and many local charity and volunteer engagement groups. Feedback from community health and social care professionals was very positive about the working relationship they had with St Margaret's and showed the service was highly effective and responsive.

The hospice was participating with various research projects. For example; a randomised trial of clinically assisted hydration in cancer patients in the last days of life; the value of early intervention of palliative care in mesothelioma patients; improving rehabilitation in palliative care using goal attainment scaling and an observational study of diagnostic criteria, clinical features and management of opioid-induced constipation in patients with cancer pain. A consultant was leading on an initiative to provide support and encouragement for other hospice groups to become more involved with active research. A consultant had led the planning for a study event in February entitled 'How to become a research active Hospice/Supportive Care Centre' with the local National Institute for Health Research (NIHR) research delivery lead.

The service continued to develop ways of helping people live with life limiting illnesses and complex needs. For example, they were developing a provision of exercise and the 'pop up gym' concept for people based in the Sunflower Centre. The aim was to improve and maximise strength, balance, and stamina of people and an awareness of the benefits of exercise.

People's views and experiences of the service were sought in a variety of ways. The hospice used a national questionnaire 'I want great care' which asked respondents to rate their care using five key questions. For example, about dignity/respect, involvement, information, caring, support from staff and whether they

would recommend the service to others. The hospice had received over 1,500 reviews and scored the maximum of five stars. Comments included, "Everything was amazing about my care. Nothing was too much trouble to make me feel so at home"; "Couldn't have been more thoughtful and caring. Gave moral support and confidence. Well done 10/10"; "I have been very impressed with the care and kindness I have received. All the staff are very supportive and it's very comforting to know that if I have a problem and not feeling too well there is always someone there to talk to" and "Everything brilliant. I do not consider that it could be improved."

There was also a visual aid for feedback within reception called 'Your token counts'. People could put a token in the clear box which matched their general views. The caption on the box explained that the hospice were continuously trying to improve the patient experience and asked how likely people were to recommend the service to friends and family if they needed similar care or treatment. There were four different colour tokens to represent the inpatient unit, sunflower centre, therapies and clinics and lymphedema. Feedback cards were available nearby so that people could write explanations for their choice of slot. People's feedback was extremely positive showing the service was highly valued.

The provider had worked to maintain and improve high standards of care by creating an environment where professional excellence could do well. Staff received excellent training and professional development via the academy. The provider had recognised the value of having a tissue viability specialist as part of their quality improvement initiatives. As a result, one member of staff was supported to complete their Masters in 'Tissue Viability' in 2017. Their work with the staff team on improving pressure ulcer care had a positive outcome resulting in reducing pressure ulcer incidence on the units by 81% between 2012 and 2017. The hospice had also developed excellent training and support for care home and nursing home staff to ensure people received the best possible care in their preferred setting.

The provider information return (PIR) confirmed a professional librarian was employed to keep libraries updated, catalogue all books and provided staff with support with literature searches for projects and for staff undertaking professional development studies. The librarian had a mailing list for staff and sent weekly updates from Kings Fund, Hospice UK, Macmillan, NICE, and the Royal Colleges. The hospice was a member of the National Palliative Care Educators for the South West. Staff worked together with other local hospices and attended national conferences. Two community staff had been awarded the certificate for 'Outstanding Commitment to Practice Based Learning' by Plymouth University in recognition of their commitment to nursing students on placement with the community team.

Staff attended various Hospice UK network meetings to keep up to date and share good practice ideas and innovation. A number of staff presented posters at the Hospice UK National conference for the past two years.   The hospice organised a successful 'Dying Matters' conference last year for all those involved in the delivery of End of Life Care in Somerset. It was extremely well attended and evaluated by over 200 people and another was planned for this year.

Staff were very well supported and valued by the management team. Staff expressed confidence in the leadership at the service and described it as good place to work, where they were "…respected and valued…" Staff felt the senior management team were supportive and approachable. All staff reported how much they enjoyed their role at the service. Staff reported feeing supported both emotionally and physically. Comments included, "We have a fantastic team here. We get great training and support. The team work very well together. We trust each other, which holds us together in this difficult job…" and "Great to be able to spend time with patients, it is a pleasure to work here." They said they could always talk to doctors, the spiritual care co-ordinator, senior staff or the external health and wellbeing agency access provided for them.

The hospice was developing innovative approaches in an attempt to reach more people in the local rural communities. St. Margaret's were working with other partners locally and nationally to move plans forward by focusing on community development work including the roll out of the Extension for Community Healthcare Outcomes (ECHO) project. ECHO is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, where they live. The aim was to increase access to specialty treatment in rural and underserved areas by providing front-line clinicians. The service had been successful in their application to become the ECHO hub for Somerset enabling the hospice to increase the reach of tele-mentoring and education for key groups across the county. They had also been successful in a capital bid submitted to NHS England focused on technology for the ECHO project.

The success with the use of the Integrated Palliative care Outcome Scale (IPOS) was being shared with other organisations including other hospices in the South West, acute trusts, Somerset Partnership, the Clinical Commissioning Group and The South West Academic Health Science Network). The aim was to support IPOS across settings, enabling patient outcome data to be shared contemporaneously and consistently to improve outcomes for people.

There was adherence to national clinical guidelines and a culture of evidence based practice. For example, there was a comprehensive clinical audit programme which included regular benchmarking with The National Institute for Health and Care Excellence (NICE) guidance. The service was a partner in the Somerset End of Life Care Strategy for 2016-19. The strategy aimed to ensure that all people at end of life, together with those closest to them, are able to express their needs and wishes, and that as far as clinically appropriate and practically possible, these needs and wishes are met. The hospice worked in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations. They had suite of policies and procedures which were in line with national best practice and were reviewed regularly to ensure they remained relevant and up to date.

A clear clinical governance structure outlined responsibilities and reporting mechanisms ensuring information was communicated to all staff within the clinical teams. The principle was to balance the risk between keeping people safe whilst promoting and maintaining their choice and independence. An organisational risk register was used to record identified risks for each directorate area and was reviewed quarterly by each Director. This included clinical risks which were reviewed by the Clinical Director with the Clinical Quality and Education committee. Working groups were established to address highlighted risk areas or concerns. For example, a working party had been meeting to ensure compliance with the new General Data Protection Regulation (GDPR) legislation.

There were robust systems in place for identifying risk and monitoring quality against national standards. A range of audits were completed regularly and informed actions to continuously improve people's experience. For example, audits of falls, drug errors, and pressure ulcer management. There was evidence that learning from incidents took place and appropriate changes were implemented. Accidents and incidents were recorded and reported in a timely manner. Incidents were dealt with effectively and action was taken to prevent them happening in the future. The registered manager monitored all adverse events and near misses in order to identify any trends. The review of incidents and accidents and near misses was a standard agenda item at board meetings.

The service was reviewing staffing requirements to ensure efficient use of staff and volunteer. The service was taking every opportunity to develop new roles within the organisation to ensure they had a sustainable and competent workforce for the future. They had one health care assistant apprentice in post and were working with the local hospital to facilitate nursing associate placements. The hospice had increased the

numbers of non-medical prescribers to ensure people received timely and effective care and treatment. Further integration of hospice community teams within local District Nursing teams was planned. For example finding ways for CNS and community district nurses to work together at the same location within the local community

The PIR was comprehensive and identified areas for improvement and development. Such as the continually improving the current electronic care records to ensure the system was effective and setting up workshops to improve various topics.

The registered manager sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements.

On arrival at the inspection the provider had not clearly displayed the rating from the previous inspection in the reception area or on the website. The registered manager explained this was an oversight and immediately arranged for the rating to be displayed in reception and on the website.

The provider was in the process of implementing the Workforce Race Equality Standard (WRES), to demonstrate how they were addressing race equality issues in a range of staffing areas. Implementing the WRES is a requirement for NHS commissioners and NHS healthcare providers including independent organisations.