

Hospiscare

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Inspection report

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

Hospiscare is a charity which was founded in 1982 as a community service which expanded to include the building of a purpose built inpatient unit in 1992. Hospiscare serves the people of Exeter, Mid and East Devon. In 1995 Hospiscare appointed a specialist nurse to work at the Royal Devon and Exeter Hospital to visit patients and provide education and this has grown to a small specialist team. Hospiscare provide palliative and end of life care, advice and clinical support for people with progressive, life limiting illnesses and their families and carers. They deliver physical, emotional and holistic care including counselling and bereavement support, outpatient clinics, occupational and creative therapy, complementary therapy, chaplaincy and volunteer services. The hospice inpatient unit at Searle House Hospice is registered to provide care for up to 12 adults who require complex symptom control or end of life care. The average length of stay is two weeks. The service provides acute care for people and does not provide a respite service or have longer stay beds. In 2006 a new visitor accommodation was opened allowing families to stay close to the ward. The majority of people are cared for in the community, currently around 770 people. Last year Hospiscare cared for 2,225 people, their families and loved ones. The service also has sister charities which provide community care for people in Exmouth, Budleigh Salterton and Sidmouth and three day centres, a Wellbeing Suite in Exeter and day centres in Tiverton and Honiton.

The service continuously looked at the local community to see how best they could provide the service. This had resulted in the expansion of day service provision and the Hospice at Home service in Seaton, East Devon. This comprised of a team of registered nurses, community nurse specialists and health care assistants working closely with local GPs. This meant that people in Seaton benefitted from a holistic service from the Hospiscare Hospice at Home team who could also provide district nursing support in people's homes therefore maintaining consistency and reducing the number of professionals visiting their homes. The Hospiscare Hospice at Home service started in July 2015 and provides responsive end of life care and support to patients and their families in their own home or a care home. The service operates 24 hours a day, 7 days a week with access to doctors, registered nurses and health care assistants as well as ancillary staff and therapists.

The Hospice at Home staff were all employed by Hospiscare and worked with other health care professionals in the community. Services were free to people and Hospiscare was largely dependent on a large team of volunteers, donations and fund-raising. A comprehensive training centre in Exeter also offered advice and support to Hospiscare staff and external health professionals such as those in nursing and residential care settings in the community. The service had also recognised a need to provide specialist training and end of life care for people living with dementia and their carers, recently employing a specialist dementia care nurse, and had established links with the local prison service. The service was outstanding in the way they explored and maintained close partnerships with a wide range of external services providing end of life care such as other charities, community health professionals, hospitals and on-call out of hours services, agencies and care providers. The service worked in partnership with other organisations to drive improvements at national level for the benefit of people who used hospice services as a whole .

This inspection was carried out on 21, 22, 24 March and 11 April 2016 as it was a large service covering Exeter, East and Mid Devon. It was carried out by a lead inspector, a bank inspector, a pharmacist inspector, an expert by experience and a specialist advisor in palliative care. It was an unannounced inspection. There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They oversaw the running of the service and were supported by a leadership team that included the chief executive and directors, assistant directors and department managers. The service was last inspected in November 2013 and found to be compliant in all areas inspected.

The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death in the place of their choice as much as possible.

Staff were trained appropriately and had excellent knowledge of each person and of how to meet their specific support needs. Staff went that extra mile to ensure people's needs were met in a holistic way including support for people's loved ones. Hospiscare were pro-active in providing support and training for external services and health professionals in the community and had a culture of sharing knowledge and education. Staff had received essential training including end of life care and were scheduled for regular refresher courses. Staff had received further training specific to the needs of the people they supported. All members of care and support service staff received regular one to one or group supervision and support with clinical supervision and professional validation. This ensured they were supported to work to the expected standards and career progression and knowledge was encouraged.

People's feedback was actively sought, encouraged and acted on. People and relatives were overwhelmingly positive about the service they received. They told us they were extremely satisfied about the staff approach and about how their care and treatment was delivered. Staff approach was kind and compassionate. Relatives told us staff were very supportive and kind and nothing was too much trouble for them. People's feedback about the caring approach of the service and staff was overwhelmingly positive and described it as "amazing." Clear information about the service, the facilities, and how to complain or comment was provided to people and visitors and there was opportunity for people to be directly involved in providing comment and feedback linked to formal audits.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place which included the checking of past conduct and suitability from previous employment to ensure staff were suitable to work with vulnerable people.

Staff communicated effectively with people, responded to their needs promptly, and treated them with genuine kindness and respect. Staff knew each person well and understood how people may feel when they were unwell or approached the end of their life. They responded to people's communication needs. People and/or their families were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. One relative confirmed, "I am always informed if there's any problem or

change in the care plan." Plans in regard to all aspects of peoples' medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people according to their individual plans and provided outstanding care.

The environment of the inpatient unit was purpose built and had been well utilised for ease of access for people. It was welcoming, well maintained and suited people's needs. The clinics, therapies, day centre and support groups were held in the same building in Exeter surrounded by well maintained, accessible and beautiful grounds. The building was opposite the Royal Devon and Exeter Hospital with whom they had a close relationship and the Palliative Care Hospital Team was based in Searle House.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered the requirements of the Mental Capacity Act 2005. People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent or refusal before they supported them.

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

People were involved in the planning of activities that responded to their individual needs. The hospice mainly cared for people with acute needs meaning they were unwell or at the end of their lives. Therefore, activities in the inpatient unit were more based on therapeutic methods such as therapies and spending time with people. Day centres provided more varied and creative activities based on people's needs such as a specialist day centre for people living with dementia. Attention was paid to people's individual social and psychological needs.

The registered manager was open and transparent in their approach. Hospiscare was clear about their visions and values, "Because we value dying as an important part of living and believe that 'every day matters' to people approaching the end of their lives." Staff demonstrated this vision in their practice and gave person centred, individualised care. Staff told us they felt valued and inspired by the registered manager to provide a high quality service. They described the registered manager as open and supportive. Relatives' comments about the management of the service were extremely complimentary.

Emphasis was placed on continuous improvement of the service. Comprehensive audits were carried out about every aspect of the service to identify how it could improve and use funds effectively to meet the needs of specific communities. When needs for improvement were identified, remedial action was taken to improve the quality of the service and care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

The environment was fit for purpose and well maintained.

Medicines were safely managed.

Is the service effective?

Outstanding 

The service was exceptionally effective.

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

The service took a vital and key role in the local community, for example providing training and support with a care home initiative and reaching out to minority groups such as people living with dementia and prisons to enable them to access good quality end of life care.

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

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

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

timely way.

Is the service caring?

The service was very exceptionally caring.

People's feedback about the caring approach of the service and staff was overwhelmingly positive. The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death in the place of their choice as much as possible.

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

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

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

Outstanding 

Is the service responsive?

The service was exceptionally responsive.

The hospice used knowledge of the local community to continue to develop a service which best met local needs.

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

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

Outstanding 

Is the service well-led?

The service was exceptionally well led.

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

Outstanding 

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

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

Information about the needs of the local population had been used to develop specialist support.

Strong emphasis was placed on continuous improvement of the service and best practice. Ideas from staff had been encouraged and implemented to drive service improvements and ensure best practice.

The service worked closely in partnership with other organisations and spoke nationally. It conducted research and projects to ensure best practice and to promote the future of hospice services to provide a high quality service.

Hospiscare

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. The service was last inspected in November 2013 and found to be compliant in all areas inspected. This inspection took place on 21, 22, 24 March and 11 April 2016. The first day was unannounced and subsequent visits were organised to ensure we met with key people within the service.

The inspection team consisted of a lead inspector, a bank inspector, a pharmacist inspector, an expert by experience and a specialist advisor in palliative care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people who approached the end of their lives.

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

We looked at the premises, spent time in Searle House inpatient unit, outpatient clinics and day services and went out on visits with the community nurse specialists (CNS) and a Hospice at Home community nurse specialist. We were able to visit people in their own homes with their permission. We looked at ten sets of records that related to people's care on the electronic computer record system. We looked at the systems in place for managing medicines, spoke to staff involved in the administration of medicines, and examined ten people's medicines charts. We looked at six people's assessments of needs and care plans, two hospice at home records and records for people in the community. We consulted documentation that related to staff management, training and supervision and four staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and the activities programme. We observed a 'ward round', staff handover, a community palliative care team meeting, multidisciplinary team meetings and the administration of medicines. We sampled the service's policies and procedures.

We toured all areas of Searle House inpatient unit and spoke with three people who were receiving care in the inpatient unit and three of their relatives. We spoke with two people in the outpatient clinic and their relatives. We also spoke with three people receiving care from the Hospice at Home service and one relative and two people and three relatives in their homes who had visits from the community nurse specialist team. We visited the specialist dementia day centre spending time with eight people and spoke to the community nurse specialists and chef based there. We also visited a nursing home participating in a care home training project with the hospice.

We spoke with the registered manager/director of nursing, assistant director, the chief executive, chaplain, the inpatient unit manager and eight registered nurses, four doctors, two specialist palliative care consultants, the Hospice at Home team leader, health care assistant and six community nurse specialists. We also spoke with the kitchen staff, training team manager and assistant, an administrator, a volunteer and the estates manager. We obtained their feedback about their experience of the service.

Is the service safe?

Our findings

People told us they felt safe receiving the service. They said, "I am very safe here", "I feel really safe and secure. I felt like I had come to heaven" and "I have faced up to dying and I don't want to die alone, I'm happy I'm here." Staff said, "Staff are dedicated to patients, families and people who work here. Staff will go out of their way, they stay on shift if someone is distressed, above everything else care and safety are everything to the staff who work on the unit."

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

Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. The PIR shared an example of how formal concerns were raised and investigated fully resulting in a report shared with the clinical governance committee and health ombudsman. Staff said, "Senior management are supportive and I am not afraid to go to them, there is a 'No blame policy'."

There were sufficient care staff on duty, to support and care for people in the inpatient unit, community and Hospice at Home. The service currently had 160 staff and more than 1,000 volunteers. The staffing levels on the inpatient unit were high, 1:2 in the morning, 1:3 in the afternoon and 1:4 at night. No agency staff were used, the hospice used its own supply of regular bank staff for consistency who covered for holidays and sickness. A team of doctors worked across all Hospiscare services and visited people in the inpatient unit, at home, care homes, in out-patient clinics or in hospitals. One of the doctors was always on-call at weekends and overnight for advice with a consultant in palliative medicine consistently available for further advice if needed.

Staff told us there were enough staff to care in the way people needed and at times they preferred saying, "I get job satisfaction, there is a lot of paperwork but I have time to give patient care." We observed staff were available to help people at various times depending on their wishes. People told us staff always had time to talk and they did not feel rushed or have to wait for assistance. One person said, "Yes, I know where the call bell is and I have used it regularly and the staff come straight away." Another person said, "The staff are wonderful and they come and talk to me day and night, whenever I want."

Safe recruitment procedures were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable to work with vulnerable people. Proof of identity and right to work and reside in the United Kingdom prior to starting to work at the service had been checked. References had been taken up when staff were appointed and were obtained from their most recent employer. Disciplinary procedures were in place

to ensure staff respected their code of conduct. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual and were reviewed and updated daily by nurses. Staff were aware of the risks that related to each person. For example, infection control, moving and handling, communication and personal care.

Risks were also communicated to the nursing team on handover and on a patient board. Risks relating to pressure sore prevention were very well documented with clear actions and records. Thought was given to balance risk management and people's preferences and comfort when they were at the end of their lives. Records showed clear involvement with people about safe management of risk that was also acceptable and proportionate to their needs. Therefore measures were in place to keep people as safe as possible depending on their needs and preferences.

Medicines were supplied by an agreement with the pharmacy department from the local NHS hospital trust, who also provided medicines information services to the hospice. There were no clinical pharmacy services being provided, but this was being looked into, with a view to arranging a service in the future. There were systems in place for checking of prescriptions, medicines brought in on admission, and medicines to take home.

Medicines were prescribed on dedicated treatment charts. These were appropriately completed by medical and nursing staff. There were systems in place for safe prescribing and use of 'when required' medicines, medicines administered in syringe drivers and non-prescription medicines for minor complaints. People's medicines use was regularly reviewed and discussed at daily multidisciplinary meetings. There were no patients looking after their own medicines at the time of our inspection, although there was a policy for allowing people to do this, if it had been assessed as safe for them.

Medicines were stored safely, although some intravenous fluids were stored in an unlocked cupboard. We were told this would be addressed immediately. Medicines requiring cold storage were kept within a monitored refrigerator in the treatment room, although processes for recording the temperature range needed updating. There were suitable arrangements for controlled drugs and emergency medicines.

Comprehensive policies and procedures were available for staff and these were kept under regular review. Staff received relevant training and checks so they could give medicines safely. There were regular medicines audits and systems for the reporting and learning from any incidents.

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

Infection control practices were evident, items such as commodes and trolleys had labels stating when they were cleaned. Infection controls audits were carried out regularly overseen by an infection control lead nurse. Detailed infection control policies were in place and had been reviewed to reflect current national guidance. These included a hand washing policy and standard precautions, such as instructions concerning how to deal with spills of bodily fluids. Hand washing audits had been introduced and staff were observed washing their hands after they had been in a person's room. Staff wore appropriate personal protective

equipment (PPE) which was in ample supply. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks that included clear guidance for staff to follow. Staff understood how they should respond to a range of different emergencies including fire, and fire training was part of their induction. Staff took part in regular fire drills which helped them to remember the procedures and there was appropriate signage about exits and fire equipment throughout the home. The estates manager was responsible for the fire safety induction of all staff carried out quarterly training for all staff so they were aware of what procedure to follow out of hours. Fire safety equipment had been serviced and was regularly checked. For example, a fire assessment was carried out once a year by the Devon Fire Service.

All equipment was maintained and regularly checked by appropriate contractors. There was a health and safety 'walk around' spot check done regularly by the estates manager. The maintenance log on the unit was checked every morning. The estates manager said, "There is good communication with nurses on who to escalate problems to". For example, there was an issue with builders arriving blocking the entrance of the hospice, quick action by staff averted the blocking of the entrance and disruption to the service as staff knew who to contact.

Accidents and incidents were recorded and monitored using an electronic patient record to identify how the risks of recurrence could be reduced. There were records showing external clinical incidents, internal and incidents relating to drugs, pressure sores or falls. All incidents are reported to the quality team who analysed the findings and ensured appropriate actions were taken. The quality team also completed notifications required by CQC.

Is the service effective?

Our findings

People consistently said staff gave them outstanding care when they needed it. People's comments included, "They are always there when I need them, I could not have managed without their support" and "I look forward to my weekly visit and if I didn't have that I would have returned to 'the bottle'." A relative told us, "Thank you for the friendly, effective and supportive service with great care given to allow [person's name] to remain in the place they loved so much." A GP working with the Hospice at Home service had written to the staff to say, "We are always amazed how you manage to keep such a high standard of care" and "It is thanks to your ceaseless support and understanding that [person's name] was able to continue doing the things they loved so much." Another inpatient unit doctor said, "Staff on the unit are very knowledgeable and we all work at the same level together."

The service continuously looked at the local community demographic to see how best they could provide the service. The service had recognised a need to provide specialist training and end of life care for people living with dementia and their carers. There had been outstanding work to ensure people living with dementia and receiving hospice services had their needs met. All trustees and many staff had completed training to become 'dementia friendly'. This meant staff and trustees were aware of the specific care required for these people. The dementia specific day centre at Pine Lodge, Tiverton. This offered day care for one day a week for eight people. Following referral people were invited with their relatives for coffee and assessment. One person living with dementia had commented in a recent questionnaire with their relative, "The care was excellent and really took me out of my usual environment, it felt like a holiday." A relative said, "It's a lifeline, I know they are comfortable and there is someone to talk to if they aren't well or if I have worries. It's a different kind of service planned for individual needs." A psychiatrist had contacted the day centre to comment, "We welcome these additional resources. My patient was at high risk of their mental health relapsing and the time at Pine Lodge maintained their stability and prevented admission to hospital."

The day centre was able to make direct referrals to the older people mental health teams, for example for treatment and medication review of increasing behaviour which could be challenging for staff and families. The day centre provided respite for relatives and appropriate activities for people living with dementia using electronic tablet dementia friendly applications, quizzes and games. All volunteers throughout the service also attended dementia awareness training. Each person receiving the service had a 'This is Me' document devised by the Alzheimer's Society which detailed person centred information to enable their individual needs to be met and trigger conversations. For example, to ensure the person had their mug half full, discreetly ensuring their clothes were on properly and facilitating personal care in a person centred way that reduced aggressive behaviour. Where people living with dementia were transferred to a care home setting, this information was shared to ensure consistent care. One community nurse specialist told us how they worked with the day centre and made referrals from the community. For example, one person receiving hospice services had a spouse living with dementia and staff made sure they were well cared for, assisting them in learning how to re-use the telephone and arranging effective personal care packages and supporting them following bereavement. There were also regular carer support groups and bereavement groups available in various locations. Staff actively looked for other projects and services external to the hospice which could benefit people. For example, the local 'Forget-me-Not café' support group and

reminiscence groups.

The hospice had recently employed a dementia specialist nurse. They were working towards launching an end of life dementia care strategy in June 2016. They had spent several days working at the Tiverton day centre, offering advice and support to the lead nurse and volunteers on how further to support people living with dementia. They gave advice about how to support one person with behaviour which could be challenging for staff. They looked at why the behaviour was happening and what strategies could be used to support them. The dementia nurse specialist was also able to advise a GP who was reluctant to visit someone living with dementia. Their advice about symptom control management was effective in benefitting the person. The dementia specialist nurse had plans to set up an outreach clinic for carers in the support and management of the disease and challenging behaviours in the very near future. They worked with the Hospiscare trainer and were devising new high quality specialist training for registered and non-registered health care professionals. There were consultations underway relating to whether hospice staff should wear uniforms to reduce social barriers and an institutional feel, particularly for people living with dementia. Training in dementia and end of life care was a mandatory part of the new staff induction programme for all staff including volunteers. Staff told us when people living with dementia were admitted to the inpatient unit there were meetings with the relatives so that all those responsible for their care could work with the relatives for the best outcome. This emphasis on how to meet the needs of people and their carers living with dementia is an example of outstanding practice.

The hospice had also identified that end of life care for people in the care of the prison community could be improved. They had developed links with the local prison through the Devon Prison Cluster Mental Well-being Co-ordinator and the community nurse specialists were available for advice and support, for example relating to managing complex symptom control. They had facilitated training specifically for prison staff caring for those requiring hospice services. This had included the principles of end of life care, management of syringe drivers (a method to deliver symptom control drugs) and nutritional advice at the end of life. Hospiscare staff had devised a nutrition resource file for the prison as previously a soft diet had been basic such as scrambled egg. This included how to present attractive and nutritious meals especially for people who required a pureed diet but in line with prison diet resources. The folder contained pictorial examples such as the use of ice cubes and blended food and pureed meals that were quick and easy to prepare. This work was then shared with a hospice in Dorset and Dorset CCG (clinical commissioning group) to encourage hospice links with the Dorset prison community.

Staff were knowledgeable about people's needs. Staff shared information about people's care using a comprehensive computer system which enabled all staff to access all of the information about a person and their needs. The inpatient unit had recognised a need for paper care plans by the bedside and printed handover information to enable easy access to important information and enable quick record keeping. Staff knew how to communicate with each person. Care plans detailed how people communicated, including mood and expectations. For example, one person was concerned about body image and had been referred to the local cancer charity for support.

Handovers took place between staff shifts and updated information about new admissions, people's health condition, their mood, their appetite and medicines reviews was communicated appropriately. Staff said there was good communication between all staff, there were multidisciplinary meetings each morning, a midday handover with the doctors and night time handovers for night staff. This system ensured effective continuity of care so that staff were knowledgeable about people's individual care and treatment. People's individual health needs were discussed in detail at multidisciplinary meetings.

Staff were well supported, especially able to discuss their feelings when a person died. They were able to

take time to talk, receive de-briefing and counselling and could access the chaplain at any time.

There was an excellent training manager and education department. The training manager was clearly passionate about their work. The hospice was keen to share their expertise and pro-actively reached out to external stakeholders to provide specialist training. An excellent project was underway. Working with Devon Care Training research had shown care providers found it difficult to release staff for end of life training. Funding had been sought to implement a model of blended health and social care experiential learning within the workplace. This was achieved by funding two hospice assistant practitioners to work within participating care homes for a six week period over ten sessions. They worked alongside care workers observing, supporting and demonstrating excellent end of life care.

There were clear assessments and measureable outcomes including increasing advanced care planning for more people, identifying preferred place of death, individualised end of life care planning and a decrease in avoidable admissions. At one nursing home involved in the project, the home manager told us how they had learnt new skills, for example, to aid with hair washing and mouth care. They said if they had any questions they could ring the CNS team and they would visit straightaway. In particular they had learnt how to prioritise care needs at end of life, for example recognising when a diabetic diet was not so important as providing some nutrition and reducing unnecessary movement. Staff from care homes had also been able to shadow staff within the hospice inpatient unit to give them a greater insight into hospice care, and free training if they were part of the programme. All staff praised the training manager saying, "He is so inspiring as an education manager. We want education to bear fruit and we are seeing progress." Staff said how good the training was saying, "We are well supported. There is training on everything and we are encouraged to improve. I've been on mentorship training, intravenous drugs training and there are tissue viability champions to give advice on skincare and dignity champions." The training manager said, "We are all about people. All staff have a voice and a value and we utilise their skills." A care home project assistant practitioner for example, had gone on to qualify as a trainer in end of life care.

The hospice offered training for many external health professionals in end of life care topics as well as all hospice staff. This included the hospital, 'bite size' training for care homes, Devon Doctors, the prison, carers and nurse master classes. All training supported the recommendations in the 'End of life Care Strategy' (Department of Health 2008) and 'One Chance to get it Right' (Department of Health 2014) in order to help improve palliative care in all settings. The education programme for 2016/17 was extensive covering topics such as dementia, verification of death, what to do when someone dies, dignity in care, communicating and grief. We attended part of a nurse master class. The consultant was demonstrating through role play communication techniques. There was time given for questions and candidates interacted with the training team. Questions were asked and responded to with good quality answers. There were also ten inspirational talks lasting 20 minutes which could be accessed by staff. There was a Managers' Education Programme including courses in managing to lead, dealing with the pressures of managing, managing time and energy and analysing employee performance, for example. All staff could also access distance learning courses and further education. People were protected from discrimination. Equality and diversity training was mandatory for all staff supported by an equality and diversity policy.

Practical clinical courses included competency monitoring for staff. For example, there was a blood transfusion champion who organised this training based on National Patient Safety Agency (NPSA) competencies. These were reviewed three yearly to ensure staff were safe to manage blood and blood products.

There was specialist training for consultants, GPs and medical students. This included 'Goldfish Bowl' training where doctors discussed peoples' 'journeys'. Training was given to medical students for nine weeks

at the hospice, three times a year. These students worked with consultants and nurses, they shadowed community liaison and support teams. Training included 'breaking bad news' using actors which was very interactive. For example, a medical student broke bad news to an actor, the actor reacted and the session was stopped with the student and fellow students asked to discuss how the news could have been broken differently. In addition a work observation week was successfully organised with Royal Devon and Exeter Hospital for the third year running for local school leavers with an interest in a clinical career. Sessions were planned over three afternoons with a total of 60 teenagers learning about the importance of end of life care, fundraising and volunteering.

Staff were supported and assessed using a thorough supervision and appraisal programme. All new staff were required to complete a thorough induction, and worked alongside more experienced staff, of a relevant grade. We saw a new member of staff being supported in their new role, they were not counted in the numbers of staff, and shadowed another staff nurse. Supervision reviews were recorded, up to date and meaningful taking into account any issues or training needs. Staff were able to apply for performance and commitment award (PCA) linked to pay awards. Staff submitted evidence to show how they were achieving Hospiscare values. For example, one nurse had arranged a visit to a person's spouse's grave and their own home for the last time. They also gave examples of how they had communicated with a person with dementia, discovering their interests, walking in the garden with them and encouraging them to play a game with another person. Their relative had then been able to leave them knowing they were well looked after. This process was seen as encouraging staff to be innovative and ensuring they understand the hospice vision and values.

The comprehensive training, monitoring and support systems for staff ensured staff had the knowledge and skills they needed to care for people effectively and had opportunities for career progression and job satisfaction which led to retention of quality staff. There were staff who had retired who returned in other roles or volunteered, for example, who were valued as part of the 'talent pipeline'.

Staff sought and obtained people's consent before they supported them. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated a good understanding of the processes to follow. Staff were trained in the principles of the MCA and the DoLS and these were applied in practice, routinely discussed in multidisciplinary meetings. When people had been unable to leave unaccompanied and needed continuous supervision to ensure they remained safe, their mental capacity had been assessed appropriately. This ensured people's rights to make their own decisions were respected and promoted when applicable.

When people had been assessed as being unable to make relevant and specific decisions, applications for the authorisation to restrict their freedom in their best interest had been submitted to the DoLS office. DoLS applications were completed by the multidisciplinary team or quality lead. Comprehensive records were made of how appropriate meetings had been held to discuss people's best interests and decision making, in accordance with the requirements of the MCA. The legislative framework ensures decisions are made in people's best interests if they lack capacity. We observed throughout the day that people were supported with decisions around their care. All staff at handover demonstrated that they were clear about not

restricting people's rights and choices without them being assessed as lacking capacity and that there should then be a 'best interest' meeting. There were many examples on the electronic computer system showing how staff respected peoples' decisions putting people at the heart of decision making.

People praised the food that was served; their comments included, "Yes, it's yummy and lots of choice, as much as I can eat" and "[The food is] very appealing, so well presented with the doily and the flowers on the tray." Relatives were able to order food too and commented, "I also eat here as well and the food is very good."

Menus changed on a five week cycle giving plenty of choice. The chefs told us how they would make anything for anyone and meals could be bespoke if there was nothing on the menu that someone fancied. Out of hours there was always something to eat on offer and kitchen staff said inpatient unit staff would drop into a supermarket and pick up things like steak or whatever was out of the ordinary for people. The coffee shop menu was available from 8am till 5pm and after 5pm people could still get hot drinks and snacks. In a smaller kitchen on the inpatient unit, people and their relatives could access tea, coffee and milk shakes and snacks and staff put small pots of flowers onto the trays as a nice touch.

People were referred to healthcare professionals when necessary. Staff worked in close partnership with people's GPs when they supported people in the community. The service's community nurses specialists (CNS) were 'attached' to GP practices and attended regular 'Gold Standards Framework meetings'. All organisations providing end of life care are expected to adopt a co-ordinated process such as the Gold Standards Framework, which is a systematic, evidence based approach, developed to improve quality of care for patients with a life-limiting illness. Hospice at home nurses had good relationships with local pharmacies and were able to access medication in a timely way. Good communication, face to face, records and access to computer systems ensured that end of life care was provided in partnership with the wider community for the benefit of people.

The environment was purpose built and had been well utilised for ease of access for people. It was welcoming, well maintained and suited people's needs. The premises had been designed and decorated taking people's physical and psychological needs into consideration. The main entrance has a spacious reception area, which led to a café and the inpatient unit, day centre and clinics. There was a beautiful garden area which people could access in their beds if needed, well maintained partly by a loyal group of volunteers.

Is the service caring?

Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided, and the manner in which it was delivered. All their comments were outstandingly positive.

The atmosphere throughout our inspection on the inpatient unit was relaxed and welcoming and interactions from the staff towards the people who used the service and their relatives were very positive and caring. Relatives praised the dedication of the staff and said, "The hospice has looked after us very well" and "The staff are very caring and very respectful and we are treated with compassion too." Other people's comments included, ""Yes, they treat me with the utmost respect and dignity." One relative said a suite or rooms were made available for them which were much appreciated. They explained that the standard of facilities were to a high standard and very comfortable.

There were many testimonies on the iWantGreatCare website, a national website which services can sign up to collect online feedback which Hospiscare monitored. The hospice had achieved a five star rating (the highest available). People's recent testimonies included, "The patient was always consulted and made to feel important and special. The relatives were advised and genuinely cared about too. The next stage of the illness was predicted and equipment suggested to deal with it. It was therefore always available when needed. We know we could call any time for help. The girls work well as a team", "The care for my sick husband, and for me, could not be more caring and loving", and "The nurse took time to allow me to ask questions and check things through. She also gave me a very comprehensive overview of the service which again gave me knowledge and understanding. The above were all completed in a caring, professional way. The overriding feeling I had was support for the individual. What great support in a time of worry and uncertainty."

Staff were positive about the care they were supported to provide. Staff comments included, "It is a special place like an extended family, everyone supports each other. It's rewarding being in other peoples' lives at a difficult time, helping them through it, it's a privileged job". Staff all spoke about how it was a great place to work. Comments by a volunteer who was part of the 'Welcome Team' greeting people and showing people around, setting up rooms and putting people at ease included, "I'm a small cog in a big wheel, but it's worth it. If I had a terminal illness I would love to face death here". A Hospiscare quarterly review of the online comments also found the feedback was overwhelmingly positive.

There was a homely feel to the service in the inpatient unit. There was a social atmosphere where people were encouraged to chat if they wished and were listened to. Visitors were welcome at any time. In 2006, the hospice inpatient unit had expanded to include new visitor accommodation so people could be near their loved ones. People said they never felt they were stopping staff from 'getting on' and that staff were there for them to talk at anytime day or night. Staff were smiling and engaging, they stopped to listen to people and responded to them with genuine interest. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they conversed with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their

preferred names.

All staff had examples of how staff had overcome barriers to go the extra mile for people. The kitchen staff told us they had catered for a 90th birthday party for one person and also for their daughter's wedding. They had put up bunting in the day centre and made it a special day. There had been a 60th birthday party in the garden and the kitchen staff had served baked potatoes and a buffet. Staff told us about five other weddings they had hosted, with two on the same day within half an hour of each other and also Christenings had been held there.

Hospiscare staff enabled one person to attend a party with limousine transport. They said on the Hospiscare website how, "Earlier in the day I had the most wonderful jacuzzi bath which lifted my mood. Hospiscare staff gave me a wonderful, massive birthday cake with huge sparklers, then a Hospiscare nurse painted my nails, and the adrenalin just flowed like a drug. I have my family and friends who are my main supporters and I have Hospiscare which gives me physical, emotional, mental and social support. A Hospiscare hairdresser cut my hair and on my birthday, the day before the party, I had a hand massage. They made me feel pretty."

Another spouse of a person at the end of their life told their story on the website. They said, "[Hospiscare staff] lifted me, from opening the front door into reception and receiving a warm greeting and knowing you are being looked after, to the spiritual help from the chaplain, to the doctors who sit quietly and talk about change of medication, to the male nurse who would just know when to give a hug, it was seamless care. It was so professional and yet so warm." They added how thrilled their spouse had been when her dog was allowed to visit her and lie on their bed, saying, "That made a big difference, especially on Christmas Day. It was so comforting."

We saw during the inspection that care, consideration and compassion were high in the culture of everyone working for the hospice. This was further seen in an address given during a 'Light up a Life' service hosted by Hospiscare at Exeter Cathedral. A hospice doctor gave an address discussing the saying, "It is a sick doctor who is not healed by his patients." They went on to give a non religious speech about how sacred ground is where human beings care and heal one another and how we are all connected. They spoke of how this was made possible by everyone involved with Hospiscare, 'a sacred ground'. There was a great sense of the privilege they felt in being involved.

Searle House Hospice inpatient unit had a chapel where people could go for quiet, peaceful contemplation and reflection. It was a very open room for people with any religious or spiritual belief, with four stained glass windows and a centre table where people could light a candle and float it in a dish of water. The main centre piece in the chapel was a 'Memory Tree' where people could purchase a small plaque and subscribe to a special message which stayed on the tree for twelve months. The plaque could be renewed for another twelve months.

The hospice was supported by its own chaplain who explained to us that there was a four volunteer chaplaincy team. These volunteer assistants to the chaplain underwent six weekly one hour courses. The chapel was an inclusive and secular place which meant it was not controlled by a religious body or concerned with religious or spiritual matters. The role of the chaplain was to support everyone, including their team who they never let leave without checking they were ok following a shift. The ethos was that the service was open to all people of different faiths, beliefs and cultures. For example, when someone of a Hindu faith was very ill they ensured that water from the Ganges was brought to the person and a temple with their own sideboard from home was brought to the hospice so they could meet their religious needs. The chaplain had officiated over several weddings in the chapel and tried to meet any special wishes people

may have. An example was given of a wedding party wanting a Devon tea party which was met by the hospice. We read that people who used the service were demonstrating different emotions which were understandable when people are searching for answers to their problems. The chaplain said that everyone's response to grief was different and it was the role of their team to support people and to be there for them when needed and someone was on-call at any time.

There was also bereavement support for families and staff. During our inspection the chaplain spent some time with a bereaved husband who would now be a single parent. They had made themselves available for as long as needed. We saw their family, including the young child, were supported in a positive and sensitive way. After the person died the family were supported by staff and given time to talk in the private space available. The hospice bereavement service provided pre-bereavement support and a range of one to one and group support for six weeks post bereavement. This was through hospice staff, volunteers and counsellors. The chaplain further explained that the hospice offered support to family members to focus on celebrating peoples' lives. Staff were in turn supported by the management team if they experienced emotional difficulties due to the nature of their work and were also able to receive counselling and wellbeing therapies. Staff felt part of a team as their views and opinions were listened to and there were regular staff meetings.

The chaplain invited people from different religious and cultural groups to visit the hospice. They reached out to internal and external staff and volunteers to share training and expertise. For example, a dignity with difference day had been held to discuss 'How we ensure dignity in death?' and 'What do we envisage beyond death?' This included talks by a doctor on medicine and spirituality and specialists in their fields on Islamic beliefs and rituals, Hinduism, Bah'ai (rational soul belief), Jewish belief, Buddhism, Humanism and Christianity. Topics included burial, rituals and mourning.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. There was a comprehensive information booklet that included the service's mission statement, the range and nature of services available, the structure of the medical team, Out-patient clinics, how to complain, and a list of information leaflets that were available such as strong medication and driving. The service had an updated website that contained clear, comprehensive information that was user-friendly.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in 'advance care plans'. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they wished to be their legal representative. These advance decisions were recorded, effectively communicated to staff and respected. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. People and their relatives were included in the discussions about the way the risks were managed to ensure people's preferences were considered.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. Each person in the inpatient unit had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered. A care home manager said, "We have learnt from the hospice staff how to

ensure we give pain relief before a task and use distraction methods too. One person gets pleasure from icy sorbet and it makes them feel better when we need to assist them too."

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

Is the service responsive?

Our findings

People and their relatives told us that the way staff responded to their needs was, "Amazing" and "I can't believe how supportive they have all been." They felt the Hospice at Home service and community nurse specialists in particular were easy to access and a lifeline for people and their families. People we visited couldn't believe they were able to access such good care by just making a call and felt strengthened by the support. 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. All were extremely positive and thanked the staff. One relative had increased anxiety as their loved one deteriorated at home, for example. They phoned the hospice at home service and was supported and reassured. This meant that the person was able to stay at home with their dog at the end of their life as they had wished, with their relative and the hospice at home nurse present. Another relative of a person receiving care from the community specialist team said, "We had trouble with our personal care service. The hospice nurse will sort it all out so we don't have to worry. We can spend our time as a family."

People could be referred to the service by a member of the Hospiscare community specialist team, hospital, community healthcare professionals, care home managers or the out of hours healthcare teams. Referrals could be taken 24 hours a day, 7 days a week. The service aimed to respond to urgent referrals within 24 hours. The teams of nurses and assistant practitioners offered specialist advice and support every day of the year, with a telephone advice line open 24 hours a day. During the financial year 2014/15 staff had supported 22,037 callers.

The service was outstanding in being clear about their local demographic and what the needs of the local community were and 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, although this is not always possible due to limited resources nationally. Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, major difficulties in adjusting to a terminal illness, or the need for inpatient end of life care. Inpatient stays were on average for the last two weeks of life or for respite. Many people wished to be cared for in their own home.

The hospice had therefore set up a Hospice at Home service in Seaton for people registered with a Seaton GP. The team was able to provide holistic care for people in the community as the staff team included a community nurse specialist team leader, community nurse specialists, registered nurses and health care assistants. This meant that people had more consistency and less health professionals visiting them as there was less need for separate NHS district nurse visits. This service was for people from diagnosis to care during their final days. This was unusual for a hospice at home service which often begin for the last two weeks of life following referral from other health care professionals or the hospice community nurse specialist teams.

The Seaton Hospice at Home service enabled people to receive care from a team who remained consistent throughout their care. For example, the skill mix of the team visited people at home from diagnosis and rather than being referred to a separate Hospice at Home service they could continue to have their needs met by the same team. This was seen by Hospiscare as very important in building relationships and being

there for people at the end of their lives. By knowing people well they were able to offer the care and support required by individuals at their pace. For example, staff told us how one young person living with a life limiting illness was able to feel supported at home knowing the team were there. The team leader said, "Because we have built up a relationship and trust we can leave them in peace for a while so they can live a bit and not focus on their condition. But they know we are here and they have a direct line to someone they know." Their aim was to consistently support people and their families throughout their journey from diagnosis to achieving their preferred place of care. Audit data showed Devon statistics for achieving a home death was around 20% and in Hospiscare overall this was a little over 40%. A Hospiscare audit of the outcomes of having the Seaton Hospice at Home service in place showed 94% of people had been supported to die in their preferred place of death. Delays in referral due to the rural location were also reduced and admission avoidance was effective. For example, since July 2015 admissions to hospital were avoided on 98 separate occasions due to the input of the Hospice at Home team, all were out of hours mainly overnight. Therefore, there were clear benefits for people.

The community nurse specialist had excellent knowledge about them and their circumstances and had built up a good rapport and trust. They had visited one person with their GP as a joint visit to manage complex symptoms and there was a sensitive discussion about difficult choices one person had made about nutrition. The person had been seen by speech and language specialists and was able to make an informed choice which was respected. Another person and their relative received a first visit following diagnosis. They were clearly relieved to have Hospiscare support. They were able to discuss the future and symptom control and how to prepare their environment for example but also to talk about their lives and what they liked to do. Hospiscare intended to expand the Hospice at Home service and a further trial is hoped to be undertaken in Crediton and surrounding villages with other areas being discussed. This was included in the Hospiscare Strategy plan for the future. Health professionals from other areas had visited to see how the project worked as they had heard how good it was.

The Hospiscare community nurse specialist service in Sidmouth prided itself on being very bespoke to respond to the needs of local people. Known as Sidmouth Hospiscare they worked very closely with the trustees to ensure funds were used effectively. For example, there was a funded community hospital bed and staff available for end of life care to enable Sidmouth people to remain locally if they wished. The CNS attended hospital meetings to discuss admission avoidance and be available for specialist advice. The CNS said they had an, "I'll find a way attitude" and did their best to enable people's choices. It was the only community team to conduct visits out of hours rather than always referring to on call doctors. The CNS said this was so people and families could relax and go to sleep knowing there was consistent support available. For example, that weekend the CNS had spent time managing a difficult situation involving someone refusing care who may not have had the mental capacity to make that decision in their best interests. They organised support from a dementia nurse specialist, social worker and family and the person was able to stay at home, which was their wish, but also to receive appropriate care to manage their symptoms so alleviating family anxiety. The service was also able to use funds in creative ways such as providing holidays for people with special circumstances, improving peoples' environment and providing respite care and specialist equipment for people at the end of their lives.

The service had also developed a new role. Following a project evaluation in 2014 people had said they wanted on-going face to face support throughout their illness from the same people. Hospiscare understood that in addition to the physical and emotional problems that came from having a life limiting illness, the financial and practical aspects could also be distressing. Hospiscare had been granted funding for a team of care navigators who were trained volunteers providing a support, practical help, befriending and sitting service. Care navigators could introduce people and their families to a range of services, helping people to find the right support. For example, one person told us how pleased they had been to have been

signposted and referred to a specialist breast cancer worker. As well as navigating through the health care system and social services available, care navigators also offered ongoing emotional and practical support such as picking up prescriptions and form filling. We heard how care navigators were matched with people's backgrounds and interests and were able to refer back to the community nurse specialists. For example, one care navigator had felt a person was more depressed and had referred them back to the team who initiated a visit. Hospiscare care navigators worked as an extension of the community nursing teams and there were plans to extend the service across the patch.

Hospiscare worked in partnership with other local services. For example, it had been recognised that Hospiscare met people at home who were vulnerable. Therefore they had recently entered into partnership with Devon and Somerset Fire and Rescue Service. The partnership aimed to work together to share information to enable the provision of home safety visits to vulnerable members of the community and minimise fire risk in the homes of vulnerable adults, providing appropriate advice regarding fire safety. In addition Hospiscare worked with a local cancer charity adjacent to the inpatient unit (FORCE). The partnership agreement enabled direct referrals to the charity from the hospice for counselling and advice, including immediate family members. Referrals could also include non oncology (non cancer) related referrals through the cancer charity oncology support specialist (families and children).

The new dementia specialist nurse at Hospiscare had already made contact with key stakeholders specialising in dementia care. This included the older people mental health team to agree client referral criteria, and care managers at the Royal Devon and Exeter Hospital. The nurse was part of the dementia and delirium group which aims to transform hospital cultures to ensure compassionate and patient centred care. They had also linked with Health Watch (a national consumer champion in health and care), all local GPs, the community teams, nursing homes and 'Memory matters' (a community interest group that aims to support people to live well through meaningful activity and support).

There was excellent communication on a multidisciplinary level. The computer system contained a wealth of information that was able to be accessed by all staff so they could follow people's journey from diagnosis to being provided care from hospice services. They were able to identify any issues with people attending and had a "toolkit" of support to offer. This meant they had a range of options to offer people that they may not have thought about and staff could check whether difficult discussions had been had such as advance care planning, resuscitation and preferred place of death. Therefore, people could talk about issues when they were ready. Alerts could be made to inform staff of particular issues such as if people requested not to receive named visitors. This was kept confidential. The electronic system was enhanced by bedside paper care plans on the inpatient unit to enable staff to document practical care more efficiently.

The Hospiscare computer information sharing system enabled on-call doctor services and the GP practices to share information to ensure all parties had up to date knowledge of people's care needs. The Hospice at Home team, for example, worked closely with the local health care professionals to ensure people had their care needs met in a timely way by professionals who knew them. Hospiscare were also in discussions with other health locations to see whether satellite clinics could be held for the rural community, for example to offer chemotherapy closer to home or lymphoedema clinics. This showed the service constantly looked at ways of forming partnerships that would directly benefit people in their care in response to specific needs.

Hospice staff worked closely with local health professionals in a range of roles from GPs to district nurse teams and domiciliary and care home providers. They had built up a responsive relationship to ensure that gaps in care could be filled. For example, the inpatient unit had a discharge facilitator providing personal care management in the hospice, coordinating on-going care arrangements on discharge from the hospice such as care home placements, equipment loans and packages of care at home. In addition, a supportive

care team provided psychosocial support and assisted with appropriate referrals for financial assessments for benefits, re-housing, grants, and carer support as appropriate. Discharge packages were explored early on and detailed records kept of all conversations and arrangements in one place which were shared throughout the service using the computer system. The discharge co-ordinator said, "It's imperative we avoid a negative experience for people and get it right. We try to understand family expectations and fears, we listen to warning signs of anxiety and provide appropriate support that meets people's needs as a whole." We saw how sensitive compromises had been made to safely meet people's needs, such as a visit home for a day and how staff always continued to look toward possible discharge to give people hope. One person, for example, was able to go home for the bank holiday with short notice with the correct equipment, personal care package and crisis support.

Hospiscare worked particularly closely with Royal Devon and Exeter Hospital. We spoke to the Assistant Director of Patient Services, the lead for the Hospital Specialist Care Team. They provided specialist input for people receiving care in the hospital, visiting those people on the wards and working with the hospital palliative discharge team. They had initiated a clear on-call handover document for example, to ensure comprehensive information sharing such as syringe driver use and medication changes. The team provided free education for hospital staff who were able to refer people with complex needs. For example, one person and their family received emotional support when active treatment was coming to an end and enabled complex symptoms to be managed effectively. A bed at the hospice inpatient unit was arranged and the person had a dignified and peaceful death surrounded by their family.

Hospiscare also worked with Devon Doctors, the NHS on-call service. One of the consultants had been involved in devising training specifically for Devon Doctors on treatment escalation plans (TEP documents that clarify resuscitation and treatment decisions) and advance care planning. Training had then been given with tailored times for the on-call doctors to attend. This had enhanced communication between the services to ensure people received appropriate care, for example, ceasing treatment that was ineffective at the end of life to reduce adverse symptoms. TEP forms were discussed with all people and their families receiving the service at appropriate times for them. People were registered on the Electronic Palliative Care Co-ordination System (EPaCCS) to ensure all health professionals were aware of peoples' wishes.

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the inpatient unit, and when people received support from the Hospice at Home service, staff sat with people, enabling them to spend as much time as they needed and encouraged them to ask questions, discuss their options and reflect upon them. People felt valued and understood because people and staff worked as a team to ensure each support plan was unique and responded to specific needs. For example, the community nurse specialist spent time listening to the person without the family present and supported them to think about beginning to discuss future plans with their children. The family were also able to talk privately with the nurse and were visibly less anxious by the time they left, having some practical tasks to do and knowing they had someone they knew to ring.

People and staff knew about the complaints policy although they couldn't believe there would be any complaints. People said, "There are no complaints, I can't praise them enough." One long standing complaint had been taken very seriously and the hospice had worked with the ombudsman, meeting with the complainant and providing all required documents to work toward a positive outcome. Learning was shared, for example, following a negative comment staff were supported to attend training about communication and misinterpretation.

Admission assessments to the inpatient unit ensured that people received a management plan of their

symptoms, emotional and spiritual support, pain relief and specialist care and was person centred. People were discussed daily in a multi-disciplinary team meeting each morning. The hospice was not a long term placement. If someone was stable enough to be moved they would be. These discussions would be held with the patient and their families to ensure they had realistic expectations.

People were involved in the planning of activities that responded to their individual needs. The hospice inpatient unit cared for people for short periods in an acute setting. There were no long stay beds (for example, some hospices have long stay beds funded by continuing NHS care). This meant that generally people were not well enough in the inpatient unit to be able to participate in organised activities. Therefore, activities were more based on therapeutic methods. Attention was paid to people's individual social and psychological needs.

A range of therapies were offered such as massage, aromatherapy, acupuncture, reflexology, reiki, relaxation techniques for patients, carers and bereaved relatives. The therapies were adapted to suit the needs of each individual. The team of therapists, which included paid staff and volunteers, worked across the whole service, the inpatient unit, outpatients, in the community and in outreach centres. Up to six therapy sessions were offered, free of charge, with the aim of enhancing relaxation and improving quality of life. These may aid symptom control and relieve stress and tension. Therapies took place in the inpatient unit and day centres. The Exeter nurse-led clinics held in the day centre started two weeks ago. One person said, "The staff make sure you have lots to do in the arts and craft room in the day centre instead of just looking at each other. I think [staff name] is doing a great job in a short period of time". There was also an art work scheme which enabled the units to display a variety of local art work, which was changed regularly.

People were proactively encouraged to give feedback about the service. For example, using the national website [iWantGreatCare](#). There were many comments posted and the recent feedback showed a five star (the highest achievable). The feedback was overwhelmingly positive. 100% of people would recommend the hospice. Additional feedback was actively sought about every aspect of the service and people, their visitors and staff. There was also a comment box in the reception.

Annual satisfaction surveys were carried out and responsive action was taken to address shortfalls that were identified as a result. An external annual staff survey was commissioned and enabled Hospiscare to benchmark their progress against 45 participating hospices. In 2015 this included five additional questions to address issues raised in 2014 such as 'How can we improve the way feedback is given to staff?' As a result comments about the performance and commitment staff awards were reviewed by the operations committee, the staffing of the advice line was reviewed and issues were added to staff meeting agendas. The results were better than, or equal to other hospices and better than the previous year.

Is the service well-led?

Our findings

There was an open and positive culture which focused on people. This was reflective of the outstanding leadership and management of this service. People received care and support by staff who upheld strong values about person-centred care, and positive connections were promoted that enhanced their experience of the service. The leadership team supported staff to make sure the service was run in people's best interests. People were placed at the heart of the service and the registered manager led by placing emphasis on continuous improvement in all aspects of their care.

The founder of the charity Hospiscare, John Searle, whom the hospice building is named after, was the long standing chairman and continues to stand as the Hospiscare president. They said on the Hospiscare website, "I'm absolutely thrilled at the expansion of Hospiscare and could never have imagined it. Hospiscare has not only kept its ethos but has managed to grow and maintain its focus on the individual and those close to them. It has also adapted to the modern world without losing its fundamental vision. That's been the brilliance of the people who have taken on the baton from us."

The leadership team that oversaw the running of the service included a chief executive (the provider), the registered manager/director of nursing, assistant directors, cluster team leaders and department managers. They had particular experience and expertise in leadership, nursing and palliative care and encouraged information sharing, education and staff development to benefit people in the service and in the wider community. All staff told us how they felt valued by the leadership team, encouraged with professional development and education and used the performance and commitment award (PCA) process to highlight their achievements. The chair of the PCA panel commented on one application how impressed they were by the application and how well previously learnt skills were applied to Hospiscare. This showed how staff were appreciated, praised and rewarded for work which benefitted people using the service and encouraged innovation.

Hospiscare took part in various research projects that directly benefitted people. For example, research in the use of infusions to control seizures enabling one person to enjoy periods of quality time with their family until their death. Other research included the benefit of self guided intervention based on concreteness training (a therapy using mental imagery) which showed a reduction in anxiety for patients with palliative care needs. In addition, one of the therapies offered to people was cognitive behaviour therapy (CBT). One of the bank nurses at the hospice had written an article for the Journal of Renal Nursing. Their interest in end of life care for people in the renal community with established renal failure had resulted in a permanent kidney supportive care nurse role at the NHS renal unit. This nurse, with a consultant lead for end of life care now represented the renal unit at trust level strategic planning meetings to continue to improve end of life experiences with trained link nurses in local dialysis units.

The registered manager was open and transparent and keen to share their knowledge. They consistently notified the Care Quality Commission of any significant events that affected people or the service. All the staff we spoke with told us they had confidence in the way the service was managed. Staff praised the provider and the leadership team for their approach and consistent, effective support. They said they could

come to the registered manager, provider or any of the directors for advice or help. All staff felt valued working in the service, and felt motivated to maintain high standards of care. The registered manager took an active part in monitoring standards of practice. Staff reported that the registered manager was good and supportive. They were inspired by the registered manager's examples and values.

Staff commented on how well they felt listened to and supported by management. There was a culture of collective responsibility between teams and services, which was evidenced at the handover meetings with a doctor saying how everyone worked at the same level for the same goal. Staff were able to work across the service which helped them understand each others' roles and they were trained and supported to do so. For example, one nurse from the inpatient unit was working with more experienced community staff. Staff stated they were able to raise concerns including whistle blowing through a range of channels. Staff representatives attended staff communication and consultation groups to share ideas, consult on changes and discuss challenging issues. There was a staff consultative council meeting. Minutes showed discussion of the staff survey, on-going refurbishment and protocols for answering the telephone. Questions were discussed about what issues to put forward to the senior management team 'question time'. A senior management 'question time' was held three times a year or more often where staff could raise issues such as pay banding and ideas to improve patient care. Following a model of care review report, for example a staff 'road show' was facilitated for staff to discuss 10-20 year plans.

Staff were encouraged to chat and have coffee with each other and take regular breaks. On the inpatient unit, a 'daily huddle' was held to discuss updates on inpatients and give key information and a safety briefing to key staff. Following feedback in the staff survey a monthly nursing and patient news email was being developed hoping to keep staff better informed and updated on how the departments worked together. Regular email refreshers were also sent from the director of nursing to all staff highlighting particular topics such as complaints and accessing TED talks (Technology, Entertainment and Design educational talks). The chief executive and registered manager were also introducing regular visits at community team meetings across the extensive geographical patch to be more visible for those staff.

The service was forward thinking and constantly looking at ways to improve the service for the local community and in a wider sense improving end of life care as a whole. Hospiscare were clear about their values, "Because we value dying as an important part of living and believe that 'every day matters' to people approaching the end of their lives." The values included respecting everyone's contribution and working co-operatively, being sensitive and honest in communications, acting fairly for all, putting peoples' needs at the heart of the service, providing timely and accessible services and making the best use of their resources." There were many examples of how this worked in practice. For example, one staff member said, "We think carefully about how we use our funds. For every pound you think, someone has done a 'fun run' or something for that!" There was a Hospiscare: Fit for the Future Strategic Plan for 2016-17. This reflected our discussion with the registered manager and all staff were aware of the focus to continue to provide high quality care and sharing expertise and for everyone approaching the end of their lives to receive the best possible care. The service needed to raise over £5 million a year from the local community and planned to grow the service enabling more hospice quality care in people's homes, offer more day services, hospice at home and provide volunteer care navigators throughout the patch.

The hospice had carried out a service review into "How do local shortages in community care impact on a hospice inpatient unit?" This had recognised that Exeter in particular had a lack of community personal care packages. This had impacted on hospice costs due to avoidable inpatient admissions especially at weekends and patient choice of place of death. The consultant in palliative medicine and clinical lead for specialist palliative care at the hospital had been pro-active in sharing their findings with external stakeholders to promote working together towards a solution. For example, the issues had been raised with

the Devon Health and Well-being board, as part of a review of North Devon Community Hospital bed availability and included in regular meeting agendas with the CCG strategic advisory group, local end of life group chaired by Hospiscare and hospital and continuing healthcare meetings. Creative use of funds has been discussed including possibly creating end of life rapid access teams. The Hospiscare lead for this project told us they would continue to support and drive change as best they could. Hospiscare had been successful in promoting the provision and use of 'Just in Case' bags across Devon (emergency bags left in peoples' homes for health care professionals to use). This work helped to raise awareness of the increasing needs for end of life care in the community as a whole and assist with continued funding. The hospice was constantly discussing improvements for the future and how all services could improve to benefit people.

With the expansion and projected need for the Hospice at Home service for example, the service had recognised that investment in training non medical staff (nurses in the community) to prescribe medication would benefit people and this was in progress. This would have a better outcome for patients in reducing delays in accessing medication to manage symptoms.

There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. Audits of findings were discussed at clinical governance committee meetings and the quality assurance and improvement committee to explore how risks could be further managed using information from clinical groups such as the quality improvement group. We saw the hospice annual audit programme. This included an annual PLACE (patient-led assessment of the care environment) audit on the inpatient unit and day services done in conjunction with people using the service and staff. Issues such as the need for a higher toilet seat, new chairs and areas where cleaning could be improved were identified and timely actions taken. In addition, monthly inpatient unit audits were done and findings shared on their intranet.

The hospice used a benchmarking system which was a collation of information such as pressure sore occurrence and falls in comparison with other hospices in the south west. There were now 100 plus hospices sharing comparable data. The quality and patient safety committee discussed a wide range of topics. For example, they realised they were having more low level medicines incidences in comparison. A root cause analysis was carried out, inviting registered nurses on the inpatient unit to a focus group for discussion. The result showed the nurses were regularly being interrupted in the treatment room. A window was put in so staff could see through and avoid interrupting those administering medication and a new medicines etiquette was agreed.

Trips, slips and falls were high one quarter. Again a root cause analysis was done and shared with regional colleagues. Feedback to the governance board showed this was not a trend and there was discussion on the balance of risk and promotion of independence. The medical director presented a case study to the board about one young person at the end of their life desperate to remain upright and be a dad and husband as long as possible. This was risk assessed and they were able to remain independent until the risk of falls became too great, which was their choice.

There was a clinical leadership team balance score card which focussed on auditing user experience, clinical risk management, user safety and effective care. This checked that significant event analysis had been followed through to completion, for example, which records showed.

The service was outstanding in the way it worked in partnership with other organisations to ensure they provided a high quality service. For example, clinical commissioning groups, local surgeries, hospitals and external health care professionals, charities, care homes and agencies. There were many examples of how this benefitted people, seen within this report. For example, Hospiscare input into the end of life care provided at the hospital had directly influenced a CQC good rating for the hospital in end of life care. The

Hospiscare Assistant Director of Patient Services had commented, "We are thrilled to see that end of life care of patients and their families at the [hospital] has been recognised. We pride ourselves on our strong partnership with them and we are delighted with these ratings." Another nursing home who worked closely with the hospice also achieved a good rating in end of life care based on their work with the hospice.

All records relevant to the running of the service that we saw were well organised and reviewed regularly. All records were kept securely and confidentially. The policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated on a continuous basis. A computerised system scheduled policies for regular reviews and these schedules were adhered to. Staff were made aware of the updates and knew where to locate the policies for guidance. Where issues were identified, staff were informed and appropriate training and refreshers provided. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.