

St. Margaret's Somerset Hospice

St Margaret's Somerset Hospice -Yeovil

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

St Margaret's Somerset Hospice is a charity which provides a range of hospice services for adult patients with life-limiting illnesses or advanced progressive conditions and support for their families and carers. This means they provide a service for people with a range of conditions including cancer. Services include an inpatient unit (IPU) with 12 beds in Yeovil. This means the hospice are able to prioritise beds for those people with more complex symptom control or end of life care needs. The majority of people are supported by community services with over 600 people supported across the Somerset community at any given time.

This inspection was carried out on 22 August, 5 and 7 September and 6 October 2016 by one adult social care inspector, with a second inspector on 6 October, a pharmacist inspector, a bank inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This was an unannounced inspection on the first day.

A serious incident occurred at the end of 17 September 2016. A person using the service died as a result of fatal injuries sustained during a fire when the person was smoking whilst using an oxygen cylinder. The service clinical director informed us of the incident on 18 September 2016. We went back to the service on 6 October 2016 to make sure action had been taken by the service to reduce the risk of this happening again. We have rated safe, effective and well-led as requires improvement. This is because we found some failings in how the risk relating to smoking materials and oxygen use was managed and risk assessed. For example, there had been a lack of communication about the person's smoking history and compliance to safe practice, two risk assessments directly linked to smoking risk had not been completed or reviewed and training did not contain adequate detail to ensure staff were aware of safe practices in this area.

There is a registered manager who is responsible for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There is a second St Margaret's Hospice in Taunton and the two services work very closely together. Services are free to people, with St Margaret's receiving some NHS funding and the remaining funds are achieved through fundraising and charitable donations. The hospices are largely dependent on donations and fund-raising and are assisted by over 1200 volunteers.

The service provided includes specialist advice and input, symptom control and liaison with healthcare professionals. The hospice has a 24 hour out of hours advice line and central referral centre (CRC). Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, physical, psychological and spiritual or complex end of life care needs or referral to other hospice services. The average length of stay was two weeks with some people being discharged home or to a local care home. The service was clear about their local demographic meaning that they had an understanding of the community they served and continuously monitored how best the service could meet their needs. They followed national guidelines

such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice and this was the aim of St Margaret's as much as possible.

The registered manager was open and transparent in their approach. Staff told us they felt valued and inspired by the leadership team and the registered manager to provide a high quality service. Emphasis was placed on continuous improvement of the service.

Comprehensive audits were carried out about at the service to identify how it could improve. Where the need for improvement was identified, remedial action was taken to learn and improve the quality of the service and care.

The service worked in partnership with other organisations to drive improvements at national level, participating in research projects and end of life care awareness which positively benefitted people in their care.

An excellent academy training centre based at the Taunton site provides advice and support to St Margaret's staff as well as staff in care settings in the community. St Margaret's were committed to sharing good practice and enabling other health professionals to provide a high standard of specialist care. People could access counselling, family and bereavement support, a lymphedema service (a chronic long term condition that causes swelling in body tissues. It can be a primary or secondary condition), occupational and creative therapy, physiotherapy, complementary therapy and spiritual support. There was also support from social workers and advice on practical matters such as finances and a dedicated discharge co-ordinator. The day centre offered activities and support for people over 12 week sessions and were able to signpost people to other local services. There were also a range of support groups and courses tailored for people with life limiting illnesses as well as their carers pre and post bereavement.

Other than in relation to smoking related risk, staff received comprehensive essential training based on best practice, national guidelines and research including end of life care and were scheduled for refresher courses. Staff had a wide range of opportunities for further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and an annual appraisal. This ensured they were supported to work to the expected standards and valued by the service. Staff were encouraged to always, "See what else we can do" to improve the service and to submit ideas for improvement.

Other than related to smoking risks, there was overall excellent communication and delivery using a multidisciplinary and holistic approach. People were able to access a one stop referral centre and advice line for advice and support. The service continuously looked at the local community demographic to see how best they could provide the service. This included dementia champions and links with homeless communities.

People were involved in the planning of activities that responded to their individual needs. A broad range of activities was available that included creative ways to keep people occupied, engaged and stimulated. Attention was paid to people's individual social and psychological needs in a holistic way that included support pre and post bereavement for carers. There was an excellent spiritual care service which was inclusive and their ethos was person centred. At St Margaret's "spiritual care honours the human spirit and cares for each individual as a spiritual person" however that may be.

People benefitted from a bespoke meal service that was tailored to their specific needs, likes and dislikes including when people felt like eating. 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. Staff communicated effectively with people, responded to their needs promptly, and treated them with genuine kindness and respect.

Staff were trained in how to protect people from the risk of abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

Although two risk assessments for people who smoked were not completed on the patient electronic recording system, overall risk assessments were centred on the needs of the individual and included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place which included the checking of references.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. Staff knew each person well and understood how people may feel when they were unwell or approaching the end of their life. They responded well to people's communication needs and worked in a holistic and multidisciplinary way. Plans in regard to all aspects of their medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people according to their individual plans and worked together to meet people's needs. This included overcoming barriers to enable people to have positive experiences near the end of their lives. There were some limitations with the use of the computer patient electronic recording system but this had been identified by the service and was being addressed and managed by a working group within the service.

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

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, compassionate and pro-active.

People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent before they supported them. Staff pre-empted and responded to people's individual needs and requirements and tailored support to suit them including sign posting to external services. The environment was well designed, welcoming, well maintained and clean and suited people's needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People were not always protected from the risks arising in relation to oxygen therapy and smoking materials.

People were protected from the risk of abuse and harm by robust systems.

Risk assessments, other than the two not completed in relation to smoking and oxygen therapy, were centred around people's individual needs and there were always sufficient staff on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

The environment was secure and well maintained and fit for purpose.

People could be assured their medicines were managed safely.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People did not benefit from staff who were knowledgeable in relation to the use of oxygen therapy and smoking materials.

People benefitted from motivated staff who were valued and supported to "Be the best we can be" and worked with an ethos of "What else can we do for people?"

Staff were well trained, other than in relation to the risks of smoking, and had an excellent knowledge of each person and how to meet their specific support needs. Staff training and sharing knowledge was important to the service and delivered via a pro-active and forward thinking on-site academy.

People benefitted from staff who understood how to provide care with people's best interests at the heart of their work. Staff were trained in the principles of the MCA and the DoLS and were

Requires Improvement ●

knowledgeable about the requirements of the legislation.

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

Is the service caring?

Good ●

The service was caring.

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

The service was very flexible and responded quickly to people's changing needs or wishes.

Staff communicated effectively with people and treated them with utmost kindness, compassion and respect using a holistic approach.

People were consulted and fully involved in their care and treatment and their wishes were respected.

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

Is the service responsive?

Good ●

People, families, friends and health professionals were able to gain support at any time and receive personalised, responsive care from staff with good skills and knowledge.

People benefitted from 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.

The service had a wide range of ways to involve people and their families, stimulate their engagement and provide support.

People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life.

The service took a vital and key role in the local community.

People, their families and friends were actively encouraged, enabled and supported to engage with events outside of the service.

Is the service well-led?

The service was well led but there were failings in the management of oxygen therapy use in relation to smoking materials.

People described the leadership of the service as, "Fantastic" and "So focussed on helping people as much as possible".

The leadership team promoted an open and positive culture that placed people and staff at the heart of the service and ensured this was put into practice by all.

The leadership team promoted strong values based on holistic person-centred care and inspired staff to work in partnership with people.

Staff were supported, valued and inspired under the leadership of the registered manager and clinical director.

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

The service worked in partnership with other organisations and professionals to ensure they followed best practice and provided a high quality service and supported other services to do the same.

Requires Improvement ●

St Margaret's Somerset Hospice -Yeovil

Detailed findings

Background to this inspection

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

This inspection was carried out on 22 August, 5 and 7 September and 6 October 2016 and was unannounced on the first day. The inspection team consisted of one inspector, a pharmacist inspector, and a specialist advisor in palliative care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On 18 September 2016 we were informed of an incident resulting in a fatality of a person using the service. Due to these circumstances two adult social care inspectors visited the service again to look at this matter specifically on 6 October 2016.

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

At the last inspection carried out on 12 February 2014 we did not identify any concerns with the care provided to people. We spoke with one person who was staying in the IPU and three relatives, two people receiving care in their own home, their two relatives and six people who used the day centre, community services and advice line. We spoke to seven volunteers across the service, eight health care assistants and senior health care assistants, seven nursing staff including community nurse specialists, catering manager and head chef and three medical staff, an occupational therapist, student nurse and a social worker. We spoke with the registered manager, the clinical director, the lead IPU nurse, three registered nurses,

discharge co-ordinator, infection control lead nurse, head of human resources and the human resources co-ordinator and the education co-ordinator. At the inspection of the St Margaret's Somerset Hospice Taunton inspection in December 2015 we spoke to two clinical co-ordinators in the CRC who managed calls to the 24 hour advice/referral line which also operates for people using the Yeovil site.

We looked at the premises. We looked at six sets of records that related to people's care (five on the inpatient unit, two in the community and one in the day centre) and examined four people's medicines charts. We looked at people's assessments of needs and care plans and observed care. We consulted documentation that related to staff management, training and three staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and the activities programme. We spent time in the day centre and visited two people receiving a service in their own homes with their permission. We also attended a multidisciplinary team meeting (MDT). We sampled the services' policies and procedures.

During our inspection we looked at the systems in place for managing medicines; spoke to six members of staff involved with prescribing and giving people their medicines, looked at six people's medicines charts and spoke to one person using the service and their relative.

Is the service safe?

Our findings

The service had not managed to fully protect people from the risk of harm or death. We were informed by the service of a serious incident caused by a person smoking in the smoking room whilst using a functioning portable oxygen cylinder. This resulted in their death and also placed other people in the service at risk.

After this incident we returned to the service to look at how they managed people using the service who wished to smoke. We found that at the time the smoking policy and admission policy for the admission of people who smoked and use of smoking materials did not fully ensure people were safe. The smoking policy did not highlight the risk posed by smoking materials in relation to the presence of oxygen, piped or portable cylinder. The detector in the smoking room was a heat detector not a smoke detector and did not appear to have gone off as a staff member had to raise the alarm at the time of the incident using the fire alarm. Since the incident the service has amended their smoking policy. A fire protection officer carried out a fire safety report on 20 September 2016 and found the service to be 'broadly compliant' subject to recommendations being addressed. These included ensuring that 'arrangements for the planning, organisation, control monitoring and review of the preventive and protective measures' be made. They referred to reviewing of policies 'currently in force with regard to the induction of patients and the use of smoking materials.'

Signage to warn people of the dangers of oxygen use in relation to smoking materials were lacking at the time of our visit. There were no clear signs on piped oxygen other than the manufacturer warning on the oxygen cylinder which was small on the collar, fifth row down stating "No smoking or naked flames near medical oxygen cylinders". There was no sign on the smoking room door, which could further have alerted staff and people using the service to the dangers of oxygen use and smoking materials. Since the incident the service has sourced large print warning collars and signage for use at oxygen sources.

Although the admission computer system had a section titled 'risk assessment' there was no individual risk assessment completed for the individual involved in the serious incident. When we visited the service on 6 October 2016, there was also no risk assessment completed for another individual who smoked, although they did not require oxygen therapy. We heard from staff following the incident, there had been at least one situation involving the person who died where there had been an increased risk of the person lighting a cigarette in the presence of oxygen. A staff member at that time had alerted the person to the dangers. However, this had not been formally highlighted to staff. We heard there was a history of risk related to the individual's previous use of oxygen in the community as a heavy smoker which had not been formally highlighted to staff, for example through the risk assessment or a computer alert system. On admission the person had been spoken to about the dangers of smoking in general, as they had been deemed to have capacity and understood the risks. This conversation was only recorded on the original daily record at the beginning of their admission and would not be highlighted again or reviewed by staff during the admission. The person's deteriorating condition had also not been highlighted as a risk factor relating to smoking. Therefore, at the time of the fatal incident there were not robust processes in place to safely manage people who wished to smoke whilst under the care of the hospice.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In relation to risks other than smoking and the use of oxygen, people were protected and their freedom supported and respected because risk of possible harm was well managed. Risk assessments had been carried out to identify and manage people's individual risk but also with regard to their needs and wishes at the end of their life. The computer care planning system included risk assessments such as falls, dietary and mobility and tissue viability. For example, care plans showed how people were to be mobilised safely and how to minimise falls. Appropriate equipment and prevention methods were followed for people at risk of skin damage from pressure. Staff handover sheets documented clearly people's identified risks and staff were aware of the risks for each individual. Staff ensured that people had their call bells within easy reach so that staff could respond when they needed help. Measures were in place to keep people as safe as possible.

However, people told us they felt safe in the service. Comments included, "All the staff understand and are patient when I take time to answer their questions. I feel relaxed with all the lovely nurses and staff and helpers. How can you improve an excellent service?", "Nothing could be improved. I felt safe and nurtured, you can sometimes feel a little bit out on a limb, your nurse are amazing at rectifying that feeling" and "I was 100% happy with my phone calls to support me. I could say to the things I couldn't say to my family".

Effective systems were in place for obtaining medicines. Staff ordered medicines from a local hospital pharmacy. There was a daily delivery service and medicines ordered before 10am would be delivered later that day. Staff told us they were able to go to the pharmacy to collect medicines at other times, if necessary, and the system worked well for them. People could be confident their medicines would be available for them.

A pharmacist from the supplying hospital visited the hospice twice a week and checked the prescription and administration charts. The pharmacist was not part of the multidisciplinary team meetings but staff told us they were always able to contact the hospital pharmacy for advice when needed. This helped to ensure that staff managed medicines safely.

Staff checked and recorded the medicines people were prescribed when they came to the hospice to make sure they would continue to receive the correct medicines. The pharmacist checked these records during their visits. This helped to ensure people received their medicines correctly.

Staff prescribed medicines on specifically designed prescription and administration charts. However, we did see a small number of examples where the instructions on prescription charts used abbreviations, which were not clear. This could increase the risk of mistakes being made. Staff recorded the medicines they had given or used a code to record the reason if they had not given a medicine. There was a separate chart for medicines given by injection via a syringe driver. Staff made regular checks of the syringe driver to make sure it was running safely and documented these checks. This helped to ensure people received effective pain relief.

Healthcare assistants supported the qualified nurses by checking some of the medicines they gave. This meant the nurse did not have to wait for another nurse to be available and people were able to receive their medicines more quickly. The healthcare assistants had training for this role and an assessment to make sure they were able to do this safely. We spoke to one member of staff and they confirmed they had received medicines training and had recently attended training about the use of syringe drivers to give medicines. They told us they had found this training very useful and felt confident with this role.

We asked one person and their relative about their medicines. They told us they were able to ask for pain relief when they needed it and were happy with how staff looked after their medicines. Staff told us people were able to self-administer their medicines if they wished to and staff had assessed they were able to do so safely. No-one was doing this at the time of our inspection.

Good systems were in place for management of take home medicines, supported by a discharge coordinator. People received information with their medicines explaining the purpose of the medicine and the times of day they should take it. Staff told us that people could practice looking after their own medicines before they left the hospice, if they needed to do this at home. Staff also said they separated medicines that had to be taken regularly from those taken 'when required', to make it easier for people to understand and take them correctly at home.

Medicines were stored safely within a secure treatment room. We recommended that staff review the security of some medicines cupboards to ensure they followed current best practice. Controlled drugs, which need additional security because of their potential for abuse, were stored securely. Suitable records were in place for these medicines to show they were looked after safely. Suitable arrangements were in place for the secure storage and recording of FP10 prescriptions. Staff used these prescriptions if they needed to obtain urgent medicines from a community pharmacy.

A medicines refrigerator was available. Staff recorded the maximum and minimum temperatures twice a day. There was no information on the record sheet about the safe temperature range for storing medicines. On four occasions staff had recorded minimum or maximum temperatures just outside the standard safe range for storing medicines but had not recorded if they had taken action taken to address this. This meant it was not possible for staff to assure themselves that these medicines were always stored correctly and safe to use. Emergency drugs and equipment were available. Staff checked these weekly. Comprehensive policies and procedures were in place. Staff reported any medicines errors; these were investigated appropriately and any action taken was documented.

Staff carried out audits to check the quality of their practice. For example, a six monthly audit of drug omissions in June 2016. This included conclusions and any action needed, as well as a comparison with previous audits. We also saw a re-audit of non-medical prescribing by community palliative care nurse specialists. This concluded that the system worked well but included an action plan, to address the improvements that staff had identified.

There was a housekeeping team and an infection control lead nurse. The infection control lead nurse worked across Taunton and Yeovil sites who kept up to date with national guidelines and research to ensure people were receiving safe care. They were involved in ensuring that clinical staff were up to date with their annual mandatory infection control training and they carried out regular audits. For example, hand washing training was a game where staff compete in hand cleaning and checking under a special light to see who had the cleanest hands. All visitors were asked to use hand gel at reception and we saw staff regularly hand washing. The lead nurse had also identified that a recurring sharps spillage was a manufacturer, not a practice issue and that it required solving to ensure the sharps bin provided secure protection. The information had been shared with the infection control forum to ensure it would not happen again. There was a pet policy ensuring people could have visits from animals safely. The infection control lead attended the national Hospice Infection Control Forum, chaired the South West Infection Control Forum and worked with the Lead Health Protection Practitioner for Public Health England South West to share best practice through a formal document agreement. For example, the policy for a particular infection screening process had recently been reviewed to reflect latest national guidance. The PIR stated there had been no episodes of hospice acquired infections in the last four years.

The kitchen had received a five star rating from environmental health inspections. The clinical areas and premises were very clean, organised and uncluttered. Waste bins were pedal operated, hand gel was easily available and sinks were wheelchair accessible. 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. 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. These areas were regularly audited including hand washing.

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. Fire safety equipment had been serviced and was regularly checked. A time of the recent fire incident staff reacted well to the situation and carried out appropriate actions in an emergency.

Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. Maintenance issues were dealt with in a timely manner. The inpatient unit was about to close for a short period to accommodate major refurbishment in this area and this had been well managed and staff had been consulted to give input to the proposed improvements.

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 told us the whistle blowing policy was included in their staff handbook on employment and described an incident where the whistle blowing policy had been used effectively. This had resulted in their concerns being addressed, so they could be confident people were cared for safely.

Staff training records confirmed that training in the safeguarding of adults was part of the induction for all members of staff. We looked at one safeguarding example. There was clear documentation showing that the issues had been taken seriously and that appropriate actions were taken as a result. The person had been involved in the process and learning points and recommendations had been actioned. For example, to ensure that where appropriate important confidential information was shared with relevant practitioners to keep people and staff safe. The hospice also used a computer system which enabled alerts to be flagged up. For example, to clarify who people wanted information to be shared with, who was identified as the main advocate for people and issues relating to family dynamics.

There were sufficient care staff on duty, to support and care for people in the In Patient Unit and Central Referral Centre at Taunton and community services. The service employed around 70 plus staff. The hospice used a dependency tool to ensure people's needs could be met by sufficient staffing levels on the IPU. The PIR stated that current staffing levels were above the required national NHS guidelines 'Safer Staffing'. Four of the IPU beds were funded by the local authority through 'continuing health care' (CHC). CHC could also be approached for further funding for additional staff for one to one care where necessary. There was an Assistant Practitioner scheme which was at foundation level. This role was a level above a health care assistant and under a registered nurse. This enabled them to have a higher level of skills to assist the nurses. These staff had input into health care assistant training and management and offered higher clinical skills

and support for the nurses.

Staff worked in close collaboration with the consultant in palliative care medicine. A team of doctors worked across all services and visited people in all areas including the community. 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. Rotas indicated there were sufficient staff. The IPU lead nurse told us the usual staffing level was three registered nurses with three health care assistants supported by the ward clerk and a co-ordinated, trained team of volunteers. Staff told us there were enough staff to meet people's needs, including at times they preferred. Further clinical volunteers had been recruited as part of a new volunteer strategy to provide patients identified as being at risk of harm with one to one supervision to maintain their safety whilst freeing up other clinical staff. Staff were available to help people at various times on the IPU depending on their wishes and there was a sense of calm so that people did not feel rushed.

Staff felt there were enough community staff to enable them to work out the frequency of visits due to people's need. A new MDT assistant role had been developed to prioritise community visits and assist the multidisciplinary community team. There was also a volunteer 'Sunflower Friend' scheme where volunteers befriended individuals to provide support to help people 'live their life to the full'. Support included assisting with hobbies, companionship, support for appointments and providing carer respite.

Safe recruitment procedures were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established they were suitable to work with people. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and were obtained from their most recent employer. Where staff moved within the organisation a full recruitment process was done. If conditions of employment were imposed these were checked as completed prior to new staff starting work. Disciplinary procedures were in place to ensure staff respected their code of conduct. This ensured people and their advocates could be confident that staff were of good character and fit to carry out their duties safely.

Is the service effective?

Our findings

Although there was an excellent training and education department delivering a wide range of training in end of life care, we found there were failings to ensure specific training in relation to the use of oxygen and smoking materials. All staff had completed or were booked for fire training. Of 129 permanent staff, 5 staff were overdue and of 17 bank (as required) staff 5 were overdue. The fire safety training tracker was part of new staff induction training and then completed annually. However, although it listed fire risk it did not include specific risk relating to the use of oxygen, piped or in portable cylinders and smoking. Staff we spoke to were not aware of the risk of oxygen enrichment for example, where oxygen which is heavier than air, can collect on clothes, skin and hair for at least 20 minutes following use. This knowledge is needed to ensure a safe situation before assisting people who wish to smoke and who use oxygen therapy. Since the incident the service has developed more detailed training to cover these areas. Staff had been contacted immediately following the incident to ensure they were made aware of oxygen enrichment and smoking prior to attending the updated training.

People said the staff gave them the care they needed and had the knowledge and skills to carry out their roles effectively. People felt the service was outstanding. One relative said, "All staff have time to really listen. [Staff name] offered good positive advice and was friendly and kind. The calm atmosphere was a joy compared to hospital. We felt 'cared for'." People praised the clinical team, one relative in the IPU said, "What was so good about mum's care was, the attentive care in addressing mum's pain and sickness, which had both caused mum a great deal of distress at home. We could never thank St. Margaret enough, as mum was able to pass over 50 successfully." People in the community said they were so relieved when the community nurse specialists visited. One relative said, "It was such a relief to know we could phone and now the nurse has arrived. We were at our wits end."

The hospice actively supported staff to ensure people experienced a good quality of life. For example, there was a dementia care lead nurse/champion and there were dementia friendly facilities within the hospice. For example, "This is Me" documentation which is a resource from the Alzheimer's Society was used to enable staff to find out more about people and this was used to provide care and develop communication. One care worker told us how they did one to one sessions with a person living with dementia. They had been a teacher and really enjoyed puzzle books. The hospice had bought gardening equipment and fragrant plants, pictures for communication and media equipment to help staff engage with people living with dementia at the end of their lives. The lead nurse role included implementing training, advise and develop a shadowing scheme for staff from a dementia care home and the hospice to share their experiences. The hospice had links with local dementia units and staff were receiving on-going training. All staff were trained as 'dementia friends'. There had been a session from a dementia nurse who works at a specialist dementia unit. Their session covered symptoms, medication, practical ways to help and how best to communicate with dementia patients. It was particularly well evaluated by staff as they brought "so much first-hand experience to the session". In relation to people living with dementia, preventative measures, in the least restrictive way, had been put in place to prevent further falls which may include one to one supervision with a member of staff. A specialist 'cognitive impairment' bay was in phase one of development, with plain floors to aid independent mobility. The volunteer strategy included training volunteers to sit with people

living with dementia who are at risk of falling as well as supporting patients with dementia. The catering department told us how they thought about how they could further make life easier for people with dementia. They had researched special coloured cutlery and crockery to aid people with dementia focus on their meal more independently.

Another project had involved engaging with the local homeless community and staff to deliver training to carers from a homeless charity. The education co-ordinator said how amazing it had been to see the light bulb moment when these staff realised how they could give better care for end of life. They now met monthly and local homeless charity carers were now accessing the hospice advice line and improving end of life care for the local homeless community. Staff said that St Margaret's were always thinking, "What else can we do?" Everyone could feed in ideas. For example, there was a Skype Business project where meetings could be held on screen remotely for education induction advice, staff in the community or for private tutorials.

Other than in relation to smoking risk, there was an excellent training programme run by the hospice academy led by the education team. This was described as a "regionally acclaimed and comprehensive academy programme to help staff increase confidence and competence in leading, co-ordinating and delivering high quality care". Staff said, "I love my job, we are one of the biggest hospices with the smallest education team but we make a difference." The hospice academy programme offered internal and external courses on a range of topics such as, what can I say and how do I say it, ethical and legal dilemmas in palliative care, dementia awareness, symptom control, syringe pumps and end of life champions which was aimed at nursing home staff in the community. Many people were cared for in care homes and the community staff encouraged them to work together, learn and take up training. This meant the hospice staff were sharing information to ensure people they provided a service for received the best care possible from others outside the hospice service.

Staff said they were always looking for opportunities to offer end of life training. The education co-ordinator said it was important to constantly evaluate and change practice through learning. The training department were now also working with 'micro providers'. These are 'one man providers' who provide personal care to people in their own homes. One man providers are not required to be registered by CQC and had formed a local group to ensure they were up to date with training in end of life care, which the hospice was supporting. This showed the hospice responded effectively to a changing work force and market. The hospice also offered placement to nursing students from local universities, four at any onetime across the sites, and offered in-house mentorship and training with a practice development nurse. This scheme was subject to tri-annual reviews to make sure staff were competent to train effectively. They also facilitated return to nursing schemes and return to practice placements. A desk was also rented out to a research and study support role. They attended clinical skills induction days and enabled staff to access online journals, projects and literary searches. We heard of discussions facilitated with staff about the use of e-cigarettes for people within the hospice setting, for example and offers of proof reading work for staff academic projects. This meant staff were encouraged to gain further education and follow ideas they were passionate about to further improve people's care.

St Margaret's Hospice Yeovil had two nurses who are nurse prescribers in the community. This enabled people to have quicker access to medication which enabled more effective symptom control. For example, one person had pain in their shoulder relating to their cancer. They were already on medication but the pain was like a constant 'toothache'. The non medical prescriber was able to carefully titrate a new medication dose bearing in mind caution with renal insufficiency, checking renal function before prescribing. This managed the pain without a lengthy wait whilst communicating with the GP. It also allowed for easier review of symptoms by the CNS, continued titration of drugs and better overall management. GPs were always

advised as soon as possible, normally within 24 hours of any changes made and prescriptions issued. Staff told us how supportive the hospice was in developing their knowledge. For example, one care worker had trained as the Tissue Viability Lead. They said, "I'm doing a Masters in Tissue Viability. What we have done here is good. People don't need to wait to see a doctor to assess wounds. Staff were all very supportive about me taking on the responsibility." They trained staff in assessing and provided expert advice, creating competencies for staff to meet. Each care worker had an information folder. The Tissue Viability lead said, "It may be end of life but we treat wounds actively and successfully here." The hospice hosted a conference on the subject with five national speakers in 2015.

New care and nursing staff had a thorough induction before they started working at the service. This included the shadowing of more experienced staff until they could demonstrate they had attained the level of competency required for their role. Competency checks were carried out regarding personal care and the administration of medicines. Staff were provided with a booklet that contained comprehensive information about the code of conduct and standards the provider expected them to uphold.

Annual appraisals involved staff self appraisal and pre-meeting preparation. Objectives were then set for the coming year. All mandatory training was managed on a computer system which could monitor who was due or had done training. All staff were up to date. This was reported on at the clinical operations meeting. All staff reported having annual appraisals and having consequent objectives to fulfil, which they felt supported on. Staff were further supported through counselling opportunities, a staff wellbeing and stress management leaflet, health promotions and health surveys. They also received de-briefs where necessary to manage difficult working situations and this had happened immediately following the recent health and safety event. Wellbeing and mindfulness training were included in the hospice mandatory training. Staff said they loved to work at the hospice. Comments included, "I do love working here, it's kind of uplifting but humbling. It puts your life in perspective. I meet incredibly strong people every day, I feel proud to be part of the tea", "There is more time to spend with people. It's a tight knit team, we bounce ideas off each other" and "We are all mutually supportive." Bank staff (staff used on an ad hoc basis to cover vacant shifts) had the same induction, the hospice mainly used their own bank staff but did use agency staff for specifically funded patients, often motor neurone disease related.

There was strong emphasis on the importance of good nutrition and hydration with focus on bespoke provision for people at the end of their lives. There was a flexible approach to meal times in that there were no set meal times and the hospice was able to meet people's special dietary requirements as well as likes and dislikes. There were also kitchen facilities for family and friends and opportunity for family to enjoy meals with people for a nominal charge. Making meal times enjoyable and good experiences was important. For example, one staff member said, "Not long ago we had a toddler visit and eat in a high chair, with his mum (a patient). Such things give good and lasting memories. Food is a social thing so we feed families." One relative said, "When we come in over a mealtime we are always asked if we need food and food quality is excellent." A snack trolley was always available on the IPU. People praised the food that was served; their comments included, " People felt there were plenty of options and they were able to request favourites that were not on the week's menu.

All food was sourced locally from a farm down the road. The hospice also used a local dairy. Complete allergy information was well known. Every staff member was trained in food allergens. There was also a detailed list of allergens per food item held in the catering manager's office. If a patient came in with severe allergic reactions, they had a cleaning process in place for food preparation areas. This used cleaning products that would remove 99.99% of allergens but not cover airborne allergens. So far the hospice had not cared for a person that would be affected by airborne allergen. The head chef said, "We do everything we can for patients and family. We always carry soya and nut free products. If needed we would go to a

specialist supplier." For dementia care there were special coloured plates/bowls to promote independence. There was a full range of assistive crockery and cutlery and bone china which was lighter for people to lift. All types of alcohol was available for people to choose from. There was a seven day rotational menu with daily specials and two choices of soups, starter, main and dessert. When people stay longer (as happened occasionally if people had complex needs) the chef varied the menu further so as to keep it interesting. The kitchen assistant said, "One patient wanted smarties (sweets) for breakfast, so we went to buy them specially. Another patient wanted curry, so we did that. Another patient wanted tea cakes so we bought those. It's all about meeting the patient's needs." The head chef said, "If it's not on the menu, we will get it. One patient wanted lobster thermidor. They enjoyed that." During our visit one person fancied a smoked salmon and avocado stack, this was made immediately and the chef said, a bit of what you fancy can trigger your appetite. We just try."

The hospice offered a personalised food service. There was a general rule of only providing food for two relatives additionally to the person, per room but they had never refused food for relatives if they requested a meal with their loved one. Each room had a folder with meal details, allergy advice and prices for relative's food. The computer system was used by the kitchen to obtain allergen and preference information for individuals such as reaction to food, food preferences/dietary needs, likes/dislikes, loss of appetite, ethnic diversity information such as kosher and family/carer information. There was also a board in the ward kitchen that listed people being supported by the IPU detailing what they had eaten or refused. Food was re-offered regularly later on if people had not wanted to eat at a meal time. Drinks were regularly checked on by ward staff and by kitchen staff.

People were supported by staff with eating and drinking when they needed encouragement. Handover sheets recorded who required assistance such as unable to swallow tablets, pureed food and fatigue with weight loss so use protein jelly. Hot and cold drinks were offered to people and each person in the IPU and day centre by volunteers. People who remained in bed had a jug of water or juice of their choice that was within reach and replenished throughout the day and night. People's individual wishes were taken into account such as how they liked to be positioned and what they liked or were able to eat. For example, every patient admitted met the chef on duty and information was collated on their likes, dislikes, specific requirements, allergies etc. The chefs delivered the food and subsequently recorded electronically everything eaten so intake could be monitored. Where people had risks associated with fluid intake there were charts showing how much people were having.

All staff were able to discuss people's needs in great detail. They shared information using the computer system, which was used regionally by most hospices. Staff on the IPU were able to tell us the correct, up to date information about people's care but had previously not always been able to find the record on the computer system, depending where it had been inputted. The newly employed Crosscare co-ordinator had worked to improve the system. For example, ensuring less repeated information and clear direction where information was recorded. The new format took staff through a set process to ensure information was all in the same place including details such as whether someone had dentures. Although the system had some identified limitations on the IPU, this was being addressed with staff input it worked very well in enabling staff to instantly share information across the service. The unit was supported by two consultants. All clinical staff could input and access full information about people's journeys. For example, each clinical area had a specific page which showed them any tasks or communication between areas. Catering staff, for example, told us how they used the system to look up any allergies and people's individual likes and dislikes. Community staff could see people's journey through the IPU. This system ensured staff knew if people had had contact with the advice line, the day centre, community nurses and the IPU and other health professionals. The most recent contact and outcomes would be at the top of the screen and other details could be accessed. Staff could also access information on their lap tops and smart phones in the

community. Staff used detailed handover sheets which highlighted diagnosis, active problems and daily updates and the co-ordinator was looking at using the system to inform handover sheets. For example, staff could input exactly how people liked to be cared for, how they liked to lie in bed, be positioned and spend their day. A current problem section highlighted issues. This system ensured effective continuity of care and that staff were knowledgeable about people's individual care and treatment.

Staff knew how each person communicated and this was reflected in their records so all staff would know. This included catering staff. They knew how people liked to be referred to and what their family support and dynamics were. We observed a member of the catering staff approach a person on the IPU. The person appeared not to be aware of them. The staff member approached very gently and spoke the person's name. It was done in a very respectful and kind manner. The person was encouraged to choose what they wanted to eat and drink, being offered Champagne and Guinness. They did not want anything and the staff member said that they would return in a while to check if they changed their mind. It was obvious from the catering staff member's approach they knew the person well and was familiar with their normal taste for food as well as their preferred style of contact. Alerts appeared on the computer to reflect people's wishes such as who to contact or not to give information to within families if there were disputes. Where people were particularly anxious staff knew what techniques people used, such as visual imagery, encouragement or sometimes additional medication. People and their families felt involved in their care. One relative said, "The staff involve me in [person's name]'s care. I have agreed with them to do what is best for [person's name]. The doctors are very honest. Dr [doctor's name] was very clear in the information he gave. They can't answer everything, but will do where possible."

Each person had a pain management programme if relevant, including people cared for in the community. Symptoms control and pain management were discussed with people before any new medicines were administered. We spent time with a community nurse specialist on a joint visit with a GP to one person in their own home. Both health professionals worked closely together involving the person to decide what new medication may help their symptoms. The GP asked the community nurse specialist for their advice saying, "They know the medication in palliative care well and we respect their knowledge. I often come out to meet hospice staff so we can provide the best care for them." The person was visibly relieved following the visit. The community nurse specialist recognised that the person may feel better if they were assisted to get up and stayed longer to support them. The person was able to have an independent wash knowing the nurse was nearby and that their future support needs had been addressed.

The PIR told us the hospice used a range of non pharmacological measures to relieve pain and distress including acupuncture, music therapy, guided imagery and psychological interventions. There was a main weekly ward round on the IPU. Records were written directly into the computer system. There were also multidisciplinary meetings (MDT) held every week, one for the IPU, which we attended, and one for the community. The meeting included a full range of disciplines such as occupational therapists, clinicians, social workers and physiotherapists. For example, discussions included people's advanced care planning such as declining further investigations, funding, equipment and preparations for people who wanted to aim for being cared for at home. MDT agreed decisions were recorded on the handover sheet and updated each week. For example, "aiming to discharge to a nursing home", "continue with symptom management", "family support", "potential barriers" and "assist meditation in the summer house". Therefore staff were all aware of people's goals and wishes. During the IPU MDT meeting we saw how detailed the care for people was. Care was considered in a holistic way and there were discussions about how other services could be approached for further support such as children's services for further support and emotional support. For example, the consultant was arranging a night out for one person and another person was very anxious so the spiritual co-ordinator chatted with them whilst doing tasks like making a cup of tea and they became more settled.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager demonstrated a good understanding of the processes to follow. Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. When people had been unable to leave unaccompanied and needed continuous supervision to ensure they remained safe, their mental capacity had been assessed appropriately. 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. The multidisciplinary team had considered the least restrictive options for each individual. Comprehensive records were made of how appropriate meetings had been held to discuss people's best interest and make a decision on their behalf as per the requirements of the MCA. For example, one person was becoming institutionalised so the team were working with the family to promote more positive experiences for the person. Staff carried out individualised assessments to identify people's own perspectives on their condition to aid information sharing sensitively. Staff could explain what might constitute a 'best interest decision' and the criteria required to undertake MCA assessment. Staff sought and obtained people's consent before they supported them. When people declined support, for example when they preferred their own company, their wishes were respected. During a meeting staff discussed one person who used alternative methods of pain relief. The person was well supported in their choices and staff commented on their positive change in mood and openness to talk as they began to trust staff.

People were referred to healthcare professionals when necessary. For example, a new multidisciplinary assistant role (MDTA) had been developed to meet demand for occupational therapy and physiotherapy. They provide support for routine requirements especially for managing breathlessness in the community. The lead physiotherapist told us two MDTA's in particular were very proficient in assisting in relaxation, fundamental to alleviating breathlessness. Staff worked in close partnership with people's GPs when they supported people in the community. For example, the community nurse specialist we went on visits with had arranged to meet the GP and one person's home. Together they worked to reassure the person and the GP asked the CNS for their expertise in palliative care medicines to manage a digestive issue, prescribing the advised medicines. The service's community nurse specialists were 'attached' to GP practices and attended regular 'Gold Standards Framework meetings' where they discussed care options for people known to the services and identified appropriate referrals. 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. People were referred appropriately and without delay to consultants such as neurologists and oncologists, to hospital specialist teams such as chronic pain team and specialist nurses such as tissue viability nurses. This ensured that staff responded effectively when people's health needs changed. The computer system showed how these health professionals could also access the records.

The premises had been designed and decorated taking people's physical and psychological needs in consideration. They were spacious, well-lit, and decorated in calming tones. Corridors were wide, with

handrails to help people move around when necessary. All doors had been designed for easy access by people in wheelchairs. The reception was welcoming with ample seating area, a shop and facilities for refreshments. People were welcomed by a ward volunteer. There was a sitting room with games to keep visiting children entertained. The attractive gardens that surrounded the premises were maintained to high standards and had been designed to promote an atmosphere of peace and comfort with areas of interest, water features, ornaments and covered areas. All rooms had pleasing views of the gardens and included ample seating areas for people to relax in. The hospice was closing for three weeks in November 2016 for refurbishment including transforming the area of the nurses' station to achieve a bright and welcoming reception area for people and visitors to the ward, replace all floor covering to uplift the ward environment and assist with way finding and signage, increase levels of lighting, relocating the ward kitchen to provide a new larger workspace with increased storage and workspace remodelling the pharmacy room, linen store and dry storage to incorporate additional storage units.

There were two four bedded bays and eight single en-suite rooms on the IPU. The nurses' office and nurses' station were situated in the IPU so staff were able to have immediate access to people when they needed help. There were rooms for complementary therapy and counselling, outpatient clinics and lymphedema clinics. All bedrooms were spacious, had attractive views, were well equipped including a telephone and specifically designed to provide a calming environment. The IPU had a sanctuary, safe multi-faith space at the heart of the unit. There were private and quiet areas for family to reflect and have time together where they could stay overnight, including a "Sunflower Suite". The Sunflower Suite was a one bedroomed, self-contained flat to facilitate preparation for discharge for people and their families. People were able to prepare for discharge and work through any concerns to reduce anxiety with staff support when they needed it. For example, setting goals for their medication or oxygen management and meal preparation. This enabled families to have the opportunity to be independent of the service but close enough to call in help and advice. It also enabled people to try out the reality of 'home' to ensure they would be cared for in the right place and give people realistic expectations for the future.

The day centre was accommodated in a vast well-lit area that included comfortable sofas, a kitchen, armchairs, tables and storage for art and crafts materials. All office space provided a pleasant environment for staff to work in and there were training rooms fully equipped in the building. There was a room for complementary therapy and another for the chronic lymphedema clinic.

Is the service caring?

Our findings

People said the hospice provided outstanding care. Overwhelmingly, they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were overwhelmingly positive. People told us, "They are angels in uniforms, it doesn't matter what you ask, anytime day or night. They do their utmost. Choice of food, help with pain, nothing is too much", "I don't have a bad word to say and the place is immaculately clean" and ""The staff become like family. They ask how you are and [the staff] all chat to [person's name]. The carers, for example, bring appropriate humour. They don't just work here; they want to be here." People's testimonies included, "My care is exceptional. There's always someone ready to help at any time, day or night. The staff are always polite, kind and nothing is too much for them. I couldn't recommend St Margaret's more highly and I can't think of anything that needs improvement", "Such lovely caring people gave us such confidence to face the inevitable" and "You are not a number you are a name." Many people had written that they could not think of any ways to improve the service. Relatives told us, "The staff understand your problems and what you need" and "Nice location. Peaceful surroundings. Caring staff. Much needed break to my normal routine. Can't think of any improvements".

There was an outstanding spiritual support service which was inclusive and available to all in a person centred way. The hospice had a spiritual care co-ordinator whose focus was, "Not upon the creed but on the spiritual requirement for every patient and their families. This might be religious or something else, perhaps art or nature". They were ordained within the Church of England and could provide all of the services related to this. Their model of care was to incorporate all models and beliefs of body, mind and spirit accessing the sanctuary space at the hospice if appropriate. They told us they let each person lead, facilitating what they referred to as 'soul midwifery' allowing the patient to give birth to what was on their mind. They were aware of every admission and ensured both people and their relatives and carers had access to them. They worked closely with the hospice team, providing support for people, relatives and staff every day of the year in both the Yeovil and Taunton hospices. They did not provide counselling but saw themselves as a "bolthole for all". The spiritual care co-ordinator had developed 'spiritual care competencies' which were used by all the teams within the hospice, clinical and non-clinical. This enabled all staff to be involved in providing spiritual support so that people did not have to wait and could speak when they wanted to. To date 19 people (including the clinical director and from across all groups in the hospice) had completed all or part of the competencies and the group would come together through the year for mutual support, additional training and sharing of conversations. A fundraising volunteer co-ordinator said, "At our hospice spiritual care is recognised to be the responsibility of us all, not just those who work and volunteer on the in-patient units but ALL staff and volunteers. It's a far-reaching type of care – we are all spiritual carers."

The hospice had a "Sanctuary" space which was a neutral spiritual space open to all, offering a place to draw apart and be still. During our visit staff had pushed someone's bed to The Sanctuary to enjoy the space. The spiritual co-ordinator said in the hospice leaflet, "It is important that everyone has time and space to 'find sanctuary', that is to nourish our emotional and spiritual selves in order that we may be strengthened and equipped to face the challenges of living with a life-limiting illness, whether directly or indirectly." The Sanctuaries were open to all 24 hours a day. Each room had small multi-faith symbols discreetly available to those who wished to use them for prayer and worship and a wide range of religious

services and funerals could be carried out by the hospice spiritual co-ordinator. The hospice had recently cared for two Muslims, each with different specific faith needs. One person was washed as their culture stated after death by their friends. The other person moved to a care home and hospice staff facilitated the Imam visiting and subsequently arranging the funeral.

Staff knew how to respond to each person's diverse cultural and spiritual needs in a caring and compassionate way. An interpreting and advocacy service was also available for independent support for people and the PIR stated there was access to Russian and Polish speakers. Staff were able to use a translator application on an iPad. There were examples of how the hospice had met the spiritual needs of people at the end of their lives with various beliefs. The hospice had representatives for a range of faiths within the volunteer team including a prison advocate, a counsellor working with alcohol and substance abuse, mental health and links with local churches.

Visitors were welcome at any time. Relatives were able to bring people's pets to visit their owners in the service, to bring them comfort and lift their spirits. Staff told us, "Dogs and other family pets are allowed. We maintain good hygiene with animals. We have had donkeys visit the ward wearing rear end bags. There is a patting dog brought in regularly. Once there was even a race horse in the gardens" and "One chap wanted to say goodbye to his pet snake, so that was brought in. I feel privileged to work here." There were Christmas parties, summer parties, Halloween, Easter bonnets, picnics in peoples' bedrooms, weddings (one had doves released). There had been theme days such as 1940's. Music and cake from the era was provided and people brought in old photos. We heard how a local company provided a free limousine and people at end of life were taken in it to a garden centre for lunch. 'Bubbly' was provided in the limo. Staff said, "One time The Drifters came to sing. At Christmas local school children come and sing carols. There is a centre choir made up of volunteers and staff. They sing at different places to raise money. We have had flower demonstrations, painting and craft. A local artist came in.

For a 30th wedding anniversary staff set up the dining room like a restaurant for a steak night as the couple could not go out. The hospice had catered for four weddings in the last year and is licenced to provide weddings. One was for 60 people. The whole hospice community shared in these celebrations with doctors fine tuning people's medication in preparation for the day, care workers helping a bride to dress, a nurse in attendance at the ceremony to top up oxygen, ward staff decorating the family room and volunteer receptionists showing guests to the ceremony. One wedding was brought forward due to the person's ill health within 96 hours of the initial request. The person felt better as time went on and the hospice arranged for the photographer to return a week later and re-do their wedding photos with the bride looking much brighter. The head chef told us, "A young person here had a young daughter. The hospice put on a pig roast in the garden for their rugby club for 120 people. A helicopter did a fly past as the man had wanted to fly but was medically unable to. It was also his daughter's birthday so it was very special." Such measures ensured that people could retain and find comfort in routines that were familiar to them. Where people had requested assistance to fulfil an experience, attending a wedding or national event, staff had worked to ensure they happened.

There was a homely feel to the service in the IPU and the day centre. People commented on the I want Great care website, "I love every minute of my time here and look forward to it", "I get weekly support and am able to talk to [staff name, Sunflower centre lead] on present health issues. I enjoy the social day of meeting people. All volunteer staff are very kind and easy to talk to which also gives reassurance on family and private matters. Meals are all prepared and enjoyed and appetising." All our observation and listening identified a consistent, caring attitude demonstrated by all staff at all times. There was a social atmosphere where people were encouraged to chat if they wished and were listened to. Staff were smiling and engaging. They stopped to listen to people and responded to them with genuine interest. Their approach was kind,

patient and respectful. They followed people's pace when they helped them and when they spoke with them.

A 'Life Story' project was running with a life story facilitator. This was time to recall special memories, people and events to capture them through words, pictures, music, poetry letters and memory boxes. For example, one person had read their child bedtime stories onto a CD for when they had gone. The hospice staff were proud to be involved in this way and unlock people's stories. The poster said, "We have, each of us, a life story, whose continuity, whose sense, is our lives."

Staff were attentive to people's needs including their emotional wellbeing. For example, the community nurse specialist tried to ensure continuity so that people met the same staff and built up a safe, open relationship. They knew in great detail where people were coming from and how they were managing their diagnosis and end of life management. For example, some people preferred to be more independent and others required more practical support. Staff skilfully managed conversations in ways that made people feel comfortable and discussed topics when people felt ready. Staff showed kindness and knew how to convey their empathy when people faced challenging situations. They allowed time for relatives to talk to them alone and comforted them appropriately and looked at additional small ways in which they could be of help, such as picking up a prescription or following up on a question. For example, ensuring they visited at times which were convenient and parking in appropriate places. We saw how the community nurse specialist, for example, reassured two relatives when they had called the hospice for help. They had felt they had let their loved one down by suggesting an admission but the nurse skilfully brought the three family members together to openly discuss needs and relieve anxieties. The person was admitted the next morning after the nurse had ensured support for the night so the two relatives could get a good night's sleep.

Staff used appropriate touch when needed such as gently holding a person's hand and always checked to assess whether such gestures of empathy were welcomed by people. They offered companionship to people who stayed in their bedrooms on the IPU when they considered that people may not wish to be on their own and promoted the use of volunteer 'Sunflower friends'. The staff responded quickly to people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected and updated in their care plans. The multidisciplinary team discussed how to support people who were struggling to come to terms with situations. Recent training had been provided in dealing with difficult conversations, "exploring how we manage difficult conversations. We have all been caught wondering how we ended up in the middle of a complicated discussion and wondered how we're going to get out of it, help someone in distress, redirect or signpost to someone more appropriate, bring it to a satisfactory close or just not know what to do at all!" Topics also had included managing people with suicidal thoughts.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. There was a range of comprehensive information leaflets that included in patient stay, last days of life, integrated palliative care, consent, bereavement support and managing leg swelling. The service were looking at ways to ensure the risks of smoking were made clearer. The current leaflets made it clear that the hospice was there for people stating, "We are here for you, our door is always open." There was a quarterly St Margaret's news publication which gave personal examples of people's experiences and additional information about specific events, fundraising and opportunities for people. For example, details about support for young families when faced with life limiting illness. A family support worker helped people explain their illness and uncertain future to their children and found creative ways to share and keep memories. The service had an updated website that contained clear, comprehensive information that was user-friendly.

Face to face information was provided to people tactfully in a way that ensured people were able to make fully informed decisions. One person said, "Very good assessment made by [staff name] and she made me feel she fully understood my situation and was able to give me advice on various aspects of my conditions and some practical advice which has been unavailable." The medical team interacted with transparency and sensitivity when a person enquired whether they would be able to finish a project or aim for a particular goal. One discharge letter stated how desperate one person was to get home and all efforts had been made to enable this with a complex care package. The doctor had ensured a bed was held for them and any time at home was seen as worth the effort. There was a discharge co-ordinator employed at Yeovil. They said they always moved in the direction that people wanted even if sometimes this was unlikely, being open and honest but as they told us, "preserving people's hope". Discharge was discussed on admission and worked through to ensure people knew what to expect and where they would prefer to be discharged to, such as home or a care home. During handovers, meetings and after 'ward rounds', staff spoke about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality.

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' using a clear booklet. 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 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. Staff were also supported where people's wishes involved treatment withdrawal and able to reflect and explore experiences and procedures based on guidance, legislation and best practice. A significant event meeting was held following one such event. There was discussion about ethical and legal issues, staff support and how the withdrawal went in practice with the person's wishes at the heart of discussion. For example, the person had wanted lots of visitors despite family reservations and the Sunflower Suite was used to protect family and friends privacy. As staff demonstrated great understanding and empathy, people could be confident that their individual needs were met and responded to in a way that may exceed their expectations. Staff were also supported through people's difficult decision making and following this event a special staff service was held to remember the person.

All staff knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal needs. People were assisted with their personal care needs in a way that respected their dignity. People followed their preferred routine, for example people chose meals and snacks whenever they wanted or felt like eating, stayed up late, or had a bath at any particular time of the day or night.

Is the service responsive?

Our findings

People and their relatives told us that the way staff responded to their needs was, "Excellent, no improvements needed", "There is no way the care given could be improved. All the carers go that extra mile to ensure you are well cared for in all aspects and areas" and "You can't ask for more." They felt the 24 hour advice line and one stop referral centre were a lifeline and enabled people in the community especially to feel connected to support, advice and feel less anxious. 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.

The service was 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. Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, physical, psychological and spiritual or complex end of life care needs. The average length of stay was two weeks with some people being discharged home or to a local care home. This was recognised in the St Margaret's 'Hospice without Walls' business plan. The hospice's aim was to provide palliative care in partnership for all those in need and to play a role in enabling everyone in their community to have good end of life care. This recognised that there was a shift in focus from inpatient beds to allocating resources to wherever the person chose where possible. Phase one of the business plan resulted in the 24 hour advice line and central referral unit (CRC) being established. It also promoted a multi-skilled approach to ensure people received the right care at the right time in the right place. Therefore we saw staff were encouraged to work in rotation throughout the service to support people throughout their journey. The staff working in CRC offered direct advice to carers at their time of need during working hours with an advice line and night staff providing the service out of hours. It also allowed referral to all services such as the IPU, bereavement support, crisis respite and nurse visits with just one call. The responsiveness of the CRC had been effectively monitored. For example, administrative tasks were now carried out less by clinicians, referral times and waiting lists had been reviewed and all staff in the CRC had had specialised training. There were comprehensive guides for staff to use during their telephone shifts and these were added to for further learning.

Information available on the computer system relating to the CRC was good, other than in relation to the risk of smoking and smoking history. For example, they were able to access medical team handovers of new patient so there was no chasing for information or asking people repeated questions. Medical records could be scanned in to the system also along with hospital discharge notes. Medical staff reported an extensive multidisciplinary approach to patient care, stating that initial admission was usually undertaken together by a clinician, to prevent repetition and ensure adequate information. Staff were able to accelerate referrals to NHS 111, district nurses, GPs and out of hours services. The computer system enabled staff to access planning ahead details, preferred place of death, other wishes and what decisions had already been made. Staff were able to note which CNS staff member was involved with people for continuity.

We spent time with a community specialist nurse in the community. The community nurse specialist team provided an excellent, responsive service. They managed their diaries depending on people's needs and

support required. The community service provided a seven day service and consisted of a varied skill mix with nurses and health care assistants working alongside the CNS team. They provided hands on care, advice, support, signposting and symptom control to enable people to stay in their preferred place at home.

Specialist palliative care services worked together with primary care teams, care homes and hospital teams to ensure appropriate access to specialist palliative medical and nursing services when required. One GP said, "We work really well together. The person we visited today won't ask for help so between us we help keep them safe at home. The nurses think of everything, equipment, support as well as clinical issues." There was also a manager and consultant on call at all times. There was a bereavement enquiry line where people could access specialist support from the bereavement support team including signposting people to a range of external services. Support included telephone support, individual appointments, counselling, group therapy and family support. Joint partnership with Macmillan (cancer charity) and Citizen's Advice Bureau (CAB) enabled a weekly clinic at the hospice provide financial advice.

The hospice day centre was open on a Monday, Tuesday and Wednesday by referral. Referrals could be for six or 12 weeks initially but were reviewed after three and six weeks examining possible alternative approaches that might assist in helping the person achieve their specific goals. People first met with a member of the clinical team so their individual needs could be understood. Personalised goals, frequency and length of their attendance were discussed and agreed on. The day service also offered 'drop in' sessions for people and their carers to attend without prior booking. This ensured that staff could respond to people's needs when they arose. The centre was person led, with suggestions from supportive staff. Activities were not prescriptive and might not actually involve practical tasks but could be discussions. The day centre provided a wide range of activities for people. This included activities people particularly liked or introduction to new experiences. For example, various hobby activities were run by a diversional therapist but there was support to also help people to make memory boxes or audio memories or talk about ways to include children in discussions. One-to-one activities were provided for people who remained in their bed on the IPU. A volunteer told us how they saw people who had minimal responses, really respond to a dog visit. In the entrance way there was a large dog bowl of water. We were told that visits from dogs were encouraged. We were also told how one person received visits from their hedgehog. There was a hospice cat that had the run of the building and people were able to enjoy stroking the cat on their bed if appropriate.

The hospice offered a wide range of support for carers and their families. There were specific courses which provided practical information, explored the emotional impact, helped carers care for themselves and provided opportunities for carers to meet others. The hospice uses Quantock House which is a carer support centre whose current running costs are jointly supported by the cancer charity Macmillan cancer support. People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life. They were encouraged to attend support groups and socialise in the day centre in a comforting setting to ease their grief. This meant families could access emotional support from the service after the persons' death.

There was a wide range of therapies that were additional to clinical available to respond to people's relaxation and general wellbeing needs. Volunteer complementary therapists included aromatherapy, massage, reflexology, reiki, music therapy, occupational therapy and physiotherapy. People were able to try a variety of options and choose the therapies they preferred and when they wished to have them. Sessions were recorded and people were able to request a chaperone if they wanted.

The hospice took a key role in the local community and was actively involved in building further links. There was a fundraising team who ensured the hospice maintained a high profile in the community and was

regularly prominent in the local press. Links with the community were actively sought and encouraged and there were many organised events such as charity runs, rock concerts and sales. Volunteers and staff contributed to the planning of events.

The hospice used many ways to ensure as many people as possible could be involved in giving their feedback about the service they received. A poster encouraged people to give feedback to help the hospice improve their service. This could be done by completing a suggestion card, emailing suggestions to a feedback email and submitting feedback via the St Margaret's website. There was a visual aid for feedback called "Your token counts" where people could put a token in the clear box which matched their general views. The caption on the box explained that the hospice were continuously trying to improve the patient experience and asked how likely people were to recommend the service to friends and family if they needed similar care or treatment. There were four different colour tokens to represent the inpatient unit, sunflower centre, therapies and clinics and lymphedema. Feedback cards were available nearby so that people could write explanations for their choice of slot. The feedback board in reception "You said, we did" ensured people that their comments were listened to and dealt with. For example, current comments stated, "I was unhappy with the content of the lymphedema letter- the hospice changed the wording of the letter to make it clearer for patients" and "It is difficult to find bereavement support for children- the hospice employed a family support worker to work with children and young people." This showed they were outstanding in enabling feedback and communicating what actions had been taken. A need for assistance with wills had resulted in a free clinic weekly with local solicitors to update basic wills.

The hospice was a member of the national website 'i Want Great Care'. This is a tool for people to leave feedback about a service and to see other feedback about the service. St Margaret's Yeovil had a five star top rating. Comments recently added included, "The whole experience was just what was needed - a totally relaxing stay. Our welcome upon arrival was wonderful and felt like I was visiting friends. [Staff name] looked after us very well and I felt so pampered - a fabulously kind woman. I cannot think of anything that could be improved upon. Thank you for recharging my batteries" and a relative commented, "Everyone I came into contact with was friendly, approachable, kind, sincere and caring. The team are all also very supportive to my wife. Thank you all."

Satisfaction surveys were carried out, next due in 2017, and responsive action was taken to address shortfalls that were identified as a result. All comments in the surveys were extremely positive about the quality of the service. Where people had raised these had all been addressed.

There was a clear complaints and concerns procedure. People were given a "Feedback, compliments and concerns" leaflet which showed them how to make a complaint through the three step process. Staff encouraged people to speak with them if they had a concern at the time or offered meetings with a senior member of clinical staff or the governance team. People were able to bring a friend or relative for support. Staff could record any concerns, however small, through the electronic system. Any concerns had been taken seriously and actions taken to address them.

Is the service well-led?

Our findings

Although, there was an open and positive culture which focused on people, we identified some failings specifically in relation to the management of oxygen use and smoking. Failings included the lack of robust risk assessment and communication to manage the risk of oxygen therapy in relation to smoking materials and the lack of detail in fire training and policies to include oxygen enrichment, smoking management and oxygen management.

Following the incident the service produced an action plan and conducted an internal investigation using an external senior executive clinician to establish the root cause of the incident. The service also introduced a no smoking policy and improved training. The registered manager has taken appropriate action to ensure this action plan has been implemented. The service now operates a no smoking policy.

People's feedback about the way the service was led described it as, "The hospice is an amazing place and the staff are wonderful and caring. Would recommend both hospice and service to anyone" and a relative said, "I was listened to as I talked about my worries. I felt that I was in expert hands and communication with my GP was very good and helpful. Whenever I need to contact someone at the hospice messages were passed on very quickly and the response was prompt. A great service." Staff all felt supported, lucky and privileged to work in St Margaret's. Staff felt well supported, valued and positive about working at the hospice. Staff praised the registered manager, clinical director and leadership team for their approach and consistent, effective support based on a person centred and inclusive ethos. The leadership team was clearly linked in with the staff council to enable staff feedback to have a defined route to the trustee board. The staff council aimed to promote effective dialogue and consultation between the hospice and its employees, to enable contribution on hospice strategic objectives and provide a discussion framework for staff. For example, actions from a recent meeting included a Fit for Future project, actively seeking opinions from colleagues, updating notice boards, compiling a staff photo board and including new ideas and suggestions on the agenda. We saw that suggestions had been listened to and taken forward.

Staff said they could come to the clinical team leads or any of the directors for advice or help and saw them as open and transparent. All the staff we spoke with told us they had confidence in the way the service was managed. A housekeeper told us, "It is all about the people because they're relying on us to keep it all clean. Some people like to off load at times, everybody supports one another and our manager keeps an eye on us. The whole establishment tries to support one another. We're close." All of the staff we spoke with told us they felt valued working in the service, and felt motivated to maintain high standards of care. Volunteers in the day centre said, "Ruth (the day centre manager) is extremely good, a wonderful person, an absolute treasure." They felt any problem would be dealt with saying they all felt very valued and praised the work of the hospice. They added, "The staff nurses are really good. They have patience and understanding. Each patient is made as comfortable as possible. The nurses are happy to meet their needs." Most volunteers had experience of a relative being cared for at the hospice and enjoyed being part of St Margaret's. One volunteer told us that recently their whole team had participated in a retreat using the Hospice retreat home in Bridgewater as a team building experience. Some staff loved their job so much they had worked at the hospice for 20 years, which they felt said something about the working environment. Another staff member

said, "I'm passionate about my job. Patients should have the very best of care and we give it."

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. From what people told us and our observations, these principles were implemented by all staff throughout the service.

People were supported by a service where management and staff embraced new ideas about how to improve quality of care. Staff all felt listened to and involved in shaping improvement. The registered manager and clinical director involved the staff with the running of the service. Regular staff forum meetings were held where staff were invited to bring suggestions about the running of the service.

Staff told us the hospice philosophy was to continually strive for improvement and look at "What else can we do?" to improve the service for people. For example, we received information in the PIR which highlighted identified areas for improvement. A key task was to continue to look at how the computer patient electronic recording system could be improved. A working group was chaired by the Director of Governance and staff champions had been identified to monitor and work towards a re-launch of the system. In the meantime there were paper systems in place to work around until the system was more user friendly and there had been further training for staff on input. There was a staff council with clear terms of reference. New ideas and suggestions were a regular agenda item. A review of the first year of the staff council showed establishment of regular, well attended meetings supported by terms of reference and the a vision and values statement. They had established a 'Who's Who' board on each site and been consulted on, Fit for the Future, whistleblowing policy, staff uniform and facilitated kettles in Taunton staff room, staff exit protocols, staff socials and individual email addresses for staff.

A consultant was leading on a research study with other hospices on palliative rehabilitation using goal targets. This aimed to improve palliative rehabilitation by aligning effective care to people's needs and individual goals further. One project about developing support courses for carers of community patients in a hospice setting had evolved from the government end of life strategy. St Margaret's community team had developed the project which supported carers emotionally and practically, for example through a cooking course aimed at male carers. These had continued for some carers post bereavement demonstrating the lasting impact of the support.

The hospice was a group member of the National Palliative Care Educators for the South West. Staff worked together with other local hospices and attended national conferences. A group of four non medical prescribers had presented a poster at the national Hospice UK conference on non medical prescribing (the prescribing of medicines by health-care professionals other than doctors). They had shown how this would have a better outcome for patients to reduce delays in accessing medication to manage symptoms. A case study was used to show what a difference this could make for people at St Margaret's and generally, such as reduced delay in receiving appropriate medication. They had also presented two other clinical innovations including family and carer support and the re-ablement approach taken with the use of the Sunflower Suites.

The hospice had a new volunteer strategy to enable staff to ensure people were as safe as they could be on the IPU. The HR department led the recruitment and training and the strategy was closely monitored to ensure its effectiveness, for example in relation to falls. For example, increasing volunteers who would be able to provide further monitoring of people at a high risk of falls.

The PIR told us about where the hospice had received recognition of good practice. For example, St Margaret's had won the Return to Practice Employer Award 2015 and a return to practice student had been

awarded a highly commended. A St Margaret's occupational therapist had received a highly commended in the "Can do attitude" award in the Somerset County Council awards 2014. The Sunflower Suite initiative received recognition at the national Hospice UK conference in 2015 with St Margaret's having input to the conference agenda relating to non medical prescribing, family and friends courses and support initiatives and their consultant partnership scheme. Many people had been able to care for their loved ones at home having used the Sunflower suite to practice supporting people and learning about how to provide practical care. This had allowed people to die in the place of their choice with loved ones who felt well supported themselves and less anxious.

There was an effective clinical governance structure that included a chief executive and the registered manager, who was the director of governance. There was a clinical quality and education committee which fed into a governance subcommittee with links to the health and safety group, tissue viability group, clinical audit group and others. This meant ad hoc working parties were also set up to manage relevant topics such as a discharge working group and a group looking at the CRC.

The multidisciplinary team had looked at a "step down" process for discharge. The discharge co-ordinator managed most discharges using a comprehensive checklist. This included specific checklists for nurses and doctors to ensure discharges went smoothly. These included equipment ordered, packages of care confirmed and by whom, explanations given to the person and family, transport and communication to the destination and intravenous access. One person had arranged to go home three times but changed their mind at the last minute. Staff supported them in their decisions. The staff set clear goals with people before they aimed for discharge such as, the ability to self medicate, use the toilet independently, walk up a few stairs, prepare a few light meals and manage at home with a package of care.

The PIR was comprehensive and identified any issues we found during the inspection such as the limitations of the current electronic care planning system set up. This showed the provider had identified any issues and was making improvements. For example, employing a computer system co-ordinator. There were robust systems to monitor the quality of the service. There was a comprehensive clinical audit programme covering a wide range of topics. For example, antimicrobial prescribing, use of steroids, prevention of skin pressure damage, spiritual care and pain management. The Director of Governance then completed spot checks to ensure that outcomes arising from the audit were embedded in practice. For example, there would be re-audits in drug omissions, assessment and documentation of spiritual care, management of pain and prevention of skin pressure damage and spot checks in areas such as management of constipation. Some audits were carried out regularly to ensure compliance with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care that defines clinical best practice. NICE provides specific quality statements and measures to provide service providers with definitions of high-quality care. Such audits to measure how the service performed were completed either monthly or quarterly, documented and used effectively to monitor the quality of the care provided. An annual audit report further monitored outcomes and gave updates on improvements.

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. As a result of findings the hospice had reviewed the documentation (policy, procedure and reporting forms) in respect of medical incidents reporting to ensure that reporting was objective, fair, consistent and timely. They now collect numbers of pressure ulcers that heal/improve which is positive for people and staff and reviewed the use of the computer system using the new Hospice UK fall toolkit to ensure it is aligned.

Monthly management meetings took place to discuss every aspect of the service, including staff training and policy and guidelines reviews. The policies were comprehensive, reflected every aspect of the delivery of

care in the service and were updated on a continuous basis. 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. There were systems in place to manage lessons learnt. For example, there were regular significant event meetings. These discussed where care could have gone better, why an incident happened and what could be done differently. One event identified the need for specific staff support in relation to MND, for example.

The registered manager notified the Care Quality Commission of any significant events that affected people or the service. There were systems to ensure that staff were receiving good quality, effective training that reflected people's needs and that staff were encouraged and supported to obtain further qualifications.

The Director of People and Organisational Learning would be responsible for undertaking a full training needs analysis and a competency programme was in place. The competency programme was rolled out four core competencies. A need for more trained supervisors for staff had been identified to further improve the level of staff support. There were also systems in place to ensure management and staff were up to date with recent legislation and national guidance. For example, a leaflet had been produced on the duty of candour for staff, patients and families. The duty of candour imposes a duty on a service to provide all necessary support and relevant information to people in the event of a patient safety incident.

Staff were encouraged to make contact with external health professionals and share knowledge. The HR department had also contacted Somerset County Council to take advantage of the Health Workplace programme and a local business had been to discuss staff support in areas such as physical activity, health eating and stress reduction.

There was an accidents, incidents/near miss procedure. This included a clear flow chart with severity rating and action instructions covering patient or staff events. This ensured relevant information was considered and analysed without delay. Action was taken to minimise risks of recurrence. These were audited to identify trends and patterns and were discussed at monthly clinical management team meetings. The falls group met every 6 months to review patient falls, discuss lessons learnt and action any recommendations to provide an environment that is as safe as possible whilst still encouraging the patients to be as independent as possible. Quarterly reports of accidents and incidents with audits were provided to a local governance committee for further examination.

Staff were encouraged to attend some fund-raising events in the community and made people aware of the services available. They were keen to emphasise that services for end of life care were not limited to people living with a cancer but for adult patients with life-limiting illnesses or advanced progressive conditions. "Light up a Life" remembrance services, for example, these services enabled people to remember loved ones in a book of remembrance and the registered manager gave a reading as part of the celebration of the 'life of someone special'. St Margaret's had also chosen to be a member of the Fundraising Standards Board. This is the regulator of charities and works to ensure charities are accountable for their fundraising and to improve fundraising standards.

The service worked in partnership with other organisations to ensure they provided a high quality service. They worked in collaboration with Continuing Health Care (CHC) with four inpatient beds funded by CHC, local authority services, GPs, and hospital palliative care services for example. This enabled people who met the criteria for CHC funding to receive more long term care in the hospice if that was their preferred place of death. Specialist nurses visited care homes in the area to establish connections with the hospice services, to check that standards of end of life care were upheld, and to provide training and support when shortfalls were identified. Staff said there had been a rise in communication between the hospice and care homes and

we saw that care homes felt able to contact the CRC for advice at any time.

The Chief Executive provided inspirational leadership and empowered the leadership team to be forward thinking and looked at how other projects and external initiatives could benefit people receiving the service. For example, the hospice had launched the "Fit for Future" review. This was designed to help the hospice understand and address the needs of people living with end of life care across Somerset. The Fit for Future review involved a live website where people could share ideas and thoughts on how the hospice could improve, what they did well and be involved in shaping the future for those with a life limiting illness. The Fit for Future panel met monthly for a consultation period of 12 months until October 2016. Recommendations were then made to the Board of Trustees with new pilot projects being rolled out in 2017. Information was also being shared with staff and volunteers at information and engagement sessions. This showed the service was committed to involving the community and staff and that they valued people's opinions in a bid to continually improve.

There were regular Board of Trustees meetings every two months. These were organised and documents shared using iPads and a 'Board Pack' system. This was to facilitate decision making, communication and information sharing such as fortnightly chief executive reports. One of their roles was also to conduct a "Walk the Floor" visit. This was based on an NHS initiative. It enables a trustee and senior member of non clinical staff to have an opportunity to understand the challenges in the clinical setting. The hospice received feedback from the visits, for example the format was changed to become more meaningful and relate to CQC fundamental standards.

Satisfaction surveys and complaints were scrutinised to identify whether people's experience of the service could be improved. People received feedback within the newsletter and also on a board showing "You said, we said" notice board and how the hospice had responded to make improvements. All records relevant to the running of the service were well organised and reviewed regularly. All records were kept securely and confidentially. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	
Treatment of disease, disorder or injury	People who use services and others were not always protected against the risks associated with smoking materials and oxygen use.