

John Taylor Hospice Community Interest Company

John Taylor Hospice

Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 25 May 2016 and was unannounced. Further phone contact was made with people using the hospices community services on 1 June 2016.

John Taylor Hospice is an independent community interest (social enterprise) company providing palliative and end of life care, advice and clinical support for adults with life limiting illness and their families. The hospice delivers physical, emotional and care from a multidisciplinary team of nurses, doctors, counsellors and other professionals including therapists. The hospice has a 16 bedded in-patient unit that accepts admissions for terminal end of life and palliative care, symptom control and respite care. At the time of our inspection there were people receiving care and treatment in the inpatient unit. The day hospice service offered a range of care and treatment to people diagnosed with life limiting conditions. This included specialist clinical advice, courses, complimentary therapy sessions and clinics. The hospice community service supported people in their own homes via included the hospice at home team which supported on average eight people and the clinical nurse specialist team who supported up to 300 people. The hospice also provided patient transport services and a health symptoms management programme.

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

Staff followed the guidance provided within risk assessments when providing care and support for people in order to maintain their safety. Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. People were given their medicines in the right amounts at the right times by properly trained staff. Accident and incident reporting procedures were in place and all clinical incidents were investigated and the findings were shared with all levels of staff. Regular checks and audits of the safety of the environment were routinely undertaken. The provider had effective recruitment processes in place. Daily cleaning schedules were completed by housekeeping staff.

Staff received all the training that was required for them to work effectively and to support them to provide the best quality of care. The provider offered the same level of development opportunities to staff at all levels who worked at the hospice. A comprehensive induction programme for newly appointed staff was provided that included training, shadowing opportunities and a period of supernumerary practice. Staff were suitably supported in their roles and attended regular one to one meetings with their line manager. Staff were able to discuss when Deprivation of Liberty Safeguard applications should be made and provided us with specific examples of when this had been necessary. DNACPR decisions or 'do not attempt cardiopulmonary resuscitation' were clearly documented and they outlined who had been involved in the discussions. People were supported to receive a nutritious diet at the service. When people needed specialist healthcare support, this was easily accessible to people as the hospice employed a variety of

healthcare professionals such as occupational therapists, physiotherapists and a dietician.

People and relatives were very positive about the care provided by the hospice and spoke of the friendliness, approachability and empathy of staff. Staff were happy with the caring approach displayed and working practices adopted by the provider. People were well supported through times of discomfort, fear or distress. People were involved in making decisions about the care and support that they received and staff communicated well with them. People were supported to maintain relationships with people who were important to them. People had access to services which provided support and counselling with regards to their emotional, spiritual and religious needs. People were enabled to be as independent as possible and were treated with dignity and respect in all aspects of the support staff provided. Information people needed was made available to them in the format that suited them best was made available to people.

People received the care and treatment they needed when they needed it and which met their individual needs. People were supported to make advanced plans for their future care, including their preferred place of death. A wide range of therapies that were additional to medical and nursing care were available to support peoples' relaxation and general wellbeing. Staff were creative and proactive in ensuring that peoples' wishes were met. People had access to outdoor space and were supported through the services provided to socialise and get involved in activities. The provider offered pre and post bereavement counselling and advice about the practicalities of losing a loved one. Staff provided personalised care, spending time with people to discuss a management plan for their symptoms. The provider was keen to meet the local needs of people as well as the wider community, through identifying areas where gaps in provision or service existed and working with others to reduce these. People living with dementia were being supported to maintain their independence by being cared for in an environment that met their needs more effectively. The provider was keen to learn and develop the service it provided from complaints made.

The provider listened to peoples' concerns and acted on them to improve the experience for all its users. There was a comprehensive program of in-house regular audits such as the incidents and complaints and results were fed into committees and board meetings for consideration and scrutiny. There were effective governance systems in place which ensured that the service people received met their needs and was of good quality. Staff understood the management and leadership structure within the organisation and they were clear about their own roles and responsibilities. People and their families had positive experiences to share with us about the quality of care provided and the values of the service. Staff were fully supported, listened to and involved in the future development of the hospice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff knew how to recognise and respond to any actual or potential abuse.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs.

People were supported safely both at the hospice and in community.

Is the service effective?

Good ●

The service was effective.

People received the support and care they needed from a staff team who were trained to meet their needs.

Staff were appropriately supervised and supported to develop their knowledge and skills, follow nationally recognised practice for people's care.

Staff understood how to ensure people's rights and best interests when they provided care. Staff took appropriate action when people did not have capacity to make decisions about their care and treatment.

Is the service caring?

Good ●

The service was caring.

Staff showed kindness and knew how to show empathy when people faced challenging situations.

Staff communicated effectively with people and treated them with kindness, compassion and respect.

Staff protected people's dignity and privacy when providing care for them.

Is the service responsive?

Good ●

The service was responsive.

People were involved in developing their care plans which were individualised.

The service encouraged people to be involved in activities and complimentary therapies that were helpful and meaningful to them.

The provider was keen to meet the local needs of people as well as the wider community, through identifying areas where gaps in provision or service existed and working with others to reduce these.

Is the service well-led?

The service was well-led.

There was a positive, open and an inclusive management culture and people expressed confidence in the staff team.

The hospice had a thorough and comprehensive system of quality assurance.

Staff were supported, valued and included in decisions about how the service was run.

Good ●

John Taylor Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 25 May 2016 and was unannounced. Further phone contact was made with people using the hospices community services on 1 June 2016.

The inspection was carried out by one inspector, a member of the CQC medicines team, a specialist advisor and an expert by experience. The specialist advisor had the experience working as a nurse within the field of palliative care. An expert by experience is a person who has personal experience of caring for someone who has used this type of care service.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The registered manager had submitted the information as we requested.

We also reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We contacted commissioners from a number of local Clinical Commissioning Groups (CCG) who had commissioned the service to provide care to people from their own locality to ask for their views on the service. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We spoke with eight people who used the hospice services, five relatives and 21 staff members. This included a volunteer, a student nurse, the ward manager, an administrator, a locum consultant, a clinical medical specialist a chef, the registered manager, the day hospice manager, the director of corporate and

clinical services and the chief executive officer.

We reviewed three people's care records, to see how their care was planned and delivered. We spent time observing how staff interacted with people and their relatives. We also looked at other records related to people's care and how the service operated. This included five people's medicines records, two staff recruitment records, meeting minutes, quality assurance documents, clinical and environmental audits and records of complaints.

Is the service safe?

Our findings

People who used the services at the hospice inpatient unit and in the community were complimentary about the service they received, they told us they felt safe and well looked after. They said, "I feel safe because they (staff) all explain what they're doing", "I feel I am in a safe place, I get privacy but I know that they're (staff) keeping a close eye on me", "We had every possible help we wanted and couldn't have felt safer in their care, they were always at the end of the phone" and "They (staff) are always there for me; that makes me feel safe".

We found that the management team were committed to protecting people from any potential risk of abuse or harm. The ward manager had a good understanding of the provider's safeguarding procedures. They described an example of when a safeguarding concern raised and referral was made to the local authority and what the outcome of this had been. They further explained to us that, "Safeguarding training forms part of the mandatory training programme for all staff, its vital". Staff demonstrated to us that they were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. Staff understood the procedures they needed to follow if they suspected or witnessed the abuse of any person receiving care. This included reporting to relevant external authorities when required. One staff member told us, "Safeguarding is everyone's responsibility, all our patients are vulnerable; I am observant for any signs of abuse, like emotional abuse, drug misuse; I am always on the alert. There is a safeguarding folder that we can access too that's full of information to guide us through the process".

All staff including volunteers had received the relevant training to help and inform them to recognise any signs of abuse and take appropriate action when required. Staff told us that they were given feedback about safeguarding issues and updates either individually and/or in meetings. Staff told us, "We have training about safeguarding and we can get advice whenever we need it about any concerns we have" and "I made a safeguarding referral and I reassured the person involved and discussed what action I was going to take, I did get feedback about what happened". The service had safeguarding and whistle blowing policies and staff told us that were aware of these and they would be confident enough to inform senior staff of any concerns they had. The safeguarding policy had an easy to follow flow chart to direct and guide staff through the reporting process. This meant that people were appropriately protected people from the risk of harm and abuse.

We looked at the provider's arrangements for managing accidents and incidents and preventing the risk of reoccurrence. We found that effective accident and incident reporting procedures were in place and all clinical incidents, such as falls or skin damage were investigated and the findings were shared with all levels of staff, to aid their learning and improve practice. Staff we spoke with were familiar with the hospice reporting system known as 'Qpop' and told us that they received feedback in relation to incidents that occurred. Incidents that occurred were reported and any outcomes noted and discussed at a variety of management levels meetings. A commissioner told us that they had a good level of assurance that the provider operated the hospice service in a safe manner and consistently reported very low levels of incidents. This meant the provider fully investigated incidents and shared its findings and implemented any learning accordingly.

Regular checks of the safety of the environment were undertaken. There was a fire safety risk assessment in place with clear procedures in the event of an emergency evacuation and staff understood what the evacuation procedures were in the event of an emergency. Tests of the fire safety equipment were carried out regularly to make sure it was in good working order and fire exits were clearly sign posted. We saw that scheduled planned maintenance took place in a timely manner which included all services and equipment used on the hospice premises. Reports on progress of any actions in relation to the safety of the environment and equipment were shared at regular governance committees, to monitor that the appropriate levels of safety were in place.

The provider had effective recruitment processes in place. Staff recruitment records we reviewed contained at least two references including an employer reference and a Disclosure and Barring Service (DBS) check. A DBS check helps employers make safer recruiting decisions and minimises the risk of unsuitable people being employed. Staff we spoke with confirmed that they had been asked to provide satisfactory evidence that they were safe to provide peoples' care before commencing in their role. One of the records we reviewed did not contain any explanation of gaps in the staff member's employment history. We spoke to the registered manager about this and they agreed to take the required action to address this.

People had individual risk assessments in relation to the support they received which were regularly reviewed. We saw that some people in the inpatient unit were being some people were being closely monitored because there was an increased risk identified to their safety from on the day our inspection due to them being assessed as being high risk of falling. Staff were knowledgeable about potential risks from peoples' health conditions or the environment, for example, they were able to describe the equipment they had to use to safely support people to mobilise. We saw that daily skin inspections were undertaken to check for any damage from pressure areas and records were updated accordingly. One staff member told us, "We are always considering any risks and refer to the peoples' skin assessment information for what to do to protect people's skin". A student nurse told us how they were updated in relation to peoples' level of risk day to day, saying, "We have a daily bed meeting, everything is documented for us to refer to, including any changes to risks and all levels of staff communicate really well, amongst themselves and also with people". Our findings demonstrated that the provider was effective in assessing and reducing any risks that people may be exposed to.

People told us they were attended to quickly by staff and we saw that there were sufficient numbers of nursing and medical staff on duty. We saw staff were available to attend to peoples' needs in a timely manner. All of the people we spoke with had call bells within their reach and we did not observe call bells ringing for long periods. One person told us, "They (staff) come quick; my longest wait was about a minute". A relative of a person using the hospice at home service said, "My partner rang them [staff] and within 15 minutes they came round to see if I was ok and sorted things out for us". Staff told us, "We manage any leave and sickness within the team and cover for each other" and "Staffing levels are met and worked out according to peoples' changing needs; we phone round and get bank staff in if we need to". As part of the daily bed meetings staffing levels were reviewed with consideration given to peoples' level of dependency and complexity, and the service's capacity was assessed for accepting new admissions.

People told us, "The way they look after me in terms of medicines is fantastic, I can't fault it", "I wanted a stronger pain killer; it was sorted for me straight away. I have all the possible side effects of my medication explained to me" and "They have got my pain under control". Relatives' feedback included, "It's been brilliant. I get a call a couple of times a week and any problems are sorted out in a day" and "(Relatives name) had his medication all sorted and put in place". All the people we spoke with said they had fast access to pain relief medicines when they needed them. One person commented that as soon as they were admitted staff 'relieved my pain straight away', and went on to say, "I get my pain relief medicines as soon as

I ask".

We found that the availability of support for people in relation to their medicines within both inpatient and community services was effective. One person told us, "The pharmacist came to see us with the nurse and they got (relative's name) pain relief changed and it has made a real difference". The pharmacists employed by the hospice were available to visit people in their own homes prior to admission or after discharge. This meant that people were supported with their medicines and had access to the specialist information and care they needed even when they were not at the hospice.

A clear system for managing the ordering and supply of medicines including controlled drugs was in place. Medicines were checked when a person was admitted to the service by the pharmacy team to make sure they were accurate, current and suitable to use. Medicines that people brought in to the service were used in addition to medicines prescribed by the hospice doctors. These medicines were kept in people's rooms in a locked cabinet. Arrangements were in place to enable people to look after and self-administer their own medicines following an appropriate risk assessment.

On the prescription charts we reviewed there was clear recording of people's prescribed medicines, which also included additional instructions for their safe administration. Although there was a process to check medicines were within their expiry date and suitable for use, we found three medicines that had gone past the expiry date. These medicines were no longer safe to use and meant the checking process wasn't always followed. The pharmacist agreed to rectify this straight away, which helped mitigate the risk of harm to people from unsafe medicines.

Records showed that medicines incidents (errors) were reported and arrangements were in place to ensure they were investigated and an action plan was completed. This helped to ensure that lessons were learned and action taken to reduce the risk of any reoccurrence. The hospice had a framework for checking the competency of staff involved in medicine administration each year. A running programme of medicines training was delivered to staff, which meant they were aware of current and important information relating to the handling of medicines. This included regular competency checks.) A staff member told us, "My competency is regularly checked, we get observed giving out medicines as part of the medication audits, and we have a medication management book that you have to complete annually".

Medicines kept in stock were stored securely in locked cupboards in a locked treatment room; only authorised staff had access to the treatment room. Staff had quick access to emergency medicines. For example, in the event of a severe allergic reaction. The service used a local nhs (hospital or community) trust for the supply of all medicines that may be needed out of working hours. Clinical staff who were medicines prescribers could also obtain people's medicines from local community pharmacists out of working hours. The service employed their own team of pharmacists and pharmacy technicians to provide in house clinical support and advice for medicines management.

Daily cleaning schedules were completed by housekeeping staff, and we saw evidence of monthly audits of clinical and non-clinical areas of the building. People commented about the cleanliness of the environment, saying, "It's clean in and out" and "I think that it is nice and clean". One person went on to say that if there was a spillage the nurses would clean it up straight away. We observed that there were adequate personal protective equipment (PPE) and hand washing facilities available for staff. We observed that staff used PPE appropriately when required. However we noted one wheelchair labelled as having been cleaned had clear signs of physical matter contamination and also smelt offensive. We alerted the ward manager who apologised and immediately removed the chair from potential use. A commissioner we contacted told us that the organisation consistently scored very high on hand hygiene and infection control audits that they

undertook.

The provider had undertaken a patient led assessment of their care environment (PLACE) in April 2016, following recommendations set out by NHS England and the Department of health. PLACE is designed to help organisations judge how well they are meeting the care needs of the people using the service and identify where improvements can be made. The assessment covered a number of elements including cleanliness, condition, appearance and maintenance of the environment. The service had taken part in this each year since its introduction in 2013. The people who conducted the PLACE were independent community volunteers and were provided with training prior to undertaking the assessment. Analysed findings from the PLACE showed the provider was overall maintaining or improving on their performance year on year.

Is the service effective?

Our findings

People and relatives said that they thought that all the staff were well trained and delivered an excellent service. People told us, "I don't know that you can train people to do this job, they are so professional in what they do and special, they definitely do it from the heart" and "I can't fault them, they are all so positive and know what they are doing, they are very knowledgeable". The registered manager said, "We build on staff careers and help them to maintain their knowledge".

The staff told us that they received all the training that was required for them to work effectively and to provide the best possible quality of care to people. They told us, "We have regular meetings and information about developments around prescribing are discussed there; I do study days and keep up to date;" "We have plenty of opportunities to do additional training, they encourage learning here" and "The training facilitator regularly updates us about what training is available". The provider was also keen to share and inform others about the service by providing sessions for all healthcare professionals to attend to give them an overview of the hospice and the care they provide. A staff member told us, "I do study sessions for other professionals about the service, I let them know what the service involves". We saw that people were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and responsibilities for people's care. The registered manager told us, "We link in with the Macmillan nurses and this enables us to access a variety of training and training grants through this established relationship".

The provider offered the same level of relevant development opportunities to staff at all levels who worked at the hospice. They actively encouraged nursing or clinical staff to develop and take on specialist roles such as non-medical prescribing (NMP) qualifications (a healthcare professional who is trained to prescribe medicines who is not a doctor) or to develop their specialist knowledge, for example in neurological and respiratory conditions. A nurse prescriber told us, "The NMP role makes our service seamless; I can prescribe and people get the medicines they need sooner, this has enhanced my role and the managers are very supportive in that way".

There was a comprehensive induction programme for newly appointed staff that included relevant training, shadowing opportunities to shadow more experienced staff and a period of supernumerary supported practice. This included time spent in various hospice departments and care settings. Staff told us, "I shadowed other staff for two weeks and got a chance to see what other departments did; I completed a specialist palliative care course during my induction", "I spent a day with all the different staff in all departments to see how they are involved in what we do; I would have a catch up every day with my mentor" and "I felt well equipped to start my job, I have always felt supported from day one". This meant that the provider was focussed upon providing people with timely care that met their individual needs from staff who had received condition specific training, alongside their palliative care training.

Staff were suitably supported in their roles and attended regular one to one meetings with their line manager. Staff were also encouraged to acquire clinical supervision to support their professional development. Staff said, "I get supervision whenever I need it, and one to one sessions", "I get one to one

support from my line manager regularly" and "I have clinical supervision every six weeks, the support I get from staff and managers is invaluable". We saw that a journal club was available for staff to attend each month; this allowed staff to discuss and review new guidance or articles which were sent out to them before each meeting.

The provider was using a locum consultant at the time of our inspection. We found that the medical staff were very experienced and knowledgeable but the provider was keen to have a permanent consultant in post and 24 hour consultant level cover available for the hospice, and was in the process of advertising the post. An on-call medical service was provided by local GPs with extensive palliative care experience and the hospice specialist medical staff. The medical specialists had access to medical consultant support provided by a local (acute/community) hospital at weekly community multi-disciplinary meetings in addition to their consultant level support provided by the locum consultant. This demonstrated that the provider was keen to ensure staff at all levels were appropriately supported in order to do their job effectively.

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 or authorisations to deprive a person of their liberty were being met. We found that people were supported by staff who understood and followed the MCA. A relative told us, "They (staff) talked (relative) through everything, always giving them options and choices". We observed that people's consent was obtained and recorded before any aspect of their care and treatment was carried out.

Staff were able to explain when Deprivation of Liberty Safeguard applications should be made and provided us with specific examples of when this had occurred at the service. Staff said, "People can become disorientated, so you need to check their level of capacity to make decisions and ensure that they are not deprived of their rights in any way", "We are mindful that peoples' capacity can fluctuate" and "If it's deemed someone doesn't have capacity and they wanted to go home, we would complete a DoLS application, in order to act lawfully in their best interests". Records showed that people's mental capacity to make decisions about their care and treatment was regularly considered and reviewed. This helped to take account of any fluctuations in people's mental capacity relating to their health condition. At the time of our inspection no one was subject to a DoLS authorisation. Staff received training in MCA and DoLS and a DoLS advisor from the local clinical commissioning group (CCG) had attended staff meetings to provide additional training and advice.

People told us, "With support I have made a decision about resuscitation, I drive the future for me" and "I have had conversations about my future and I have decided I want to die at the hospice, also any other interventions such as resuscitation have been discussed with me and my partner". Documentation relating to 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions were recorded on a 'medical alerts' form in people's clinical notes. They demonstrated that discussions had been held with the person and their family where appropriate. The rationale for DNACPR decisions, were clearly documented and they outlined who had been involved in the discussions. A staff member told us, "It's important to document everything around peoples' choices".

People told us they enjoyed the food provided to them at the hospice. One person told us he was happy that the food met his requirements saying, "I am quite fussy." He told us that if he didn't want something from the menu the staff would cook him something else. Other peoples' comments included, "I get unlimited drinks all day, I have to drink a lot of fluids, (staff) make sure I do drink; drinks are made for everyone's individual needs", "You get the right amount of food, good portions, there's a menu to choose from but if you fancy something else they do it", "The chef comes round himself and will suggest alternatives to you that you could have from the menu or ask what you fancy" and "I take a diabetic diet and they make special puddings for me, it's all tailor made to every single person". Another person told us that he was given portions he felt he could manage, which he said was key to him maintaining his appetite.

People had freely available access drinks. We saw plenty of fresh drinks within easy physical reach of people in vessels suitable for the individuals needs. A person said, "I'm never without a cup of tea and I always have fresh iced water". Kitchen staff we spoke with us in detail about people's individual dietary requirements. One staff member told us how the hospice met peoples' diverse dietary preferences and cultural needs and said "We can meet most dietary needs on site". The chef told us that in addition to the nutritional assessment that they and staff do when people were admitted; they would also go and speak with people individually to ask their likes, dislikes and preferred portion size. We saw that records were kept in the kitchen area, which showed people's dietary requirements. This included dietary allergies and special diets for all staff to refer to when preparing food and drinks. Staff demonstrated they knew those people who needed additional support and monitoring to ensure their nutritional needs were met. Staff told us, "As part of peoples initial assessment an assessment of their nutritional needs is completed, we refer to the dietician if any concerns arise and review for any changes regularly" and "A member of staff goes around with the chef to each person daily, to make sure the person gets the food they need and want, dependent on how they are feeling".

Nutritional assessments and documentation in relation to peoples' food and fluid intake were completed properly. The provider employed their own dietician meaning that clinical dietetic expertise was readily available for people. The dietician provided onsite specialist input for the care of people who received their nutrition via a tube into their stomach or those with health conditions that make eating and drinking difficult. We observed the lunchtime meal and saw that food served on the day looked appetising; we saw that where people required assistance with eating, staff spent sufficient time to ensure they ate enough food. This meant that people were supported to take a nutritional diet and remain hydrated in a way that best suited their needs and choices.

When people needed specialist healthcare support, this was easily accessible to them as the hospice employed a variety of healthcare professionals such as occupational therapists, physiotherapists and a dietician. People and their families could access advice and support via a helpline seven days a week operated by the provider. Information booklets about specific health related conditions were given to people to help them understand their health needs and how to manage them. Staff were able to describe their continuous liaison and working relationships with a wide range of care and support services both internally and externally to meet people's needs. During our visit we listened to one of the multidisciplinary staff meetings that were held weekly and saw that staff discussed which health professionals may be best placed to provide people's care and treatment. This included referrals to the appropriate external healthcare support services when required. Records we reviewed reflected showed that staff were responsive to the immediate and more specialist health needs of people.

Is the service caring?

Our findings

People and relatives were very positive about the care provided by staff at the hospice and spoke of their friendliness, approachability and empathy. People told us, "Staff make me feel welcome, and that they really care; they listen to me and are good natured people; I haven't met one bad one", "They (staff) keep you in a positive frame of mind if you are upset or scared, they (staff) have so much positivity" and "They (staff) have been a huge emotional support for me". Relatives said, "They (staff) are absolutely brilliant; I am being referred to the hospice well-being team for support too;" "I call them the angels who walk the earth; a beautiful set of human beings", "They (staff) are kind to me not just (relative's name)" and "They (staff) are nice and easy to talk to". A commissioner told us they had a good level of assurance that the organisation was caring and went on to say, "We have undertaken several visits and spoken to people and their families, and the feedback has been very positive".

People described positive relationships with staff. People and their relatives told us, "(Staff member's name) is beautiful inside and out, she is an integral part of my support system, I couldn't do it without her", "The support is great from the doctors and nurses, they are all great, we treat them like family, they are always welcome" "They have definitely improved my mental and physical health and increased my longevity" and "(Relatives name) was a very proud man; they (staff) were great with him, he got to know them and became comfortable with them. I would hear him singing to them (staff), he was happy right to the very end". Staff told us they were happy with the caring approach and working practices promoted by the provider. Staff said, "We get time to care for people properly", "I have never worked anywhere where people care so much", "I have never witnessed such dedication, it's a nice place to work" and "I enjoy coming to work; there are always resources available to help me to support people properly, its exceptional here".

People received the care and support they needed through times of fear or distress. A relative described how staff supported their loved one when they were fearful, they said, "They (staff) would use reflective listening and say things to (relative) like 'what is it that we can do to help you?'. They went on to say that they felt staff always showed care and interest in her relative's welfare by asking her how she was feeling as well as caring for her. We saw that a number of support groups were provided to help people develop their own coping strategies for their experience of living with a life limiting illness. For example, help with anxiety and chronic pain. This helped to improve people's emotional well-being. Staff said, "If people are worried or anxious we approach them and ask if they want to have a chat, provide them with reassurance and comforting words". When a person using the hospice dies, a ceremony is held for those wishing to pay their respects or to remember them. This involved people, relatives and staff placing a heart shaped pebble in a pool located in a spiritual space at the service, whilst being invited to reflect on the person who has passed away. Those who have died were also remembered by having their name added to a calligraphic memorial book kept in reception. After someone passes away relatives were invited to view the book, there was total flexibility about viewing this. In addition there were more formal larger gatherings throughout the year for family members to remember loved ones.

People and their families had access to services which provided support and counselling with regards to their emotional, spiritual and religious needs, which included bereavement support before, during and after

death. People told us that they were able to access the spiritual and religious support they needed and their preferences were respected by staff. People said, "They (staff) respected our beliefs in our religion", "If you want communion, you can access this" and "I was asked about all my spiritual support needs and staff suggested ways they could support me to access these whilst at the hospice, which has been very helpful". There was a spiritual and family support team available to offer support to people if they wanted this. This aimed to support the multi-faith and spiritual needs of people and their relatives. There was a multi-faith room available for people of all beliefs or for those seeking quiet reflection. Staff told us, "We can respond to different religious needs as we have access to various religious leaders; but first we ask people if they would prefer to have their own and if they want us to contact them", "The spiritual lead here helps us to access specific cultural or religious support for people" and "We address any cultural needs that the patient or relative has informed us of". We saw that the provider had designed a very clearly written publication which was given to families after the death of their loved one called 'what do I do now?'

People and their family members or friends had access to in-house counselling by staff and volunteers. Staff could also use this service. The provider also offered pre-bereavement and post bereavement counselling and advice with the practicalities of losing a loved one. This could be accessed at the hospice but also at home or in a neutral space such as a GP surgery.

People were supported to maintain relationships with people who were important to them. People told us that their friends and relatives visited regularly and were welcomed to the hospice. There were no restrictions on times or lengths of visits. People told us, "You can have family with you whenever you want; they (staff) are always respectful to family and everyone else who visits" and "I was scared about going in for respite, but my partner was able to stay overnight on my first night and it helped me to settle, it made such a difference to me". A person told us how staff had accommodated eight of their family members over one weekend so they could spend time with them. Facilities were provided for people's families visitors to stay overnight either within the person's room or nearby in a private room.

People said they were involved in making decisions about their care and support and that staff communicated well with them. People said, "I like things to be said, no nonsense, (staff member's name) gives me that", "I am being supported to make future decisions; (staff member's name) is not in your face and goes at my pace, definitely", "They (staff) have explained to me what's happening, I am fully involved in all decisions; if I have any questions they always know the answer" and "They provide us with all the advice and information we need about the future, I was told everything and if I had any questions, they could always answer them".

Staff told us, "I show people empathy and compassion, whilst being open and honest, allowing people to speak and be listened to; offering the information people need at their own pace" and "Some people are open to talk about end of life decisions and care straight away, others are not; we can revisit it when they are ready, go at their pace and with sensitivity". Records detailed discussions that had taken place with people and/or their relatives about the plans for people's care that were agreed with them.

People told us and we observed staff respected their privacy and dignity. A person told us, "There are no rules, you can do what you want, and they (staff) respect your routines". A relative said, "They (staff) would use a screen to preserve (relatives) dignity. I would hear them (staff) reassuring him, he said they took away any embarrassment he might feel". We saw staff knocked on bedroom doors before entering people's rooms and they closed curtains and door there if they were providing intimate personal caring to people. Staff demonstrated they knew how to provide care with respect and how to maintain people's dignity. For example, when one person was visited by a member of the medical staff they used signage on door to help ensure privacy while they discussed the person's care and treatment with them and indicate that the room

was in use, so that the person was not disturbed. Staff said, "I did a first visit to someone today; they are quite poorly so I spoke softly but clearly to the person, introduced myself and talked them through how I planned to help them; I check in all the time and give constant reassurance whilst seeking permission to make sure the person feels okay when I deliver the care they need" and "I like to be very attentive and respectful of peoples' needs, what they want and like, and spending time with them and making sure I respond to their needs as soon as possible". People told us that staff helped them to do as much as they could for themselves.

People had access to independent advice and support and were referred on to external organisations when necessary. Leaflets and information was made available to people and was provided in whichever format best suited their needs. One person said, "I have been given leaflets and information which have been very helpful". The information leaflets provided covered a range of topics, which included practical support with finances, along with information about how to access advocacy services, and information of other organisations that provided support. At the time of the inspection there was no one who required an advocate; however staff were able to explain how they would respond should a person require one.

Is the service responsive?

Our findings

People received the care and treatment they needed when they needed it. People told us they felt staff listened to them and followed their agreed treatment and care plans. They said that staff valued their opinions and responded to their views about their care and they were encouraged to express their views freely. People said, "We had an issue and got in touch with (staff members name) and they told us what to do, they (staff) are there when you need them; they have got your back", "They sit there in the background, ready when you need them; they really are excellent people you can't fault them", "The doctors talk to you properly, they know you well, the support they give is instinctive" and "Any concerns they get the right person for you; I had an issue at home and they got the occupational therapist to come out and see me".

Relatives confirmed the responsiveness of the service, telling us, "They (staff) have been there every step of the way; if I mention anything they have supported me and (relative) with it;", "The support is really good, if I need anything I can call the hospice; there is always someone there to speak to, always someone at hand for us" and "They came to see us and asked what we wanted, me and (relatives name) wanted him to be able to die at home; they organised everything you can imagine, bed, chairs etc". Staff said, "We arrange equipment that can make a difference to people in their own homes and help them to make advance care plans" and "The care here is person focused and peoples' every request is met".

People told us they were supported to make advanced plans for their future care if they had wished to do so. One person said, "I was able to plan out exactly what I wanted and what I know will be best for my family and me". Staff demonstrated knowledge and understanding about these important but sensitive discussions. We were told that they liked to discuss and record where possible the persons preferred place of care and/or place of death.

We were told by people and staff of many instances that demonstrated the personalised focus of the care being provided. A wide range of complementary therapies were available to help and support people's relaxation and general wellbeing. For example, aromatherapy and body massage. All of the people we spoke with had been offered complementary therapies and access to social and occupational activities in the day hospice. People said, "I have had complementary therapies, including Indian head massage, it all makes you feel so much better, it lifts you both mentally and physically" and "I had respite care at the hospice, I managed to have a bath with support for the first time in years, I had bubbles, pretty lights and was able to have a glass of wine if I fancied it". Another example we were told about was that the cost of a honeymoon had been funded by the charity attached to the hospice for two people who were married there. Other marriage/commitment ceremonies had been conducted at people's bedside by the spiritual co-ordinator at peoples' request.

We heard wonderful stories of people being supported to enjoy sensory experiences when they were close to death. For example, staff enabled one person to hear evensong they passed away, which was their dying wish. Staff said that several patients had 'died under the stars' as was their wish in the comfort of their own bed. The hospice gardener told us they had worked hard to make plants visible from peoples' bedrooms. The doors to garden facing rooms could be opened to allow people to view the garden whilst bed-bound

and there was also an outdoor lift to allow people with restricted mobility to access the multi levels of the garden. A person told us, "The garden is beautiful there, which I really appreciate as I can't get into my garden at home". A staff member said, "We make sure we do the little things for people, like taking them out into the garden if they enjoy that and facilitating getting their pets to spend time with people". We saw that one person had been able to surround themselves with items that were familiar and comforting to them such as photographs and posters on their wall and they were burning their own aromatherapy incense in their room. People also told us they had good access to Wi-Fi.

People who received care at the day hospice spoke of the positive effects had upon their well-being and how it had reduced their feelings of isolation. They told us this was a good opportunity for them to socialise with other people with similar conditions. They said, "We are able to chat and lift each other, even if people can't speak to each other, we are all involved in some way", "The staff put on special events to help raise money, we all get involved, making craft items to sell, no matter what our physical or mental limitations" and "I have the most amazing friends there; the hospice has given me my life back and helped me live in the moment".

Staff used a variety of methods to help them understand people who were not able to communicate directly with them because of their health conditions. For example, such as white boards and electronic tablets to help people to understand. People told us that staff spent the time with people to understand how they communicated, for example through eye movements. Staff told us about the interpreting service they used and how they accessed this support. The spiritual co-ordinator had made extensive inter-faith links with both male and female representatives so that patients could access spiritual support of their choice in a timely manner. The spiritual space contained artefacts and literature relating to different faiths. We found it to be a quiet and calming environment. A family liaison person who was a social worker was able to provide practical support to people, for example benefits advice.

Initial assessments had been undertaken to identify people's support needs and care plans had been developed outlining how these needs were to be met. There was a strong emphasis for people to receive care that was personalised and meaningful to them, which had a positive effect on people. We observed the staff provided people's care in this way. For example, staff spent time with people to discuss a management plan for their symptoms; including their emotional and spiritual needs and identifying their preferences and choices. People's care plans included strategies with regard to their pain and symptom management which were updated on a continual basis. The updates included changes in people's health and how to respond when people experienced changes in their symptoms or pain levels. Staff were aware of the contents of people's care plans and were mindful of people's likes, dislikes and preferences.

Meetings involving staff from all disciplines employed at the service were regularly held to discuss people and their changing needs and decide who was best placed to provide the care and support they needed. We observed a meeting and observed good interaction, communication and discussion between the team. Discussions about people's well-being in the meeting included physical, psychological, social and spiritual aspects of care. Other areas discussed included symptom management and how best the person and their relatives could be supported. The discussions were recorded in the individuals' clinical notes, for example the recording of the on-going need for one-to-one nursing for one person due to their risk of falling. A commissioner we contacted said that they found that staff were able to anticipate rapidly changing needs and were reactive in a crisis. People told us that all their care was planned with their involvement and they received updates following any meetings that took place about their welfare if they were not involved.

The service had links with all the local hospitals and meetings were held with each known as 'super specialist meetings' and were attended by a variety of allied health care professionals and the clinical nurse

specialists from the hospice. These meetings allowed discussions and planning to take place in relation to people who were due for discharge from the hospital. A dedicated triage nurse was available, nine to five, seven days per week for all incoming calls and queries from people, relatives and professionals.

The provider was responsive to the health needs of its service users and the local population. We saw that the pharmacy technician had worked with a pharmacist from another hospice after they identified the out of hours palliative care medicines were not easily available in the community. They completed an audit and found that many community pharmacies did not keep the medicines people may need at the end of life. They worked together to put in place a scheme so that the community pharmacies kept the medicines in stock and that there was also an on call pharmacist available for health care professionals to access out of working hours. This resulted in 20 pharmacies across the local region keeping these medicines in stock. This collaborative project involved NHS England and local health care commissioners and also helped to ensure the medicines were available in more community pharmacies across the midlands and black country region. This meant that people living in the community with palliative and end of life care needs would receive the medicines they needed at the time they needed them outside of normal working hours, even if they were not using the hospice services.

The provider identified that they were increasingly providing care to people associated with their end of life and palliative care needs who also experienced enduring mental health problems. For example, anxiety, schizophrenia or bipolar disorder. Staff had established links with relevant organisations to help them understand and support people's mental health when they received care from the hospice service and to ensure best practice in relation to mental health. For example, they liaised with the local community mental health teams so they could understand how better to support people. A number of support groups were also operated at the hospice to teach people coping strategies for anxiety or chronic pain. This helped to improve people's emotional well-being in a way that was meaningful to them.

We were able to observe a fatigue, anxiety and breathlessness programme (FAB). The provider recognised that these were often common and distressing health symptoms associated with people's life limiting illnesses, which they needed support to manage and overcome. Each course ran for nine weeks in small groups and aimed to teach people techniques to minimise the impact of their symptoms upon their physical and mental well-being. People told us that the advantage of the group was being able to share experiences with other people there, with similar issues. This meant that people were enabled to live as well as possible and gain control of their symptoms.

In 2015 dementia was included in an independent patient led assessment of the care environment (PLACE). PLACE is a tool designed to help organisations identify how well they are meeting the needs of the people using the service and where improvements need to be made. A number of improvements were made as a result of this. New pictorial signage had been added within the hospice inpatient unit and rooms had been redecorated to be more dementia friendly, for example the use of colour to aid people's orientation and recognition. Further plans to complete more rooms to the same standard were in place, which community volunteers had been recruited to complete and funds had been raised for. This meant that people living with dementia were being supported to maintain their independence by being cared for in an environment that met their needs more effectively.

People, relatives and staff were encouraged to comment on the way care was being provided. People were aware of how to make a complaint and who to raise their concerns with. They said that they felt their concerns would be taken seriously and acted upon. Information was openly displayed for people to refer to about how to raise a concern or make a complaint. One person told us that when they raised a concern about not being able to sleep, they were listened and immediately offered a bed in a quieter area of the unit.

They told us they knew what the complaints procedure entailed and said that staff had also explained this to them verbally on their admission. A commissioner we contacted said that the provider consistently reported very low levels of complaints, and their patient experience survey results were consistently reporting high levels of satisfaction. The provider gave people a range of opportunities to raise any issues anonymously if they chose. For example, through their website, through social media or in writing on comment cards available in the reception area.

The provider was keen to learn and improve their service from any complaints made. For example, we saw that a complaint had led to changes in how the food service operated, by a revised system each day of a member of the care team accompanying the chef around on their meal order round. This was to provide the chef with added awareness of peoples nutritional requirements. The registered manager told us that complaints were acknowledged within five working days and that a written report with the outcome of their investigation was shared within 20 days. Record showed that complaints were fully investigated, any immediate action taken clearly outlined and learning was demonstrated. All complaints were discussed and their progress or outcomes shared at governance meetings. This demonstrated that the provider fully investigated complaints and used them to improve the quality of the service it provided.

Is the service well-led?

Our findings

People and their families were all very positive about the quality of care provided and the values of the service. People said, "The care is second to none, they treat you as a person not an illness", "The hospice don't get enough credit for what they do", "An amazing support, words can't describe" and "It has all been so helpful and has taken a lot of the stress off me". Relatives were complimentary about the support they had received, saying, "They are excellent, I don't know what I would have done without them" and "Out of ten, it's a fifteen; they were marvellous from beginning to end, I couldn't have got through it without them".

During the inspection it was clear to us that staff and volunteers worked closely together and had shared values about the hospices care philosophy. People who used the service and staff described the volunteers as very caring and very important to the success of the hospice. A commissioner we contacted said that the 'hospice provided an excellent day hospice and in-patient service'. Staff talked to us with passion about their role and the people in their care, they were happy in their work and clearly took pride in working in the service. A staff member said, "I am proud of being part of a team".

The registered manager consistently notified the Care Quality Commission of any significant events that affected people or the service. We requested information from the provider about their service in the form of a Provider Information Return (PIR); this was fully completed and returned to us within the given timeframe.

The staff we spoke with said they had good support from both their peers and management. They felt they could speak openly and a staff member said, "We receive and give criticism and then let it go". In response to exploring perceptions of the organisations leadership, vision and values staff told us, "I'm proud of the unit but we can always improve", "I'm proud of the team", "I do feel communication top to bottom is open and transparent" and "They (management) are fair and supportive". A health commissioner we contacted described the provider's working relationship with them as 'very good and very positive, and we have confidence that they are open and transparent with us'.

A new Chief Executive Officer (CEO) had recently taken up post. Healthcare commissioners we contacted were positive about the CEO's appointment to the service and said from their introductory meeting with them the CEO had demonstrated a great passion for the role, showed a strong emphasis on leadership and strategic direction and was very patient centred in their discussions with them. Staff we spoke with were aware of the new CEO and most had had the opportunity to meet them. A staff member said, "The CEO made them self known to us straight away".

Staff understood the service's organisational management? structure and were clear about their own roles and responsibilities. They said, "I know the structure of the management here; you are able to get to know people and their role", "We have in house communication, this highlights the organisational structure, this keeps us up to date with any changes" and "There are clear lines of management here, there are managers on call and there is always someone here to talk to". All of the staff we spoke with said they felt very happy in their roles and well supported emotionally and professionally. A staff member said, "My manager is very approachable and very helpful". A health care commissioner we contacted said they had a good level of

assurance that the organisation is well-led.

Staff and volunteers told us they could speak openly and influence service change, regardless of their role. Staff told us they felt informed and were consulted about plans for development of the service. A staff member said, "We are involved in the development of the service, we get feedback from our clinical governance lead about any ideas that come through so we I do feel part of it". The provider used a number of mechanisms to ensure staff and volunteers were kept up to date and able to give their comments and opinions about the hospice future. This included updates through emails, a regular department meetings, newsletters and surveys to seek their views about the service.

The provider surveyed the staff each year, analysed the results and shared the findings from this. As a result of feedback received from the surveys improvements were made to help staff meet or understand the roles of their colleagues working in other departments. 'Mix and Mingle' sessions were organised and held each month with representatives from each department who attended an informal lunch together. This gave them an opportunity to chat, develop working relationships and meet new and existing members of staff. A staff member said, "Mix and Mingle sessions were developed so staff can get to know other staff from the different departments and get to know their role; feedback from the staff survey bought about these sessions." Another staff member said, "I wasn't there for the staff survey feedback sessions but we were emailed the slides they presented so we could see what the findings were; one of the findings was that the management are looking into why there was such a poor response to the survey". This meant the provider valued its workforce and was keen to address any areas identified that needed review or improvement for their staff.

Feedback from people could be left on the hospices social media pages, along with questionnaires that were sent out to people. The provider had received negative feedback from people which related to student nurses being brought along on community visits who were unfamiliar to them. The provider took action and ceased this practice, with support from their district nurse colleagues. However as this left a gap in student nurses experience and learning from the hospice, a training package was created, which prepared students for what they may experience and to give them an overview of the services the hospice provided. This was initially just for student nurses, but due to interest and demand from other healthcare professionals the training was introduced to a range of other external staff. This meant that the provider listened to peoples' concerns and acted on them to improve the experience for all its users.

There was an effective system in place to regularly check and monitor the quality and safety of the service. There was a comprehensive program of in-house regular audits such as medicines, infection control, environment, incidents and complaints. The findings from this fed into the service's quality and safety committees and board meetings for their consideration and scrutiny. For example, the recording system for incidents demonstrated that all the relevant information was considered and analysed without delay. A health care commissioner we contacted described the provider as 'professional in their approach and amenable to changing and reviewing processes where necessary; to ensure a safe and effective service was provided to people'. A staff member said, "If we do badly on an audit, we are asked how we can improve our performance". We saw that comprehensive reports were compiled and shared on all aspects of service provision at senior management meetings. The agendas for those meetings included reviewing any ongoing actions plans to check on progress made and longer term service developments programmes which were discussed and updated. This meant there were effective governance systems in place which ensured that the service people received met their needs and was of good quality.