

St. Nicholas Hospice (Suffolk)

St Nicholas Hospice

Inspection report

Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QY

Tel: 01284766133
Website: www.stnicholashospice.org.uk

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

This unannounced inspection took place on 19 and 20 April 2016. At previous inspection the hospice had been compliant with regulation and offered a quality service.

St Nicholas Hospice provides day, community and inpatient care and support to people of West Suffolk and into Norfolk. The Sylvan ward in Bury St Edmunds provides palliative and also respite care for up to 12 people. The Orchard Centre in Bury St Edmunds and the Burton centre in Haverhill provide support, care and activities for day patients and their families. The Community Hospice Team provides care, support and advice to patients in their own homes. St Nicholas Hospice also runs a Hospice Neighbours scheme - trained volunteers offer people companionship and practical support. Approximately 500 people were being supported in the community and 150 through the day centres.

There was a registered manager in place and they participated fully in the inspection process. 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.

St Nicholas Hospice is an outstanding service. It is truly focussed on the individual needs of people that they support, giving people support at the time they need it in a way and place that best suits them and their family. People spoke overwhelmingly of the positive support, guidance and healthcare interventions they had received. People were full of praise of the staff in terms of their kindness, compassion and knowledge about end of life matters. People viewed the healthcare clinicians as expert in their knowledge.

People spoke of a service that was tailor-made for them and their families saying that staff truly went the extra mile to offer understanding, empathy and choices that were based upon information and keeping people informed and involved. Informed consent was embodied into all work that was undertaken at the hospice. The various departments within this hospice worked well together so that people had a seamless experience of moving from one department to another as the need arose.

Staff were motivated and keen to convey to inspectors their pride in the service they worked at. Staff were involved, listened to and empowered with training and support to offer excellent end of life healthcare and support.

Management were inclusive and promoted a culture of excellence. They listened to people and involved them in the running and development of the service. They actively sought out people's views and used criticism as an opportunity to improve and develop the service. There was a kindness and warmth about the management team that made them approachable to everyone and people knew them by their first names and told us they were visible, approachable and solved matters raised. Governance of the service was of a high standard that was benchmarked against similar services and communication was very good. The board

of governors and others who needed oversight were appropriately informed of how the hospice operated. The measures of quality in place showed that people were right to have the confidence in this local 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.

People felt safe and trusted using this service. Staff had been trained to recognise and respond to any actual or potential abuse. The service had developed systems for reporting and monitoring.

Potential risks to people were assessed and measures put in place to reduce risks. Accidents and incidents were analysed and learning was shared amongst staff to prevent reoccurrence.

There were the right numbers of staff with the appropriate skills and knowledge to meet people's needs at all times. Staff were able to support at the pace that people wanted and wished for.

Complex medicines were well managed. People received their medicines from staff who were trained and qualified in safe administration of medicines to ensure people received their medicines in time and safely.

Is the service effective?

Good ●

The service was very effective.

People received support and care from a staff team who were specifically trained to meet their needs. Training was well managed by a dedicated team within the service. Staff were keen to develop and share their knowledge and skills.

Staff understood and followed the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were genuinely informed and involved in making decisions about all aspects of their treatment and care.

People were supported to eat and drink and maintain a balanced diet. People were able to choose from a varied menu of fresh and appetising food. People with a reduced appetite were appropriately supported.

People had consistently good access to the healthcare support they needed. Health clinicians worked well together to ensure

the best outcomes for people.

Is the service caring?

Outstanding ☆

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

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

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

People were consulted about and fully involved in their care and treatment. The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

Is the service responsive?

Good ●

The service was responsive.

People and their families were fully involved in assessing and reviewing their needs and planning how their care should be provided, which included their wishes and priorities regarding their end of life care and preferred place of death.

The service provided person-centred care based on best practice and focussed on continuous improvement. Staff understood and anticipated people's needs which enhanced the quality of the care people received.

The hospice had innovative and positive approaches to seeking and responding to complaints and concerns to improve the quality of the service and this was closely monitored by the management team.

Is the service well-led?

Outstanding ☆

The service was very well-led.

St Nicholas Hospice had a track record of excellence and place in community. The service promoted a positive and open culture and provided a range of opportunities for people who used the

service, their relatives and people from the wider community to comment and influence the running of the hospice. The management team were highly visible and approachable for everyone.

The hospice listened to all people involved about their experiences of different aspects of the service to drive the quality of the service on offer. Staff at the hospice were aware of the same shared values and demonstrated these consistently.

The service worked in partnership with other organisations to ensure they followed best practice and provided a high quality service. They participated in national and local research and had developed 'champion' roles within the staff group to drive improvements.

St Nicholas 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 19 and 20 April 2016 and was unannounced.

The membership of the inspection team consisted of an inspector, a pharmacist, a specialist adviser 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. Our specialist adviser currently worked in services provided to people affected by life limiting illness.

Information was gathered and reviewed before the inspection. This included notifications of significant events that affect the health and safety of people who used the service.

We spoke with 19 people who used the inpatient service and hospice at home service, 12 relatives/visitors, five volunteers, over 15 staff members and this included nurses, physiotherapist and health care assistants. In addition we talked to a pharmacist, a consultant, the chief executive and also the registered manager for St Nicolas Hospice.

We reviewed people's care plans to see how their support was planned and delivered. We looked at a selection of medication records to check medicines were managed safely. We looked at a range of policies and procedures, quality assurance and clinical audits and meeting minutes for different departments.

Is the service safe?

Our findings

People and relatives spoken with said that they thought that people were safely cared for at the hospice. One relative said, "The staff fill us with confidence. They are so attentive. [Named relative] is definitely safe with them". One person told us that they trusted the staff. "I felt safe in their hands. They made me feel comfortable".

Staff had a comprehensive awareness and understanding of their responsibilities for protecting people against the risk of avoidable harm and abuse. Staff told us and we saw that they had safeguarding and child protection training and regular updates to ensure they were knowledgeable in safeguarding vulnerable people from abuse. They described how they would refer people to the appropriate organisation if they had concerns to ensure people were protected from potential abuse. Staff were aware of policies around safeguarding and expressed confidence in these. Staff felt able to approach their line manager or more senior staff if they had any issues or concerns. One person [a trained social worker] within the hospice had taken a lead in safeguarding vulnerable people from abuse and child protections matters. We found a culture of openness within the hospice. Staff told us about how they could raise matters of concern that may implicate other staff, but this would be used to learn from the mistake and develop people and not be used to blame and condemn. The transparent and objective way of dealing with matters was favoured by staff.

People had risk assessments which were individualised to them. There was evidence of capacity being assessed and people's choice being supported whilst maintaining safety. People told us that they were involved in determining their care and support and this included managing risks. We found that falls risk assessments were detailed and specific to the individual. They were dynamic in nature because they were so individualised and not based upon a predetermined template risk assessment. Falls prevention had been a clear focus of the hospice and a specific role to focus on this had been developed entitled Falls Prevention Link Practitioner. We spoke with this person and found them to be knowledgeable, enthusiastic and that they used other external resources such as the local hospital and national hospice resources to ensure they had access to the best possible up to date thinking and training. Everyone who used the inpatient service had a falls risk assessment completed within 24 hours. If there was a fall then this was monitored and a post fall assessment completed to ensure the person was safe. We discussed one particular person who had complex needs and therefore had a review of their risk assessment every 24 hours to ensure they were as safe as they could be, whilst maintaining their independence and self-determination. This level of monitoring and review ensured the person was as safe as they could be and did not suffer any ill effects brought on by an untimely fall whilst in the care of the hospice. This focus on a falls prevention strategy had led to a reduction in injury from falls.

Staff were also observed assisting people to mobilise from chairs to wheel chairs by means which were both safe and observant of the person's dignity. There was evidence within people's electronic records that people were regularly assessed for any risks relating to their care. This included using assessment tools relating to moving and handling, nutrition and hydration, falls and skin integrity. There was a clear impact that measures in place were working. The registered manager is required to notify us of pressure ulcers grade 3 and above. We have not been notified of any such incidents. This was also corroborated in quality

assurance audits completed in relation to this matter. Risk assessments were proportionate and centred around the needs of the person.

The hospice offered respite care for people, where there is evidence that their informal carers are becoming fatigued. Therefore, reducing the risk to both patient and carer and lessening the added risk of inappropriate hospital admission due to the inability to be able to cope with the stress situation.

People were overwhelmingly positive about the staff who they confirmed were available to them and safely met their needs. One person told us about the hospice at home service, "They were absolutely amazing. They were available to us on a daily basis for six weeks. They were there for us, answering every one of our questions." Another person said that they had built up a good relationship and rapport with the nurse that visited them regularly. They told us that the nurse was able to coordinate their care skilfully. "[the nurse] gets things sorted for us".

We spoke with people using the inpatient unit. They told us, "They have enough staff to always be able to take time to discuss with you." People also said that staff responded to call bells; "They come quickly when you ring the bell - they come in no time".

The hospice used a recognised dependency staffing tool as a basis to guide staffing levels. We examined the rosters and spoke with staff. People were clear that there were sufficient staff available to meet their needs. This included every level of staff from doctors, nurses and catering and domestic staff. Staff were able to tell us that they were able to take time when they needed to respond to individuals need for time and counsel. We were able to observe that staff were able to take sufficient time with people being considerate of genuine individual needs led care and support. One person was able to explain to us what this meant to them. "There were numerous male and female nurses. Each one had their own qualities. They were all good. But what was important to me was that I was able to determine who did what. I could allocate certain jobs as to who I wanted to care for me. Because of this I was comfortable to receive the care I needed."

The hospice used volunteers in a variety of roles within the hospice setting. We found that both volunteers and employed staff were robustly recruited. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff/volunteers had not started working at the hospice until it had been established that 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. For more prominent jobs, applicants were required to make presentations to establish their values and motivations for the prominent roles they were to undertake. This ensured that not only did people have the requisite skill but also the shared values of the organisation, thereby ensuring people were suitable for this job.

Medicines were managed effectively and safely and people were involved and informed about medicine usage. One person told us, "They respond quickly if you need pain relief". A different person said, "The doctor's been really good in sorting out my pain". We made a home visit with a community nurse specialist. Whilst there the nurse checked the medicines that had been pre-emptively prescribed. Pre-emptive medicines means rapid access to drugs and this can avoid unwanted or unnecessary admissions to hospital in the last days of a person's life. These were safe and secure in a sealed bag that was accessible but followed the principles of ensuring confidentiality. Once checked the nurse then completed an audit trail made clear by a new seal applied to the tamper proof red bag of medicines. The nurse checked with the person and their relative that they were happy and understanding of the medicines contained within the bag. They offered further explanation and guidance where needed, but respected the persons prior knowledge of medicines management and cognition around their circumstances. The interaction was

supportive, respectful and informative.

We spoke with a person whose relative had died but had been supported by the hospice at home. They were extremely positive about the care and support given specifically with regards medicines and their usage. They explained that the hospice were expert in their knowledge around medicines needing to be prescribed at the end of a person's life and the hospice had given advice to their GP on the best medicine combinations for a better outcome. They went on to tell us, "We had control all the way along. Everything was explained very carefully to us".

At the in-patient unit nursing staff were observed discussing with a person how to take a medication which previously they had had difficulty with and together agreeing that they take it with yoghurt. This showed us that people are consistently involved and supported with their medicine management to suit their individual needs.

A pharmacist visited the hospice three times a week. They carried out medicines reconciliation, which involved taking a detailed medicine history and checking that the prescription was correct. They also reviewed prescription charts and provided advice to the clinical staff. Advice was available at other times, including out of hours. A pharmacy technician visited regularly to top up the stock, and nursing staff told us that medicines were available when needed. This meant medicines were supplied and available when needed and were monitored to make them safer.

Medicines, including controlled drugs which require extra checks and special storage arrangements because of their potential for misuse, were stored safely and records were appropriate. Controlled drugs were checked every night against the register and the pharmacist audited regularly. Refrigerator temperatures were recorded regularly.

Records showed that staff, including temporary staff, were assessed to make sure they were competent to administer medicines. We saw positive intervention of additional support and supervision was provided to help staff improve their performance if they made errors. This was as a result of the regular auditing process that had identified concerns. These actions showed effective and appropriate actions were seen to be taken to increase the safety of medicines management where possible. The records we checked showed that people were given their medicines as prescribed. Guidelines were in place to support the administration of medicines 'when required', for example to relieve pain or bleeding. Emergency medicines were available, securely stored and checked regularly. They were kept in a locked trolley in the treatment room. Nurses knew where they were and two different staff told us they could be accessed quickly, and that in an emergency one person would run for the medicines while someone else managed the patient, thus ensuring no delay.

We saw a comprehensive medicines policy, approved by the clinical governance committee, and a range of guidelines covering all aspects of medicines management. We noted that the policy was being reviewed at the time of our visit, and were told that it was being updated to reflect current and best practice and would be re-issued soon.

Is the service effective?

Our findings

People using the service thought staff had the right competencies, knowledge, qualifications, skills, experience, attitudes and displayed the right behaviours. One person who was new to the service told us, "I have been introduced to the team supporting me. I have found them all extremely helpful. I had difficulty coping and they have given me useful techniques. I know they have given me good professional advice. They are able to answer my medical needs". A different person said, "They know the answers to my questions and are so skilful. There is always an element of choice. They do not just tell you". One person was extremely complimentary about staff competency saying, "They are so comprehensive – they know everything. If they cannot immediately answer they will put you in touch with someone who can. I had a money issue and they even helped me out with that".

People received care and support from staff that was based upon best practice. Staff members were aware of the Royal College of Nursing resource to support care at end of life which includes an educational resource regarding nutrition and hydration. The on going development of roles within the hospice of link practitioners, sometimes known as 'champions' were roles that were given to staff who were additionally trained in those areas. They linked with other professionals and used external resources to ensure best practice was followed. Link practitioners roles were developing a specific role description and included: falls prevention, medicines management, understanding dementia and diabetes. This meant that people with specific conditions benefitted from specialist knowledge and therefore were kept safer with a higher quality of care given. The falls link practitioner had made a real impact upon the safety of people using the service. The role of the dementia link practitioner ensured the on-going development of the staff group to prepare for more people who live with dementia that are expected to access this hospice services. The ability for all staff to have increased knowledge around dementia and subscribe to being 'Dementia Friends' will strengthen staff knowledge to underpin peoples already high confidence in the skill and knowledge of the staff group.

We spoke with a nurse who was still completing their induction period. They found this to be quite thorough as it included an introduction to the whole organisation including the fundraising and day centres as well as her role specific work place as a nurse. They explained that the induction training included moving and handling, safeguarding adults and children and infection control and was of good quality and meaningful. They explained that even on their second week they were still supernumerary on the roster, which meant they had time to get updates and pass competencies on blood glucose monitoring and medicines administration. They were also expecting to have some quite specific training on aseptic techniques for management of a Rocket drain. This specialised training was to manage one person's medical needs safely and increase their comfort levels. We had the opportunity to meet nine nurses who were on a study day receiving updates and training. All the nurses were positive about the level of training offered, stating it was equal opportunity access to training for all as they were all informed of training available and that it was of good quality and enabled them to support people who used the service appropriately. We also met the person responsible for managing the training program. We saw that appropriate records were kept of training received by the whole workforce. There was a rolling program of updates that was repeated four times a year. A moving and handling session of three hours was held once a month to ensure all staff,

including volunteers who supported with care, had the timely appropriate training for their roles and responsibilities. We attended some training in progress, but also did see staff safely supporting people to move at the hospice. This level of focus on training that was well timed and repeated emphasised to staff its importance and the impact was to keep people as comfortable, well for longer and as safe they could be.

We were told of 'mini bite' training sessions. These were topic specific training delivered in house by expert specialist or clinicians. These lasted 45 minutes and included topics that were pertinent to palliative care. Twice a month the education team ran two hourly sessions covering workshops on symptom management in palliative care. For example constipation in palliative care, nausea and vomiting and having difficult conversations. These sessions were available to all staff and volunteers. Staff spoken with believed that these regular sessions were key in ensuring staff were confident in using the skills they had. One nurse told us, "All staff are happy to work together to assist other staff members attaining a skill or competency and share their knowledge and skills base. We have close connections with West Suffolk Hospital and they are always happy to provide support with training". An example being the Falls Prevention Link Practitioner had attended training at the hospital. The hospice was also ensuring that nurses had access to training courses outside the hospice that were nationally recognised. These were to benefit people using the service so that they could experience the best possible care based upon current thinking and skill. The new cohort due to start were enthusiastic to learn and bring back their knowledge to the hospice.

Volunteer workers spoken with said that they had had both induction and further training for their job role. They said that they were given regular feedback and felt involved and valued by the hospice; one told us, "This is worthwhile work".

Staff were appropriately supported in their roles. One health care assistant told us, "I have a regular one to one session each month as well as an annual appraisal. There is always someone to talk to if needed. There is the regular once a week reflection available". We were informed that the regular reflective practice was available to everyone of any role within the hospice. The idea being that all staff could be potentially affected by the work they did and therefore equitable support and reflection on how the course of events developed was beneficial to all. The reflective practice would enable staff to consider and critique their own performance and preparedness for the potential next time. We met seven members of the family support team and sat in on their regular weekly team meeting. This enabled case reflections and discussions on dilemmas. This enabled suggestions and ideas to develop and improve the support given to families, but also the individual staff member delivering the support. The nine nurses we met confirmed they had consistent and appropriate support and supervision to maintain their well-being to perform their roles. In addition, the service also paid for external counselling should staff want to take advantage of this. One nurse told us that this was beneficial from time to time especially if one's personal experiences of bereavement needed more support then additional support was needed to maintain a person's well-being.

People were always asked to give their consent to their care, treatment and support. Staff always considered people's capacity to make particular decisions and knew what they needed to do to make sure decisions were made in people's best interests and involved the right professionals. One relative spoke about end of life wishes and how these were discussed and agreed upon. "We have been informed and supplied with literature. We have the yellow folder and this is all about what he wants clearly written down". Another person said, "They always seek consent. Decisions are made upon information freely given. The whole care team are involved. They help us to make big decisions simply. You can't fault them".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw examples when people were supported and involved in decisions. We sat in on a multi-disciplinary team meeting. [MDT] Staff recorded appropriate conversations with people and their informal carers. Inter-professional communication at the MDT prompted discussion and debate, which yielded learning for all staff in attendance. Leadership of the MDT was effective and motivational encouraging all staff to share their views and contribute to outcomes for the person and informal carers based on best practice. More senior staff shared anecdotal evidence relating to their experience in alternative non pharmacological interventions which may benefit people presenting with specific symptoms. Capacity and consent were consistently discussed throughout the MDT and staff hand over, and documented within the electronic records for each individual using the service. We found that decisions relating to treatment, disease progression or approaching death were made involving the dying person and their informal carers/family. Where people lacked capacity staff had evidenced the discussions with families which contributed to best interest decisions.

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 hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection people using the service had capacity and did not require any DoLS. However staff understood the role of the MCA and the need to act in a person's best interests if the person they cared for had difficulty making a decision, for example about their treatment or their wishes as they approached the end of life. The registered manager knew the process to submit applications to the relevant authorities and had completed these in the past where relevant and we had been appropriately notified.

People were encouraged and supported to have sufficient to eat and drink and maintain a balanced diet. A whole variety of tempting foods were on offer all based around individual preferences and choices made directly with the chef. One person told us, "The food – you cannot fault it. It was lovely. Perfect in fact. The cook came and saw me. You make a suggestion and they will make it for you". A different person said, "My very first day there the chef came and spoke with me. The homemade mushroom soup was amazing. We discussed the recipe. The omelettes were beautiful. They came and chatted before and after each meal to check everything was Okay. It was hotel quality really. At 12 O'clock at night if you were hungry, they made me a cheese toasty". We ate whilst at the hospice and found fresh nutritious ingredients were used and food was presented very well to tempt people. This showed that staff went out of their way to meet people's individual preferences. One person told us, "I think the food is very good; they'll prepare it specially in the way you like so you will eat it". Another said, "The food is divine".

Risk assessments were completed and nutritional needs were identified. Records showed that these were managed and monitored well. Staff were knowledgeable and keen to demonstrate and share their knowledge around nutrition and hydration. Staff members were aware of the Royal College of Nursing resource to support care at end of life which includes an educational resource regarding nutrition and hydration. The link practitioner for nutrition and hydration supported people, carers and staff to ensure that each individual's nutritional care was assessed, discussed and managed according to their preferences and their need. We could measure the impact of this from the overwhelming positive feedback from people.

People received access to on going healthcare support that was timely and specific to their needs. One person explained to us, "You cannot fault them. They were there when we needed them. The local hospital had let us down at a weekend – no pain relief, but they organised the palliative care nurse and sorted it all out for us. We transferred to St Nics. I cannot praise them enough. [Name of a doctor] was superb. Right through to the end". They went on to tell us, "[Named the doctor] was very reassuring and relieving for my

wife. Constipation and pain control everything taken care of". A different person said, "I was recently referred by my GP. They ring me regularly and I can ring them 24/7. I speak to the doctor and they give advice to my GP". People consistently told us that all the departments within the hospice worked together. One person said, "The specialist nurse visits regularly. Things can change from hour to hour and she checks everything is OK. The OT is fantastic. They are working well as a team for us and they let us know that".

Consultants in palliative medicine were employed. People had medical support over weekends and bank holidays as well. There was cover to ensure specialist medical support was always available and this included consultants on call.

We spoke with one person who had used hospice at home and had recently stayed for three weeks to regain control of their pain. This was successful and they had also used other complementary services on offer and had found them beneficial. "I used the reflexology and acupuncture. The level of care was amazing. I was so relaxed". We met and spoke to an Advanced Practitioner. She led a team of physiotherapists, occupational therapists, rehabilitation specialists, complimentary therapists and volunteers. The team worked well with other departments and were to be found in the day services in Bury and Haverhill as well as linking to Botesdale GP surgeries, Riverdale centre in Thetford and running outreach and drop in sessions. Education, advice and support with breathlessness, along with acupuncture were being developed and moved forward. We could see that this was a gradual development to reach out into rural area of the community to support people where they needed the support.

There was evidence of care being coordinated between staff employed by the hospice and statutory services (NHS). Partnership in care provision was evident, working alongside the acute service provider in arranging blood transfusions and ascetic drainage. The hospice also facilitates rapid admission to a hospice in patient bed for people with appropriate needs presenting at accident and emergency departments of their local acute hospitals.

Is the service caring?

Our findings

People valued their relationships with the staff team and felt that they often go 'the extra mile' for them, when providing care and support. As a result they felt really cared for and that they mattered. One person told us, "They are so caring, genuinely welcome me and interested in me as a person. I was fearful to step into the building. They are fabulous real people. They are thoughtful, loving and nurturing. It's not a job for them – they love their job. Finding them has hugged me". A different person said, "In my darkest hours I rang them. Not only were they wide awake to listen to me, they were so helpful with their brilliant advice and to top that they were sympathetic to me". All the people and relatives spoken with emphasised the quality of care provided by the hospice and the friendliness, approachability, empathy, kindness and compassion of staff. A person said that when she had been admitted to St Nicholas from hospital, "It had been like coming home".

Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. One person spoke of their individual diverse needs that were private. They explained, "I was not sure who I could trust. I was vulnerable and anxious. Having had a one to one session with [named staff] I feel my fog is clearing. They handled it so sensitively...so sensitive. They were beautifully genuine with me". People consistently spoke of the support and spiritual support being appropriate balanced uniquely with what they needed. One person said, "I'm not particularly religious and when we met the vicar, I felt a blanket of calmness around on me". A different person said, "The vicar made themselves known to us. I felt free to say what I liked. They were just like me or you. It was confidential and I could put my trust in them". Another person said that they had been encouraged and supported to rekindle their meditation. On the hospice site was a multi faith room available to all to use as well as private rooms in which to meet and talk. A Holy Communion service was held during the day of the inspection.

There were a wide variety of bereavement support services available for both adults and children. The Nicky's Way bereavement support was for children and young people to have space and time to manage the death of someone close to them. There was a set six week course with professional support staff that led children through art and craft sessions, expressing anger and even an 'ask the doctor' questions, as well as remembering good times. For adults they were able to access one to one counselling for a one off session or as long as was needed to come to a mutually agreed ending. We spoke to some people who were part of the group work program on bereavement attending the hospice. Other groups had developed such as Stepping Forward – this was a monthly walking group. Two people told us how beneficial this had been to them and how inclusive they felt it was of their ability to walk and needs on bereavement. Other activity groups were also based around skill development that may have needed development now a partner had died, such as cooking, gardening and care maintenance. The hospice believed it was their role to support the development of these social groups that would go on to support and care for bereaved people longer term. The hospice had a new website to give information to people on matters such as Head start -coping with hair loss, men's group, positive living, creative writing. Senior management told us how they had ensured the new website had taken account of a concern raised by a person. Therefore, there would be a warning about information about to be clicked upon that may cause potential distress to some people. This response was mindful to respect people's sensitivity.

Staff displayed professionalism at all times, discussing people and carers with dignity and respect. An observation of the palliative medicine consultant, interacting with a GP demonstrated care and compassion for the person being discussed. The development of empathic relationships was evident at both the MDT and the inpatient handover. Staff recognised the rights of people to make choices independently and supported these choices even if they did not fully agree with them. Staff demonstrated kindness when advocating for and discussing people's care planning.

People were pivotal in their own care. They were fully consulted and informed about decisions to be made and these were respected. People were fully involved in deciding their end of life wishes and people experienced a caring and pain free death. One person said, "They worked closely with our GP. We had monthly meetings. They let us know everything. It was very transparent". Another person said, "I cannot thank them enough – they made the ending bearable for us. We were as prepared as we could be". A person told us, "My doctors have explained things very clearly to me". We observed a nurse speaking with a relative on the telephone to a new referral. The person themselves was too ill to talk on the telephone so a relative was answering questions. But we saw at key points the nurse guided the relative to check with the person themselves that they were consenting and happy with the decisions being made all through the consultation.

People consistently told us that their privacy and dignity was maintained. One person said, "They were always respectful when giving me support and kept my privacy. I never overheard conversations and I do not think anyone overheard mine". Our observations of home visits, telephone calls and time at the in-patient unit assured us that staff held these values and acted appropriately at all times. One person particularly valued their own private room, but that they could move to the communal areas if they wished to.

People had access to information about the services provided by St Nicolas Hospice, which was given to them when they started using the service. The information leaflets provided covered a range of topics, which included practical support, information about advocacy services, and information of other organisations that provided support. Information booklets about specific health related conditions were used by staff in the hospice and given to people to help them understand their health needs and how to manage them. This meant people were supported to have access to information relevant to them to help them make decisions about their care.

Is the service responsive?

Our findings

People received consistent, personalised care, treatment and support so they were enabled to live and die where they chose. The service focused on the individualised needs of people and supported them with their diagnosis. People said that they felt involved in the planning and delivery of care, one relative said, "They listen to the patient; if she says she doesn't want something they respond", another person said, "They explain clearly the need for any change in medication". A person said, "The OT was brilliant and arranged for all the equipment we needed at home, a wheeler, a commode, a stool and even a hospital style bed. We could not have asked for more. It was all coordinated and I would thoroughly recommend them".

People spoke about the responsiveness of staff to their requests and needs; their ability to give clear straightforward information; and ability to provide emotional support when needed, "They give you straight forward answers which is what I need". The hospice provides facilities for relatives to stay overnight; relatives and friends can visit at any time.

The Hospice has a weekly multidisciplinary team [MDT] meeting which was well attended, with representation from: Palliative medicine consultant, Advanced nurse practitioners, Clinical nurse specialists, Family support therapists, Physiotherapy/Occupational therapists, Day hospice staff, In-patient staff and Chaplaincy. All people discussed at MDT had been assessed holistically and care planning discussed and recorded. This multidisciplinary approach meant that people could move through and use different parts of the service at different stages of their illness. We spoke with one person who had received support and treatment in the day service, hospice at home and the in patient unit. They told us how they were easily able to move and access each part of the service as staff were able to readily understand their needs and suggest new options with which to support them.

On review of the electronic nursing records there was evidence that records were well maintained with respect for the person. We found that care was based on the five priorities for care that is outlined in The Leadership Alliance for the Care of Dying People (LACDP) The Alliance's five Priorities for Care puts people and their families at the centre of decisions about their treatment and care, and follows the recommendation made by the independent Neuberger review of the Liverpool Care Pathway. We found good evidence to show that staff understood the five priorities that were: The possibility that a person may die within the coming days and hours was recognised and communicated clearly, decisions about care were made in accordance with the person's needs and wishes, and these were reviewed and revised regularly. Sensitive communication took place between staff and the person who was dying and those important to them. The dying person, and those identified as important to them, were involved in decisions about treatment and care. The people important to the dying person were listened to and their needs were respected. Care was tailored to the individual and delivered with compassion – with an individual care plan in place. One person said, "They definitely know my wishes. There is always an element of choice. They do not tell you – they inform you of your options. I have set myself goals to achieve with their support. They have encouraged me as an individual to face this situation".

Care planning and management plans were discussed at MDT and at handover and shared within the

electronic record, which showed good communication between departments within the hospice. Following on from an encounter when treatment or intervention may have changed, a letter was sent to the person and copied to the persons registered GP. This change in practice was implemented in order to put the person at the centre of the care and changes the focus from the traditional letter to the GP with a copy to the person. People had access to a 24 hour advice telephone service that was well publicised. This meant that care and support was available around the clock.

A range of complementary and creative therapy, exercise, chaplaincy and support group activities were provided for people by the Orchard Day Service team. During the day of the inspection people were observed enjoying organised massage and arts therapy sessions, a communion service and lunch together between 10 am and 3pm. All the participating people spoken with said that they appreciated and valued the service. One person said, "This is the most wonderful place; I come here weekly for therapy and lunch". Another said, "This is the best thing that's happened to me". A different person said, "To me this is a salvation". Two of the relatives spoken with said that the hospice's Burton Centre in Haverhill also provided activities for carers which they valued. The Hospice Neighbours scheme was where by trained volunteers offer people companionship and practical support. This was for people in their own homes and may be something as simple as collecting a repeat prescription or putting out a refuse bin regularly. This was based upon people's individual needs and request of the volunteer neighbours. This showed us that people who use the service were encouraged and supported to engage with services and events that have a positive impact on their quality of life.

The hospice truly listened to people's experience of their service and responded positively to any feedback and actively sought out how to develop and improve the service. We found that as well as having all the usual formal complaints policy, procedures and methodology the hospice monitored social media and actively responded to posts made by people who may not have been completely satisfied. This showed us that the hospice were developing and grasping the challenges as well as the positives that come from our modern world in using social media. People that we spoke with where overwhelmingly positive about the hospice staff listening to them and going out of their way to make their use of the services as positive as it could be. One person said, "We were given loads of literature and information. I could not sit here and say how I would make a complaint, but I know it would be very easy to find out if I needed it. They fill us with total confidence and I'm not sure how it could get any better". A different person said, "I do not envisage a complaint, because [staff named] gets things sorted for us. But I have the information with all the phone numbers on it should that occur...but everything has been excellent".

We met and spoke with the CEO who told us that they personally see every complaint that the hospice receives – no matter from which section of the service it stems from. They believed that the best way forward was to speak with people and truly understand what concerns were had and to decide the best resolution for the complainant. A detailed log of all complaints was maintained in terms of receipt, response and actions taken to improve the service for that person and others that may follow. A synopsis of all complaints was collated quarterly and presented to the board so that they were aware of what concerns were being raised and how these were being responded to and to determine if there were any trends to be aware of. A positive example of developing the service came from a recent complaint made by a health professional. Not only had this been looked into and responded to with on going action being taken from the hospice and monitored, but hospice staff met with a whole team of the health professionals and associates to see if they could understand matters further and develop positive working to benefit the people they were supporting. This showed that on going improvement was seen as essential.

Is the service well-led?

Our findings

St Nicholas Hospice has a track record of being an excellent role model, and is well known and respected within the local community of West Suffolk and into Norfolk. They have a visible profile in local media, local high streets and social media. People were keen to tell us that management of the hospice were visible and approachable. Everyone we spoke with knew and was on first name terms with the CEO and managers of the service. One person said, "The, [Chief Executive] is very responsive to any issue we raise". We found evidence on complaints management to support this view. Volunteers spoke of being well supported and of being valued by the hospice. One volunteer said, "Everyone's friendly and supportive. I feel I'm doing a worthwhile job". We found that a significant number of volunteers had moved on to more progressive paid employment or training in a similar field that showed us how well supported and managed they were. Staff said that they felt well supported both by their colleagues and by the organisation and that they liked working at the hospice. One staff member said, "There truly is an open door policy. It is more friendly and relaxed than ever before. Managers are accessible and they do listen to staff". A nursing assistant said, "I love what it [the hospice] stands for, their values are right. There is brilliant team work. They are a lovely bunch". A nurse told us that St Nicholas hospice enables her to have, "Integrity to do what I know is best ever end of life care". A relative told us, "Even [named a staff member] in finance understands the values and ethos of what they are all about. Care first and foremost, but the background stuff gets done thoroughly". This was our experience too that staff not in front line care and support were aware of values and demonstrated these in how they behaved.

The hospice was actively seeking and acting on the views of others through creative and innovative methods. This included the use of social media, but also the hospice has a User Advisory Group comprising of people, their family and friends, the Chief Executive and Clinical Services Director. The volunteer chair of the group said that the hospice was trying to include people with dementia and carers with experience of dementia as members of the group. The CEO and manager explained to us that the hospice wanted to remain progressive and people focussed. Therefore following an away day and reflective practice of the team, the hospice wanted to develop its service to access the widest parts of their community. Not just a lovely service for a few people. Therefore, the vision statement for the organisation had changed and a new community strategy was developing and processing. We found people using the service, volunteers and staff were telling us consistently the same information, therefore the new developments and focus was widely known and people were on board with the strategy for change. In spring/summer 2016 the hospice hoped to have a new website available to support these developments.

People, their family and friends were regularly involved with the service in a meaningful way, helping to drive continuous improvement. We examined the minutes of the user advisory group and found that they had real influence and involvement in a number of issues within the hospice. They had a representative on the hospice research and ethics committee, this was to help decide what research the hospice participated in. This was both local and national research in the last year. There was clear information about developments given and robust questioning on matters by the group. In addition we saw that the hospice monitored the quality of experience of people with regular feedback and seeking views. We saw 'patient feedback' relating to consultations with specific doctors. This was both qualitative – with free text to explain and quantitative –

with sufficient people asked to gain an overall view. This enabled both the individual doctors and management within the hospice to gauge how effective they were and any areas for development. In addition, people were asked for their feedback on specific parts of the service such as the newly opened Burton Centre and specific activities and classes held. These also enabled the hospice to decide where they needed to focus or improve the service on offer.

The hospice also participated in a national research paper to evaluate the satisfaction of bereaved relatives with end of life care provided by specialist palliative care service such as St Nicholas Hospice. This was completed by the national Standards Committee. This did not necessarily influence the service at this hospice, but enabled a national picture to be developed and monitored in relation to responsiveness and effectiveness.

The hospice was keen to drive improvement and therefore had appointed the link practitioner roles. Managers had actively facilitated the role and ensured that these staff had appropriate support and training to develop further and champion their individual areas of concern within the workforce. Falls prevention was the most developed so far and real measurable progress and prevention had been the outcome.

Staff told us that they felt able to influence the running of the hospice and were consulted. A regular staff forum was held with dates every other month throughout the year. We examined recent minutes from these meetings and saw that communication was clear of matters discussed with action points highlighted and then up dated when completed. We saw that staff had influenced changes in language used in publicity material as well as requesting staff training. These minutes showed an effective staff team following through on agreed issues and that people were enabled to question and ask about developments and change. We found a culture of transparency with mistakes and staff were encouraged to raise concerns openly and without fear of recrimination. We saw a key example of this in action where a matter had been resolved with staff, enabling closer support and offer of additional training to ensure greater effectiveness for people using the service. The service was looking at innovative ways of communicating with staff and was considering an app for use on mobile devices to keep staff informed and updated, but also to access policies and procedures.

The safety and well being of staff was considered and monitored. For example, due to the nature of this service staff may work in outreach centres or in peoples own homes where they may place themselves at risk of unforeseen events. Lone working was well managed, the hospice had a policy and procedure in place that all staff knew and we saw evidence of it being regularly reviewed. Before we went out on a home visit we were required to inform the office in writing of our intended journey and timescales. In addition emergency contact details were noted. We were required to check back in upon return. This was good practice to ensure all staff returned safely from any visit within the community. Staff in the office were clear about their responsibilities if there were an event.

The service had an array of systems for auditing and reporting to ensure a high quality service delivery. This included, but not limited to, patient safety and quality, medicines management, reports to the board of trustees, and quarterly reporting to the clinical commissioning groups in Suffolk and Norfolk as well as the clinical committee within the hospice itself. We had sight of the minutes and reports of the last meeting for all of these events. This demonstrated the oversight and that safety was being monitored and reported effectively. This showed a transparent organisation that had clear links of accountability from the 'floor to the board'. Information on matters such as infection control, falls prevention, pressure ulcers, medicines incidents, staff recruitment/competencies, complaint management, safeguarding and finances were known about by those responsible and accountable within the organisation. This showed us that effective methods of communication were in place as well as systems to address any matters arising. Reports to the

CCG's gave outcomes of work undertaken and ensured they were updated with events in the hospice and the effective management of those events. The statistical information contained in these reports was benchmarked against Hospice UK to ensure there were no outlying anomalies that could not be accounted for. The outcomes for people using this service was that they could be assured that their local service was measured with similar on a national basis and that they were in receipt of an equitable quality service. In some areas measured such as falls and pressure ulcers, people were less likely to incur this event at this hospice compared to a similar size hospice elsewhere. This was consistent with what people told us their experience was and from analysis of the statutory notifications sent to us The Commission.

St Nicholas Hospice was complex to manage and run because it provided many different types of services. We found that the senior managers worked together to ensure that it was a seamless service and that the quality of service was consistent over all parts. An example of this was where staff were inducted to the whole organisation and staff were expected to work across departments. Systems and communications enabled staff to work together and be equally valued. We found that doctors were not just based within the in patient unit, but did home visits and participated in elements of the day service courses and were accessible to people. This seamless service meant that people using and accessing the hospice were readily referred and able to receive the service best suited to them at that given time.