

Cornwall Hospice Care Limited

Mount Edgcumbe Hospice

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Good 

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

The inspection was announced with 48 hours' notice. Due to people's complex health needs this allowed people and their loved ones time to prepare for our visit.

Mount Edgcumbe Hospice provides specialist palliative care for up to 14 people over the age of 18, with a life limiting condition. Mount Edgcumbe Hospice provide an

'in patient unit' which provides accommodation with up to 14 beds. The staff provide treatment and care for physical symptoms and help people with addressing emotional, spiritual and social wellbeing. They also provide support to families and close friends during the illness and bereavement. The hospice provides a day case treatment from its building in St Austell and hospice doctors provide regular ward rounds at Treliske hospital and specialist palliative input to the oncology outpatient clinics. At the time of the inspection there were eight people staying at Mount Edgcumbe Hospice.

Summary of findings

Mount Edgcumbe Hospice is located near to the local community hospital and housing estate. This meant that the hospice is located in an area which encouraged the whole community to engage with the service.

There was a registered manager in post at the hospice. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People and their relatives told us that they felt safe when in the care of the hospice staff. However we noted that safeguarding procedures had not been followed and staff lacked an understanding regarding Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS). This meant there was a potential people could be placed at risk of harm.

Staff working for the hospice understood the needs of people and consulted with them throughout the time they received care. People and their families were involved in the planning of care and were treated with kindness and compassion with due regard to their privacy and dignity.

Staff were appropriately trained and skilled and provided care in a safe environment. They all received a thorough

induction when they started work at the hospice. They fully understood their roles and responsibilities, as well as the values and philosophy of the hospice. The staff had also completed additional training to ensure that the care provided to people was safe and effective to meet their needs.

The provider had robust recruitment processes. They employed skilled staff who took steps to make sure the care provided was based on local and national best practice. Individual staff had taken on special roles, to make sure that best practice was followed by all staff in the hospice.

Mount Edgcumbe Hospice had the resources and had developed positive contacts with other professionals who ensured effective care delivery for people wherever they needed and wanted it. Feedback from all sources was used in a constructive way to improve the service.

There was a strong management team which listened and looked after the staff and volunteers working for the service. There was a clear clinical governance structure in place that involved staff at all levels to establish and maintain the best possible care for people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not completely safe as the registered manager had not followed safeguarding procedures. The registered manager and staff did not have up to date knowledge regarding the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.

People who received a service from Mount Edgcumbe Hospice told us they felt safe and knew who to speak to if they had concerns.

Risks were assessed and managed to ensure people were safe, without restricting their independence. Staff managed people's medicines safely and encouraged people to decide about their medicines whenever possible.

Staff were recruited safely. There were systems in place to ensure the environment was well maintained and safe

Requires Improvement



Is the service effective?

The service is effective.

People and their families were involved in their care and were asked about their preferences and choices. People received care from staff who were trained to meet their individual needs.

Staff had good systems to help them quickly identify any changes in people's condition. They could also access appropriate health, social and medical support as soon as it was needed, even outside of normal working hours.

Good



Is the service caring?

The service is caring.

People told us that staff were kind and compassionate at all times and treated everyone with dignity and respect. People's views and preferences were central to the care provided, which was individually tailored and took account of loved ones.

The design of the hospice allowed for private time and people were supported spiritually, in accordance with their wishes.

Outstanding



Is the service responsive?

The service is responsive.

Staff communicated with other professionals to make sure people were admitted and discharged in a coordinated way. There was effective communication with people to enable them to express their views about their care, and future wishes.

Outstanding



Summary of findings

People received support when they needed it. A telephone 'advice line' allowed professionals, and access for people and their loved ones, to call with queries about their care and receive a prompt response.

Family involvement at all levels was encouraged. Staff and space in the hospice were provided to ensure this took place. Facilities within the hospice to prevent social isolation were available for people to use.

Any feedback on the service was used to change and make improvements for the benefit of people and staff.

Is the service well-led?

The service is well-led

The values of care and compassion were promoted to staff and people using the service. This was promoted and led by the management team. The culture of the hospice was open. Staff and people were encouraged and supported to share their views. The registered manager and other senior staff provided strong role models.

Clinical governance systems ensured that best practice standards were put in place and followed. The service learnt from incidents. Risks assessed, planned for and were monitored to make sure the care provided was safe and effective.

Good



Mount Edgcumbe Hospice

Detailed findings

Background to this inspection

The announced inspection was carried out by two inspectors and a specialist advisor. The specialist advisor had experience in the area of palliative care. We visited the hospice on 5 August 2014.

Before the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. We also reviewed the information we held about the hospice and notifications we had received. A notification is information about important events which the service is required to send us by law. At our last inspection in December 2013 we did not identify any concerns about the service.

During the visit we spoke with eight people who used the service and two visiting relatives. We spoke with the registered manager, and 10 other members of staff. We

looked around the premises and observed care practices during our visit. We looked at records which related to people's individual care and to the running of the hospice.

This included two care plans, six staff records, staff rotas and documents in respect of the hospices quality assurance systems.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

People who used the service and their representatives told us that they felt safe and secure. Some comments we received from people included: “We feel very secure and cared for”, “I’m happy to leave the (bedroom) door open. I feel safe here.”

From discussion with the registered manager and staff we had concerns in how the safeguarding, process was followed. Staff had a good understanding of abuse and the types that may take place, but were unsure of reporting procedures to be followed if they suspected a person was at risk of harm. We also saw records where a person had raised a concern. The registered manager had looked at the concern but had not referred this to the local authority or CQC to ensure the allegation was correctly investigated. This meant that safeguarding process were not followed and could have placed people at further risk.

Training records showed staff had received training in safeguarding vulnerable adults. Volunteers also attended training on safeguarding adults as part of their training programme. There was a safeguarding adult’s policy in place for staff which gave guidance on what abuse was. However, this needed to be updated to reflect current practice so that any concerns or suspicions of abuse would be reported to the safeguarding team who would advise on the investigation.

We discussed the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) with the registered manager. All staff had access to training and policies on the MCA and DoLS. However, the policy was dated 2011 and was not up to date with recent legislative changes. The registered manager and staff were not aware of the recent change in legislation or guidance. The registered manager told us that there was no one within the hospice with a DoLS in place and that everyone had the capacity to consent to personal care needs and treatment as required. The registered manager commented that training was “not comprehensive enough”. The lack of understanding regarding MCA and DoLS could place people at risk of having their freedoms restricted unlawfully.

We looked at two people’s care records and saw they contained risk assessments which were reviewed regularly and reflected any change in their condition or risk. Personalised risk assessments were in place in respect of

skin integrity, mobility and environmental risks. Records confirmed discussions with the person, their families and carers as appropriate had taken place and took account of promoting people’s independence, choice and rights. For example, we saw records, including risk assessments, related to one person with deteriorating health, who wanted to maintain their own mobility. Staff ensured the person had access to mobility aids that met their individual needs which enabled them to move around the hospice in the safest manner. Staff were knowledgeable about the care needs of people living at Mount Edgcumbe, including associated risks and when people might require additional support.

Staffing arrangements ensured people’s needs were attended to and people were safe. People and relatives said they felt there were enough staff to meet people’s needs and they always appeared competent and knowledgeable. Call bells were available. People told us they received support quickly from staff when they required it. One person said, “I press the button, they come straight away – day or night.”

The registered manager told us the numbers of staff were reviewed regularly to ensure the correct number of staff were available at all times to meet people’s care needs. At the time of our inspection eight people were staying in the hospice. The registered manager told us that although the hospice had 14 beds they currently only used up to 12. They said the additional beds were used for ‘throughput beds.’ This demonstrated that the provider ensured the service was appropriately resourced, including having the relevant staff with skills and knowledge, before increasing its capacity.

In the staff office there was a “Patient Status At a Glance” board, on which all people were listed together with important information about their care needs, for example mobility information. From this information the registered manager reviewed how many members of staff were required to meet all people’s needs. Staff told us there were sufficient staff on duty. Duty rotas demonstrated the hospice was well staffed with a multidisciplinary team able to meet the complex care needs of the people who used the service and their relatives. The duty rota showed there were always two registered nurses on duty at night with two care staff. In the day four registered nurses and two care staff were on duty in the morning, and three registered nurses and one care staff were on duty in the afternoon/

Is the service safe?

evening. The nursing staff were supported by domestic, catering and housekeepers, and volunteers. They worked in collaboration with the medical consultants, specialist doctors and other professionals working for the hospice. These professionals included a therapy team, spiritual care team, and pre and post bereavement services.

People and family members told us they felt staff were highly skilled and able to provide them, or their relative, with the care they needed. The staff employed by the service had completed a thorough recruitment process to ensure they had the specialist skills, qualifications and knowledge required to provide the care, treatment and support that the people at the hospice needed. We looked at six recruitment files and found they included all relevant recruitment checks to confirm the staff member's suitability to work with vulnerable adults. This ensured the hospice could be confident the staff they employed were competent and safe to work with vulnerable people.

Care records demonstrated people's care needs were assessed, planned and monitored. People were complimentary about the care, treatment and support provided by Mount Edgcumbe Hospice. Most people were admitted for symptom control for example to help with pain relief. The care records demonstrated the effect of medication was closely monitored and adjusted accordingly. One person told us they were admitted with "chronic pain" which could not be resolved in hospital during their two week stay. The person told us that hospice staff reviewed their pain and "Within one and a half days I was without pain". Another person told us if they asked for additional pain relief this was provided "Within minutes of asking. Staff then come back to you within half an hour and see if it has worked." We saw that extra pain relief was prescribed on drug charts to ensure that break-through pain could be effectively managed.

Is the service effective?

Our findings

Discussion with people showed us confidence with all staff and volunteers was high. People felt that staff were well trained and had the skills to care for them. One person said, “they are all excellent.” People and their relatives said staff not only provided physical support to manage, for example their pain relief, but also provided emotional support to help the person manage with the effects of their illness.

The hospice provided people and their families with information about the service in a format that met their communication needs and their ability to understand when they were admitted. The information included a welcome pack which provided information about the hospice, the facilities and support offered.

Staff files showed staff had completed an induction programme, received supervision and attended training relevant to their role throughout the year. A newer member of staff told us they had worked with experienced members of staff to enable them to get to know people and see how best to support them prior to working alone.

Volunteers completed a thorough induction program which enabled them to support people effectively. The volunteer coordinator ensured volunteers received training in the areas of infection control, basic food hygiene, manual handling and health and safety. They received a ‘duty handbook’ which outlined the duties the volunteer undertook on each shift. It also provided clear guidance on hospice procedures and the boundaries that the volunteer needed to work within.

Staff told us they attended regular meetings (called supervision) with their line managers. This enabled staff to discuss how they provided support to people to ensure they met people’s needs it also provided a opportunity to review their aims, objectives and any professional development plans. Nursing staff also told us they received clinical supervision to support their practice. Staff files contained a record of the most recent supervision. These showed they were a two way process which gave staff an opportunity to raise any issues or concerns they might have and identify any training needs. There was also an opportunity to make suggestions. Staff told us they found supervisions useful and felt management listened to any ideas they had.

Training had been provided to support staff in their role, for example infection control and moving and handling. The registered manager told us six registered nurses were supported by the organisation to complete their degrees. A staff member told us they requested diabetes awareness training; this was listened to and was provided. Records confirmed the clinical update training programme covered additional skills that included resuscitation, palliative care and anaphylaxis. Staff told us that the training was good and gave them the skills to undertake their work effectively.

The registered manager told us they had implemented an ‘education strategy meeting’ with the chair of the group being a Clinical Trustee. This was to look at the training provided across the organisations for all its employees and ensured training was appropriate and of a good quality. In addition the hospice had a resource library so that recent guidance in how to provide specific care was available to all staff.

People were complimentary about the food provided by hospice. We were told the food was well presented, people had a choice of portion size (small, medium or large) and the choices were good. People told us their preferences and special diets were catered for. Some comments included “the food is as good as any restaurant”, “I didn’t like what was on the menu and asked for something different, and it was given”, “The food is very good, I am passionate about tomato soup and I have it when I want it.” We saw a thank you card which stated “The food is yummy. I want to take the chef home.”

The chef told us “We do everything they (people) ask for, steak, curry whatever.” Menus were reviewed every six weeks with lighter meals available in the summer months. Catering staff were available from 7am to 7pm and nursing staff could access the kitchen to make snacks and drinks throughout the evening/ night. Breakfast, lunch and supper were served at set times but snacks were available at any time. Nutritional supplements were readily available for people who needed them. Beverages were offered regularly. Staff ratios enabled staff to spend time with people individually, monitoring and encouraging them with their nutrition as necessary.

Each person had a nutritional assessment on admission. Some people’s meals were given on a ‘spotty tray.’ This indicated to the staff member/ volunteer that the person may need assistance at meal times. We joined a staff handover meeting where staff discussed people’s food and

Is the service effective?

fluid intake for that day and recorded if any further action was needed to support the person in this area of their care. This showed us that staff monitored people's nutritional needs and people had access to food that met their needs and preferences.

People told us their day to day health care needs were met and they were involved in the planning of their care. Family members also felt they were involved in this process, as people wanted. Staff spent time with people and involved people when reviewing their care plan. Options were given with regard to medicines used and how these were to be administered. For example, people had control of their pain relief. Discussions with staff indicated the occupational therapist was readily available and ordered additional equipment, such as specialist beds and lifting equipment when needed.

We joined a handover staff meeting where people and their relatives' care and support was discussed. The staff team discussed discharge planning when it was time for the person to go home. This included a discussion on what support the family would need when the person returned home, equipment issues, and liaising with other agencies such as the local authority, the NHS and Specialist Palliative Care Nurse Specialists. There was also evidence of support for bereavement care for relatives when required. In addition to discussions held with staff directly, weekly multi-disciplinary meetings were held in the hospice. A full review of the person's care was undertaken at this time with any further interventions discussed and implemented.



Is the service caring?

Our findings

People who were cared for at the hospice were supported by kind and caring staff. Some comments we received from people included: “It’s like a five star hotel, no, even better!” “Nurses are wonderful, doctors are interested they’re caring and “Care is super, absolutely wonderful they (staff) really do care” and “When we first came we were frightened but within an hour we were comfortable, the nurses came up to me and calmed me down.” A family member told us “Staff would sit and talk to him and hold his hand even though he wasn’t able to respond. Staff are so caring.”

Another person told us that the chef cooked a wedding anniversary meal for them. The meal was of their choosing, the chef acted as a waiter for the evening and laid out the room and table, including placing a rose on the table as if they were in a restaurant. Staff told us people had married at the hospice and to celebrate their wedding they turned the guest bedroom into a honeymoon suite to recognise their special day.

Family members and visitors told us they used the main concourse facilities which were furnished comfortably. Here they would meet and talk with other family members. From this they had gained a “natural support network”.

We saw throughout our inspection that care, consideration and compassion were high in the culture of everyone working for the service. We saw staff and volunteers were respectful and polite to all people receiving a service and visiting the hospice. Staff demonstrated a caring and compassionate approach. They talked to us about the care and support they provided to people in their care, including their relatives and friends, but also talked about caring for their colleagues. All staff spoke positively about spending time with people and their loved ones; having time to listen to people and respond to their wishes and not to be rushed. A staff member said, “We like to talk to people to find out what makes them special. The best thing is being with the person and asking them about their journey.” From this staff then provided opportunities for people to create a ‘memory box’ or write a card so that memories could be shared with loved ones after their death. The staff member said “it’s not for everyone but it may help some people.”

People told us they felt they were consulted and included in discussions about their care and treatment. Staff

listened to people, showed concern for their wellbeing and responded to their needs. Staff also made time to explain things to people, so they could understand what options were available to them. One person told us “The doctor is wonderful, he instils confidence in you. He’s so gentle, he kneels at the bed and talks to you. He tells you what is wrong, what he is going to do but not in a frightening way. He’s reassuring.” A family member said “We are included in everything. One night I was worried I rang the hospice. They kept me informed and told me I could ring anytime.”

Mount Edgcombe Hospice was supported by local religious leaders who are ‘on call’ and can be contacted when needed. Their role was to support people of any faith, and those with none, with whatever helped them cope with a life limiting illness. We saw there was a room for ‘reflection’ which was furnished to ensure that all faiths would be welcomed. Staff told us people could also use free rooms and the gardens in and around the hospice for spiritual support or solace. People told us these areas were valued.

The design and layout of Mount Edgcombe Hospice had taken into account the need to promote people’s privacy and dignity. For example, people were given a choice if they wanted to be in a bed in a side room or the four bedded bay. The screens used provided better privacy than curtains. People told us they felt that their privacy was well responded to.

Staff demonstrated appropriate skills in promoting people’s privacy and dignity. During a staff handover we heard staff talk about how people wanted to be cared for that day. For example, a staff member said that a person did not want their hair done that day as they were tired. This was recognised as unusual for this person and staff considered what further support this person needed. Staff talked about the delivery of personal care, and also the need for people to be respected as individuals. One member of staff said, “It’s always an individual approach working with each person and their carers differently.” They explained how important independence was and how this was promoted for as long as possible. Staff received training on promoting privacy, dignity and ensuring confidential records were appropriately handled. We saw that computers were turned off when not in use to ensure confidential records were kept safe.



Is the service caring?

People we saw throughout the day were dressed and looked physically well cared for. There was a hair salon and two health care assistants had hairdressing qualifications and so were able to provide hair care to people at the hospice.

People told us, and we saw that visitors were warmly welcomed and able to spend time with people in all areas of the hospice. Close relatives or loved ones were able to stay the night and accommodation was available for this purpose. One family member told us they had recently spent the night at the hospice and staff were “excellent” in caring for them, as well as their loved one. Another person told us they recently had eight family members visit them and they used the conservatory area. The person said “it felt like we were in our own living room.”

Records had been completed in accordance with people’s wishes and demonstrated that staff were actively seeking people’s views on end of life care. We also saw people were well supported and cared for at the end of their lives. Records and the staff handover meeting demonstrated people’s needs and their preferences regarding their individual care were regularly reviewed and responded to. This included planning bereavement support to family and friends. Staff communicated with other health care professionals to ensure people’s care was consistent and their needs communicated. People also had access to specialist equipment and support when needed and as their needs changed. Records had been completed relating to ‘Do Not Actively Resuscitate’, advanced personalised care planning and advanced directives.



Is the service responsive?

Our findings

The manager told us that people's length of stay at the hospice varied from a few days to 12 days depending on the care they needed at the time, for example with the management of pain relief. Staff responded appropriately to people's needs for support during their stay. People told us that their individual needs were met. One person told us "My family and friends can visit me at any time." We spoke with people about how they spent their time. People liked to use the gardens, had a pet visit weekly, had access to books, music and television and could make use of the hairdressing and hand care facilities. One person said "We go for a walk every day in the gardens, they are kept beautifully. We love the birdfeeders". There was also a therapy room and people were able to receive complimentary therapies in this room or at their bedside.

Staff described the varied care needs of the people, their relatives and friends that the hospice cared for and supported. They described how staff and services met these needs and how they were individually tailored to people and their needs. For example people came to the hospice as an emergency stay, respite stay, pain relief or end of life care. A full overview of each person, who was receiving care and treatment was discussed in depth at the staff handover. The views of people in respect of their care were included in this meeting. For example, one person did not want to discuss their end of life wishes but when they approached staff to record their wishes staff responded to this with thought and care. As the person did not have English as a first language, staff quickly arranged for an interpreter to attend so the person's wishes could be recorded accurately. Within two hours an interpreter visited the person to gain their views on their end of life care. The person was asked if they wanted to be on their own or would like a staff member to be present when the interpreter came. A staff member attended at their request.

Staff used a tool called a "Distress Thermometer" to record how distressed people were and what was causing them distress. There was an area on the back of the form for the nurse to record an action plan to help alleviate this. This was formally reviewed some days later to see if the level of distress had altered. The hospice also used a tool called "SKIPP – St Christopher's Index of Patient Priorities" to assess the patients on day three and day 10 of their

admission. This allowed the person to record their quality of life before and after admission. On day 10 the person could record any concerns they had, for example pain relief, any concerns about family members and so on. People were fully involved in outlining what was important to them and how staff could work with them to alleviate some of their anxieties.

Staff had sought the views of people when discussing and planning care. There was evidence of detailed admission and discharge planning. The discharge planning was thorough with strong links developed across the different services and professionals involved. "Just in case" medicines were discussed and written up before discharge, to prevent known complications. People and their families were involved in the 'going home planning' as well and this was reflected throughout the care documentation. One person told us "I am going home, it's a relief to know we have the back-up of the hospice." This showed that all elements of aftercare on leaving the hospice had been discussed with the person and their family member to reduce the levels of anxiety for all.

Staff maintained regular contact with people, either through a visit, telephone call or when they attended outpatients or when they were within the 'in patient unit.' This regular contact was used to re-assess people's welfare and health. People said they were always able to contact the hospice directly. A family member said they had contacted the hospice on a number of occasions for advice and for a further visit.

The registered manager told us the hospice had introduced a telephone 'advice line' service, which initially started for professionals to contact them with any queries when supporting a person living with a life limiting illness in the community. However, due to an identified need for people who used the service and their family members, they are hoping to expand the service to them. Staff told us this 'advice line' was used regularly and the feedback they had received was people found it reassuring and of great benefit to contact someone from the hospice at any time, day or night. The staffing and on call arrangements ensured that specialist nursing and medical advice was available 24 hours a day.

People told us that discussions with staff encouraged them and allowed them to express what was important to them and how they wanted to be looked after. Staff showed us documentation used to record people's preferences when



Is the service responsive?

planning care for end of life. One staff member told us this was done sensitively and said, “We are careful when to discuss these areas and when not to, it can take some time before people are ready to discuss in an open way.” This showed us that people were helped to express their views on planning their care and areas to be taken into account for the future.

Staff and volunteers were welcoming to people’s loved ones. There were facilities available that allowed family to stay overnight at the hospice. Staff told us that people’s loved ones were an integral part of care for people and care and support was extended to them as well. In this way, people were enabled to maintain relationships.

Discussions at the staff handover meeting demonstrated that bereavement care and support was part of the planned package of care. For example staff availability took account of time needed for talking and listening to people

and relatives. One person said, “The hospice also provides night sitters who can just be with you. They have been marvellous, they put you at ease and you can then go to sleep.”

Feedback on the hospice, both positive and negative, was asked for within the homes statement of purpose. This document was accessible to all who stayed at or visited the service. The document contained information on how to make a complaint. People told us they knew how to raise concerns and said they would if they ever needed to. One person said they were aware of the complaints process but added “I have no complaints, it’s wonderful here” and “If I had a problem I’d tell them.” A family member said “I couldn’t fault it here”. The registered manager confirmed the system for dealing with complaints included a report being sent to the chief executive, sharing of the complaint with the board and with staff at team meetings.

Is the service well-led?

Our findings

People and staff were aware of the management arrangements and felt there was good leadership within the hospice at all levels. People said, “This is excellent. If there was a word better I’d use it but I don’t know it” and “everything is well organised and I cannot speak too highly of them.”

Mount Edgcumbe Hospice had a well-established clinical governance structure, which was used to drive continuous improvement. Members of the hospice board visited the hospice every three months and in the latest report they concluded “it was very apparent that the whole team at Mount Edgcumbe is very committed to the highest quality of care and very supportive of each other.” The main clinical governance structure was divided into four areas; patient safety, patient experience, policy and clinical effectiveness. The medical director and registered manager provided clinical leadership for the hospice covering key areas of people’s safety and clinical effectiveness. There were a number of sub groups and working parties which included representation from all levels of staff, which fed into the process. These included clinical effectiveness meetings that covered for example, infection control and nutrition.

There was a clear management structure at the hospice. The staff we spoke with were aware of the roles of the management team and they told us the managers were approachable and had a regular presence in the hospice. Staff told us that the registered manager at the hospice was a “Good mentor” and trusted manager. They said, “We have the best manager, they are fair and always kind and compassionate to people,” and “My professional development is down to my manager and the team will benefit from this development.” Staff told us that they enjoyed working at the hospice and said, “I love working here,” and “It’s really rewarding coming to work as the team work is fantastic.” Volunteer staff were also well motivated and well organised. During our inspection we spoke with the registered manager who demonstrated to us they knew the details of the care provided to people which showed they had regular contact with them.

Mount Edgcumbe Hospice was described to us as ‘a community resource; it was funded and supported by local people, and every effort had been taken to ensure the new building was part of the community. Local people had been

involved from an early stage planning and developing the service for local needs. This philosophy had continued and people from the community were encouraged to visit the hospice, work as volunteers and be involved in its on going development.

The hospice had clear visions explained to staff and volunteers through their induction programme and training. There was a positive culture at the hospice where people felt included and consulted. People and their family members told us they felt staff not only offered to care for the person receiving treatment but also for family members. We found the culture of compassion, caring and kindness was embedded within all staff and volunteers working for the hospice. All people including staff and volunteers told us they valued the kindness and compassion of everyone, be they staff, colleagues or volunteers. We could see that people and their loved ones were central to the care delivery.

Staff spoken with were aware of the whistleblowing procedure and told us they felt they would always be listened to and their views would be acted on. They reflected on the open culture within the hospice and said they felt able to talk directly with the registered manager or a member of the Board. They also said they could talk freely at team meetings which allowed for open debate. We saw that team meetings promoted an open culture and encouraged discussion and challenge when needed. There were good support networks for all team members when discussing upsetting situations. This showed us staff were supported to question practice, they were not judged and everyone’s view was important. Staff were also supported and learning was shared across the team.

Staff were highly motivated and excited about their roles within the hospice. They talked about a “Good morale” and “Working together” as a team. The managers of the hospice were seen as part of this team and were seen to motivate staff. We saw that the manager worked with staff in the hospice. Staff felt valued by having access to training opportunities and lead role allocation. Staff members said they had allocated roles within the team, for example tissue viability and spiritual care, about which they fed back in team meetings. The aim was to drive improvement. Staff development in their lead role was financed and supported by the hospice.

We talked with staff about coping with the stress and emotional strain associated with the hospice services. All

Is the service well-led?

staff spoken with told us they felt well supported by management and colleagues. They told us support was provided through an approachable and available management structure, regular one to ones, and a coherent and caring team. We were also told that staff could use the counselling service and the chaplain was also available.

The registered manager and unit manager monitored the quality of the care provided by completing regular audits of medicines management, care records and educational resources. They evaluated these audits and created action plans for improvement, when improvements were needed. For example, one audit demonstrated improvements were needed in combining the educational resources, and they have now made the improvements needed.

Records showed staff reported accidents, incidents and near misses. These were investigated, analysed and reported on. This took account of how these had impacted on people's care safety and experience or clinical effectiveness. Reports included actions to be taken to address issues identified and how they were to be addressed.

Audits were used to review and measure the performance of the hospice and included performance of care and clinical treatment. For example, the hospice shared information with other hospices to assess performance and provided clinical data for benchmarking at regional level. The hospice had established policies and procedures to

guide staff on delivering good care based on most recent guidance and research. These were reviewed and updated regularly and ratified through the clinical governance structure.

The hospice used questionnaires to gain feedback from people and their representatives. They contained very positive feedback, such as a comment "the perfect harbour of peace". The findings were shared with staff to extend best practice across the service and to promote good staff morale.

Staff at the hospice had been approached by the Pain and Palliative Care Team to join a research project to explore the impact of intrathecal analgesia on the patient experience. The hospice had discussed this project with relatives to gain their views about pain relief devices for the treatment of cancer pain. In addition the hospice provided support to the Community Specialist Palliative Care Nursing Team (Macmillan) They had also supported General Practice trainees to carry out work around the challenges of delivering end of life care to all patients in the community. Feedback from this were analysed and if the pilot was successful it is envisaged it will be rolled out across Cornwall. The hospice also leads the National Advanced Communication Skills training programme across the peninsula and delivers training to nursing homes in Cornwall. It had developed links with specialist dementia services to provide high quality care for people at the end of their life and support for those caring for them. This showed the hospice provided specialist advice and worked with other organisations to develop local and national practise.