

St Joseph's Hospice Hackney

St Joseph's Hospice

Inspection report

St Joseph's Hospice
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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 23, 24 and 28 July 2015 and was unannounced. At our last inspection we found that the provider was meeting all of the regulations we checked.

St Joseph's Hospice provides palliative care to up to 61 people at the main site and a community palliative care service to approximately 385 people living in the boroughs of Newham, Tower Hamlets and Hackney and City. The on-site service is split into three wards including one respite ward where people stay for a short length of

time and are supported to gain skills to better support themselves in the community. The provider also runs a day hospice three days a week on-site which both people living on site and in the community may attend.

There was a registered manager in post. 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.

Summary of findings

People were protected from the risk of harm and potential abuse and relatives told us the service was safe. An on-site social work team provides expert advice in safeguarding matters. However, people were not always protected from the risk of systemic poor practice because staff were not always supported to escalate concerns. Despite recent steps taken by the provider, not all staff felt they could raise concerns freely within the service and did not know which outside agencies to contact.

People told us that pain control was effective, however, the storage, administration and prescription of medicines was not always effective. There was good practice around people self-administering medicines that supported their independence.

Although there were clinical vacancies, the provider employed agency and bank staff to cover these vacancies and people told us their needs were met. However, this meant that people did not always receive care from the same members of staff and people and their relatives could not always tell us who was in charge of their care. People were kept safe by a robust recruitment procedure.

People were protected from the risk of harm because effective risk assessments were completed to prevent an occurrence of a specific risk. We noted that assessments were updated as people's risk level changed.

The control and prevention of infections was well managed and the service was clean and odour-free.

Staff had the knowledge to meet people's needs. Staff completed an induction and probationary period to equip them for their roles. There was a programme of training available for clinical and non-clinical staff as well as volunteers that was tailored to their roles.

People were supported to live their life in the way they chose. Staff discharged their duty under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported to express themselves and make choices about their care. The provider had arranged for advocates and people were fully involved in care planning, including decisions about what they wanted to happen to them at the end of their life.

People were supported to eat and drink enough with input from the on-site dietitian when required. Staff were aware of the significance food plays in a person's life as their health deteriorates and dealt with this sensitively. People were supported by a wide range of on-site health care professionals to maintain their optimum health.

Staff developed caring relationships with people using the service and feedback from people was very positive. The provider respected and celebrated people's diversity, including their sexual orientation, religion and culture. The service strove to promote people's independence and the respite ward gave people the opportunity to "recharge their batteries" and learn new coping mechanisms.

People received personalised care that was responsive to their needs. There was holistic psychosocial support available to people to increase wellbeing. People were supported to maintain their interests and partake in activities. The provider limited isolation by encouraging visits from loved ones.

People felt their concerns were listened to and the provider worked hard at obtaining feedback from people and their relatives.

Team work and staff morale was not always well managed which posed a risk to the quality of care delivered. There were a number of new initiatives coupled with managerial vacancies and a period of high turnover of staff which meant teams were not always well led. There were pockets of tension amongst staff and not all appraisals had been completed.

Incident and accidents were well managed and improvements were put in place to help prevent them re-occurring.

The service was organised in a way that promoted safe care through effective quality monitoring. The provider was part of networks in the sector to ensure standards at the service met those of the field

We have made two recommendations about the management of controlled drugs and staff culture.

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?

Aspects of the service were not safe. Staff were not always supported to escalate concerns regarding poor practice.

The storage, administration and prescription of medicines was not always effective. There was good practice around people self-administering medicines that supported their independence.

People were supported by an adequate number of staff.

The control and prevention of infections was well managed and the service was clean and odour-free.

Requires improvement



Is the service effective?

The service was effective. Staff received training and support relevant to their roles.

The registered manager and staff understood the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Staff supported people to eat and drink enough.

People were supported to maintain their optimum health by a wide ranging team of healthcare professionals.

Good



Is the service caring?

The service was caring. Staff developed compassionate relationships with people and supported them to express their views.

The provider respected and celebrated people's diversity, including their sexual orientation, religion and culture. The service strove to promote people's independence.

Good



Is the service responsive?

The service was responsive. People received personalised care that was responsive to their changing needs.

Staff were adept at identifying people's deteriorating health and took appropriate and prompt action.

People were supported to maintain their interests and visits from family and friends were actively encouraged.

People felt they could raise concerns and the provider dealt with complaints appropriately.

Good



Summary of findings

Is the service well-led?

The service was not always well led. Team work and staff morale was not always well managed and there were pockets of tension between staff.

Incidents and accidents were well managed and improvements were put in place to help prevent them re-occurring.

The service was organised in a way that promoted safe care through effective quality monitoring. The provider worked in partnership with other organisations to increase the quality of care.

Requires improvement



St Joseph's 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 23, 24 and 28 July and was unannounced. The inspection was carried out by three inspectors, a pharmacist inspector, a specialist advisor and an expert by experience with experience in end of life care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service including statutory notifications received. We spoke to two representatives from local authorities to

get their views about the service. During the inspection we used a number of different methods to help us understand the experiences of people supported by the service. We spoke with 13 people using the service and 11 relatives.

We spoke with the registered manager, the Chief executive officer, the senior consultant specialist Palliative care doctor, one consultant doctor, the clinical governance lead, pharmacist, consultant pharmacist, eight nurses, nine health care assistants, a dietitian, an occupational therapist, a physiotherapist, an on-site lead nurse, the respite ward nurse consultant and a community palliative care team consultant nurse. We also spoke with five nurses, three student nurses, eight health care assistants, three volunteers, a maintenance manager, the human resources director, one chef, two members of the chaplaincy team and five other staff members. We also spoke with the visiting link lecturer and a paramedic. We looked at 10 people's care records, seven staff files, as well as records relating to the management of the service.

After the inspection we made phone calls to five people and their relatives who used the service in the community.

Is the service safe?

Our findings

People were protected from the risk of harm and potential abuse. Relatives told us, “[The service] is safe.” Staff, including volunteers and those who did not work directly with people, had received training in safeguarding adults and had a good understanding of what may constitute abuse and how to report it. The registered manager had a good understanding of her responsibilities in reporting allegations of abuse to the appropriate authorities. She was supported by a social work team who were able to give advice about any safeguarding concerns. We noted that allegations of abuse had been recorded and dealt with appropriately and reporting duties had been carried out properly.

However, people were not always protected from the risk of systemic poor practice because staff were not always supported to escalate concerns. Despite the introduction of a ‘Guardian Service’ in June giving staff a forum to share concerns anonymously, staff did not always feel they could raise issues freely and without the risk of recrimination, from staffing teams rather than the senior management team. Not all staff knew to which outside organisations they could report such instances and the whistleblowing procedure did not include contact details for the local authority safeguarding team, the Care Quality Commission or the nominated trustee to guide staff. Work had begun in this area but it would benefit from further improvement.

Medicines were not always well managed. One person told us, “Since I have been here I am improved. I am feeling better off here. I can’t fault staff, they have helped me with pain control.” Relatives told us that their family members got their medicines on time.

However, written guidance was not always up-to-date. It is important that the prescribing of medicines and their administration is undertaken using the most up to date information. There were documents on notice boards that were used to check syringe drivers and calculate doses of analgesics used by nursing staff that either did not have the source of the information or the date on them or were in need of updating; one document was dated 2001. In one treatment room we saw a copy of the British National Formulary (BNF), a pharmaceutical reference book containing information and advice about the correct dosage, indication, interactions and side effects of medicines was out of date. The medicines policy document

had expired and was overdue for review. There was no policy covering the responsibilities and accountability of non-medical prescribers. However, all the standard operating procedures seen were comprehensive and up to date.

Medicine administration records were not always accurate. There were some omissions where people had not received a medicine but a code or reason had not been recorded. A recent audit had also highlighted this issue and the hospice were taking steps to address this including the development of a critical medicines list as recommended by the NPSA alert (NPSA/2010/RRR0009: Reducing harm from omitted and delayed medicines). The pharmacy team were providing teaching sessions to aid learning.

Medicines were stored securely in locked medicine cupboards within a secure treatment room. Medicines requiring cold storage were kept within a monitored refrigerator in the treatment room although on the few occasions when the maximum temperature reading had exceeded that which is recommended it was unclear whether any action had been taken.

Controlled drugs were stored securely. However, the hospice did not comply with the regulations in the Misuse of Drugs Regulations 2001 with regards to the information supplied on a requisition and the supply of controlled drugs to patients during visits to hospital for appointments. Controlled drugs were dispensed from stock rather than obtaining them on an individual prescription; however, there were sufficient controls in place to ensure the safety of the process. One ward was holding excess stock of controlled drugs for two other wards which meant that stock controlled drugs were being transferred between wards and from one register to another, this is usually reserved for use in an emergency on an individual basis and should not be routine practice.

The system for ordering medicines was adequate and enabled the hospice to get medicines urgently should they be required.

On one ward people were encouraged to administer their own medicines. This was outstanding practice in enabling people to maintain their independence and enable staff to monitor whether people were having difficulties with their medicines and support them where necessary. There was a

Is the service safe?

robust system in operation to check the suitability of medicines brought in by patients and to monitor people each day to make sure they were managing their medicines.

It was very clear when 'as required' medicines were to be administered as each medicine had a reason for being prescribed and we were satisfied that people received medicines when they needed them.

There were not enough permanent members of staff employed at the service to meet people's needs; The registered manager, clinical lead and human resources department confirmed that there were a number of key vacancies including consultants and nurses. The provider was going through a period of high turn-over of staff and was relying on agency and bank staff to provide adequate support to people on a day-to-day basis. People told us that they felt staff had enough time for them including time for "company or humour" when it was needed. One person said, "Staff don't make you wait, they will come if they are free, I think there are enough staff on duty" However, this meant people did not always receive care from consistent staff members and families did not always know the name of the staff members caring for their relatives and whom to go to directly if they needed more information quickly. One family member told us, "There are quite a few nurses and doctors looking after [my relative] there are different people in charge of [my relative's care]."

People were protected from harm by effective risk assessments. Risks such as those associated with nutrition and pressure ulcers had been identified and the associated assessments provided staff with clear guidance on how the

person should be supported. The assessments were regularly updated and amended when there was a change in the levels of risk someone faced. For example, following an assessment by a dietitian. Wound care was managed well from assessment to treatment.

Environmental risks were well managed. The environment was clean and well maintained. The provider had made the improvements necessary to comply with the actions required following an assessment for Legionella. There were weekly fire drills with training and there were evacuation plans in place.

A thorough recruitment system meant people were supported by staff who were suitable for work in the caring profession. We reviewed seven staff files that contained criminal record checks, application forms, proof of their right to work in the UK and two references. Interviews tested people's skills, competency and approach to care and staff found it "tough and challenging as it was focused on how to support patients in a holistic way".

The control and prevention of infections was well managed. Staff were seen to be wearing gloves and following good practice around hand washing. Staff were supported by a wide range of policies and procedures. The service was clean and was without odour and domestic staff were observed to be adhering to the cleaning schedule. Infection control was monitored by the provider via an effective auditing system.

We recommend that standard operating practices are reviewed in line with current controlled drug legislation.

Is the service effective?

Our findings

Staff had the right skills to carry out their roles in order to meet people's care needs. People told us they considered staff to be trained and motivated to care for them. All staff underwent an induction and probation period so they knew how to work with the people at the service and within the service setting. One person in the respite unit explained they had very particular mobility needs and had a specialised piece of equipment. This person explained that a nurse who was familiar with this equipment and had taken the time to ensure that anybody else that would be involved in their care understood how to operate the equipment safely and effectively.

All staff and volunteers were required to complete mandatory training in areas such as safeguarding adults and first aid. Not all staff had completed their training or refresher courses but this was an ongoing piece of work that the provider was committed to achieving. There were different training programmes tailored for clinical and non-clinical staff managed by a professional development team. Volunteers received additional training such as wheelchair training dependent on the requirements of their roles.

Staff received supervision on a regular basis and gave examples of how they were supported to reflect on their work in line with best practice. The medical team had clinical supervision every six weeks and there was a system for clinical staff to access free counselling by an external organisation. Student nurses were provided with a mentor to whom they could go to for support and learning.

Teaching sessions were held to brief staff about correct procedures, such as around medicine administration.

The Mental Capacity Act 2005 (MCA) provides the legal framework to protect and support people who do not have the capacity to make specific decisions. We noted that the provider had carried out mental capacity assessments when required under the MCA. Upon admission a doctor would provide nursing staff with information about the patient's mental capacity, which was recorded on their care records as part of a core assessment.

Care staff had completed relevant training and had an understanding of the principles of the Act. For example, staff understood people's right to make their own decisions whenever possible. The service had involved advocates to support people to make decisions about their care.

Staff were aware of the need to continually review a person's capacity because of the impact of physical and cognitive deterioration due to palliative diagnosis and analgesia. One member of staff gave the example of morphine causing temporary confusion.

The registered manager had submitted Deprivation of Liberty Safeguards (DoLS) applications where appropriate and had a good working knowledge of current legislation and guidance. DoLS are in place to protect people where they do not have capacity to make decisions and where it is deemed necessary to restrict their freedom in some way, to protect themselves or others.

People were supported to eat and drink enough. People told us that food met their expectations in terms of preference and dietary requirements. One person explained that during every stay in a hospital they had arranged for their family to bring in food but it was only since being at the service that they thought this was not necessary.

Prompt referrals were made to the on-site dietitian and speech and language therapist when required and their recommendations were adhered to by kitchen and care staff, such as preparing pureed food. In the community, staff made referrals to the community dietitian where necessary. Where appropriate, relatives also received emotional support from the on-site dietitian when they observed their loved ones eating less.

We observed that staff supported people to eat in a calm manner and did not rush people. Staff strived to create a relaxed atmosphere and spoke to people warmly about their interests, such as their football team.

We noted snacks were available on the ward kitchen for people to eat as and when they wanted, such as bread and jam, jelly, eggs, tea, coffee, cereals and ice-cream. We observed fluids with straws were within people's reach.

People were supported to maintain their optimum health because they had good access to healthcare services. There were a range of healthcare professionals on site including physiotherapists, occupational therapists and a

Is the service effective?

podiatrist. A multi-disciplinary approach was taken towards a person's care to ensure the correct response. Staff were aware of how to identify signs of deterioration in someone's health and wellbeing and people were kept informed of their condition. Prompt referrals to health care professionals were made when required. A relative told us, "They have all the support here on the team. They refer you to whatever service you want."

Although the community palliative care teams' remit was largely advisory, good working relationships had been developed with the district nurses and local GPs. A person told us, "I live at home, if it wasn't for this place I wouldn't have found out about my diabetes and need for a hearing aid, which I got so quickly."

Is the service caring?

Our findings

Staff developed positive caring relationships with people using the service. Every person we spoke with used words such as “supportive”, “friendly”, and “cheerful” to describe staff. People had a real sense that all staff cared and would go the extra mile to provide emotional support, “I wouldn’t want to be anywhere else. I want to be here 100%. I feel a bit tearful today and I burst out crying, the nurse was so supportive. Then I saw the doctor and she is amazing... The doctor gave me a hug. Nothing is too much for anyone. I can talk about issues that I can’t discuss with anyone else. I couldn’t wish for a better team, the consultant will sit down by my bedside for a chat.”

Another relative said, “There are no words big enough, no thanks loud enough and no description grand enough to tell you how wonderful everyone here has been to my mother. She wants to adopt them all!”

Staff supported people to express their views and involved them in day to day decisions about their daily lives and support. Staff were aware of how to communicate with people who could not express themselves fully. One person told us, “I can’t really talk very much but I need to say this. My illness means that I speak very slowly and sometimes I get a bit muddled but no-one ever hurries me or tries to finish my words for me. Everyone lets me talk for myself. That’s a really nice thing.” In a recent survey, 92% of people stated they felt their nurse involved them in their care choices.

We observed that staff lowered themselves to people’s level to speak with them and maintained eye contact and did not rush people. We noted that staff gave people choices about when to perform care tasks and people’s wishes were respected. Staff explained what they were about to do to people before they did it and understood their preferences.

People’s diversity was respected. People were able to access a multi-faith chaplaincy service and there was a large multi-faith chapel on site. People told us that it had been arranged for their religious leaders such as Imams and Rabbis to visit them. One person described how valuable these visits were and how they had helped them resolve some deeply personal matters. Information about people’s religion and sexual orientation was recorded in

people’s care records and passed to the chaplaincy team. The chaplaincy service was staffed by employees and volunteers who had received training from the provider and treated all information confidentially.

One member of the team explained that they were available to offer support to people of any religion or no religion. “We go and speak to people and have a chat. Just to see how they are. We can talk about anything, about football. We talk to their family and pray with people if they would like it. Some people don’t have any visitors.” One person told us about how much she appreciated the visits of a member of the team and fondly recalled how happy the team member was to say a prayer with her and even try to say some of it in the person’s language. The kitchen met people’s cultural needs such as arranging for Kosher and Halal food to be available.

People’s sexual orientation and personal relationships were respected and celebrated. The provider had arranged for marriage services to be carried out on-site for people as they were nearing the end of their life. One person wished to comment specifically on how they felt their same sex relationship had been regarded in an equal light by all staff at the service. They wished it to be known that from the moment they arrived, they appreciated that staff used the word “husband” rather than “partner” to refer to one or the other. They said, “From the moment we arrived here, we’ve felt like a part of a community.”

People’s privacy and dignity was promoted. People told us, “I need help to use the toilet and they help me in a way that I don’t feel degraded.” A relative of a person receiving care in the community stated, “[the staff member] is very respectful and courteous of my [family member].” Staff took measures to maintain people’s dignity such as closing curtains properly in wards where there was multiple people. Staff also discussed the heightened significance of being respectful towards others as their health deteriorated and they neared the end of their life.

The service was set up to promote people’s independence. A relative told us, “My [family member] won’t even try to walk at home and here? [They’ve] been out with the walking frame twice today already!” There was a ‘respite’ ward and a day hospice at the service. These services offered people the opportunity to “recharge their batteries” and support people to gain skills that would help them to look after themselves in the community. For example, people were supported to administer their own medicines

Is the service caring?

on the respite ward so that people did not lose these skills when they returned home. A family member was concerned that [their relative] was at risk of losing their

sense of independence and was pleased to be able to work with a physiotherapist to develop mobility exercises which might allow them to regain control over a few simple daily routines.

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People told us how they felt care was structured entirely around their needs. One person jokingly told us that they'd stopped calling the staff, "nurses" and started to call them all "my people who did things". People received holistic care that met their emotional and mental health needs. One person told us, "I couldn't say enough goodness about them. If they know you're feeling down they come and see you. They don't leave you." Another person explained how they hated to be on their own and staff made themselves aware of when she didn't have any visitors and "popped in for a chat". Family members were moved by how much thought had been put into making their loved ones comfortable and happy, sometimes in the most difficult of circumstances. One relative said, "My Dad is very ill now but that hasn't stopped the nurses from making sure that he is comfortable at every minute of the day".

There were a number of psycho-social services available to people such as, bereavement support, complimentary specialists and community engagement sessions and support groups. We noted that referrals to a psychiatrist had been made where people needed further support around their mental health. The service had implemented an initiative similar to a befriending model for people receiving care in the community, whereby volunteers visit people to provide wellbeing support.

People felt confident that changes in their health needs would be responded to by all staff. A person explained that on one occasion they'd had physical difficulty eating and that ever since, someone pops in a few times to check on her and help if necessary. "I like that someone is there to notice whether I can manage and help me on those days when I just can't." We found that people's care records were regularly updated with new information about people's changing needs to guide staff. Staff were aware of how to identify if someone's health was deteriorating and take quick and appropriate action.

Risks associated with isolation were minimised by the service. People were supported to have visitors as there was a visitor's room and children's play areas on the wards. During our inspection a person was visited by their dog, as important to them as any other visit. Prior to one person's admission to the service a member of the community

palliative care team visited them and their family members and explained that there were open visiting hours and that they could visit anytime. At the end of their first visit the provider arranged their travel home which was greatly appreciated.

One person whose family lived in another country explained how staff helped them to call them or to speak with them via the internet and have helped them to deal with visa applications on their behalf.

People's family and friends felt that the service not only wrapped support around the individual but also around all connected to them; "The ethos here seems to be that they look after the whole family, not just the patient."

People were supported to maintain hobbies and interests because staff were aware of their likes and dislikes and the service offered a range of activities. For example, a member of staff had suggested that somebody who had an interest in beauty and fashion had a pampering session. The person thoroughly enjoyed it and said, "a bit of pampering mends soul and body and makes you look fabulous whilst you're doing it". People using the on-site service and people from the community could join in with activities in the day hospice such as working with clay. One person told us, "It's like entering a different world. There is so much laughter here."

People and their relatives were supported to be involved in planning their care. Advanced planning about what is to happen at the end of someone's life is particularly important in a hospice setting. Where possible, people were fully involved in developing their care plans and were helped to explore and understand their own needs. Patients reported staff had instigated discussions where they had been able to describe what they wanted such as, how they would like their medicines to be delivered and how they'd like to be treated as their condition deteriorated. One person said, "I have a death plan written, it says who I want in the room with me."

People in the community discussed where they would like to be at the end of their life, such as at home or in the hospice and this was recorded in people's care records.

Staff discussed how they would take a multi-disciplinary approach to these discussions and felt supported by other health and social care professionals. For example, we saw

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evidence in a person's care records that a consultant had attended a community visit with a palliative care nurse to discuss a resuscitation decision to provide the person with all the information required to make an informed choice.

Relatives felt they were involved in care planning where it was appropriate. Staff told us, "I ask the family about people's wishes at the end of their life. They don't mind, they prefer you ask." Staff were dedicated to hearing the person's voice and spoke intelligently about being respectful towards relatives at a difficult time but would always adhere to the person's wishes, talking to them in private to plan aspects of their care when needed.

The provider gave opportunities for people to feedback about the service. People and relatives indicated that they felt able to raise concerns and had confidence they would be welcomed and dealt with appropriately. One relative

said, "They wouldn't be considered as complaints, rather as a way of making things even better." One person had experienced just this; They had been in pain and "had a bit of a rant". They said the member of staff continued to be concerned for their comfort throughout and stayed with them until she was feeling better and then sought to understand if there was anything they could learn from them about how they could do things differently for them in future. Staff explained they would escalate any concerns appropriately and treated all concerns seriously. One staff member said, "Sometimes people don't want to complain formally, but we advise they should."

We saw evidence that complaints were logged and dealt with appropriately and leaflets were given to people about how to make a complaint.

Is the service well-led?

Our findings

Team work and morale was not always well managed which posed a potential risk to the quality of care delivered. Although cover was provided, there were vacancies or people working their notices at different tiers of management, such as team leaders. This had meant that others had absorbed the work load. This included the registered manager whose areas of responsibility had become very large and wide-ranging. In addition to this, the service was going through a period of significant change. The provider was implementing new developments and initiatives, such as a new electronic care record system and a new model of working in the community. These were large areas of work adding to staff workload.

Staff reported there were pockets of tension between members. For example, one member of staff said, “I’ve seen staff stressed here [on St Michael’s ward]. There’s something between the team. On the second floor the staff work more as a team and are more relaxed. Here...they are tensed up. There’s an atmosphere.” Another member of staff said, “Overall, the majority are brilliant, there will always be a few that ruin it for everyone else. Not that many, not to patients but staff to staff. Just rudeness from senior to staff. But this place overall is fantastic.” A person using the service said, “Sometimes they disagree but they always find a way of just getting on with it.” Staff were not always provided with relevant guidance as records were out of date such as medicine policies and procedures.

The provider was in process of conducting annual appraisals; however, only about half had been carried out so not all staff had had the opportunity for feedback and reflection on the work carried out.

The registered manager was described as “open” and “visible” and there were systems in place to support staff. Staff received supervision that they reported was useful and there were ‘Schwartz rounds’ which staff found helpful. In brief, Schwartz rounds are meetings for staff to reflect on the emotional impact of palliative care work. Staff reported that they were supported to relax and use a form of meditation if necessary.

The provider facilitated effective staff communication methods which included informal conversations, supervision sessions, and team meetings and handovers. In the year previous, the provider had conducted an annual staff survey to gather anonymous feedback.

The service was organised in a way that promoted safe care through effective quality monitoring. The provider tailored a range of methods to gain feedback from people and their relatives so that they were appropriate in a hospice setting. These included online questionnaires, ward surveys and feedback cards. The provider developed reports and care based on the results. We observed surveys being conducted during our inspection and staff gave people enough time to express themselves. People were consulted about which new activities were to be introduced and the layout of the building as a whole. The provider held service user groups every two months where people could share their experiences.

Staff had some input into the direction of care. For example, steering groups had been developed which enabled staff to drive forward improvements in particular areas such as the ‘End of life care group’.

Incidents and accidents were well managed. Any such events were logged appropriately and monitored for trends. For example, falls and medicines errors. There was evidence that the service learnt from mistakes and developed action plans to increase the quality of care and to minimise the risk of re-occurrence. For example, medicine incidents were reviewed by a medication safety and improvement group which had developed an opioid patch monitoring chart to reduce errors.

The service carried out a range of audits and reported all benchmarking information to Hospice UK. The registered manager belonged to networks involving other providers and directors in the field to critique good practice in the sector and to use this learning to increase standards at the service.

We recommend the service seeks guidance and support from reputable sources to improve the culture amongst staff.