St Michael's Hospice Hastings and Rother

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

St Michael's Hospice Hastings and Rother is a local registered charity that provides palliative care to adults with advanced progressive life-limiting illnesses, both within the hospice and in the comfort of their homes. It aims to meet people's physical, emotional, social and spiritual needs. Services are free to people and St Michael's Hospice is largely dependent on donations and fund-raising by volunteers in the community to fund its operations.

The service includes a 26 bed In-Patient Unit (IPU) across three wards with 26 rooms with en-suite, a hospice at home service and clinical nurse specialist team, day services, a re-enablement and fitness service, chaplaincy and bereavement services. At the time of our inspection, there were 16 people staying in the IPU, and 61 people receiving regular support in their own homes. Another 118 people in the community were consulting the hospice's 'out of hours' service for advice and guidance.

This inspection was carried out on 13 January 2017 by three inspectors, one pharmacist inspector and an expert by experience. It was an unannounced inspection.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

There were sufficient care staff on duty, to support and care for people in the IPU, the day services and the hospice at home service. People and staff told us there were enough staff to care in the way people needed and at times they preferred. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place to ensure suitable staff were employed to care for people.

We have made a recommendation about improving some aspects of the arrangements for managing medicines. Although remedial action has been taken on the day of our inspection, the required improvements need to be embedded in practice and sustained over time.

There was an effective system in place to ensure people remained as safe as possible from the risk of acquiring an infection. Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to complete these promptly.

Staff understood how they should respond to a range of different emergencies. The hospice had worked closely with the East Sussex Fire and Rescue Service to ensure that robust fire risk assessments were in place and these were fully embedded in day to day practice.

People said they were very satisfied about the way staff gave them the care they needed. They told us, "I have never had such wonderful treatment; I get lots of attentive care and they have really good equipment."

Staff had appropriate training and experience to support people with their individual needs. Staff were well supported in their personal developmental. They received a thorough induction, one to one supervision, an annual appraisal and training suitable for their role.

Staff knew how to communicate with each person and understood their individual needs.
Consent was sought, obtained and recorded before any aspect of people's care and treatment was carried out.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Staff were trained in the principles of the MCA and the DoLS and were scheduled to attend further training. An appropriate template for mental capacity assessments was in use and staff knew how to consult the Local Authority if they were in any doubt about people's mental capacity, in the service and in the community.

Staff protected people effectively from the risks of poor nutrition, dehydration, swallowing problems and other medical conditions that affected their health. People told us, "The food is marvellous."

People were referred and signposted to appropriate services without delay in order to respond quickly to their healthcare needs. When necessary they were referred to healthcare professionals whose recommendations were acted on.

The premises had been rebuilt in part, renovated and adapted to meet people's needs effectively. They were well designed, welcoming, well maintained and suited people's needs.

People were proactively supported to express their views and staff were skilled at giving people face to face information and explanations they needed and the time to make decisions. Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. The service provided emotional support for families that was continual, beyond the provision of care for people.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. People's care and support was planned in partnership with them. People took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in 'advance care plans'. Their views, wishes and plans were respected.

A wide range of activities was provided to stimulate people's interests and creativity.

People were actively encouraged to give their views and raise concerns or complaints. Complaints were addressed promptly and followed up with an action plan when necessary in order to drive improvement. There was an open and positive culture which focussed on people.

There was a system in place to maintain and monitor the quality of the service across all departments,

which was effective in driving continuous improvement. When needs for improvement were identified, remedial action was taken to improve the quality of the service and care. The audit system was not fully effective in identifying shortfalls and this was intended to be improved. Several policies needed to be reviewed and updated, and a need had been identified for the introduction of additional policies and procedures; the head of clinical services told us this was intended to be remedied and showed us their improvement plan which was underway.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely. There was a robust system in place to monitor accidents and incidents.

Robust and safe recruitment procedures were followed in practice.

We have made a recommendation about the arrangements for managing medicines.

Is the service effective?

Good

The service was effective.

Staff had appropriate training and experience to support people with their individual needs. Staff were well supported in their developmental needs by the service. Staff were trained in the principles of the MCA and the DoLS and were scheduled to attend further training.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink. People's feedback about the food was very positive and complimentary.

People were referred to healthcare professionals and other services promptly when needed.

Is the service caring?

Good

The service was very caring.

People valued their relationship with staff and gave very positive feedback about the caring approach of the service and staff.

Their feedback included, "The care is excellent and professional", "They are angels." A member of staff told us, "This isn't a job – it's a community."

Staff approach towards people was kind, patient and respectful. People's dignity and privacy was respected. People were supported to express their views and staff were skilled at giving people face to face information and explanations they needed.

Clear and comprehensive information about the facilities and the services on offer was provided to people, relatives and visitors.

The service provided emotional support to people and their families, that was continual.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People were placed at the heart of the service and were fully involved in the planning of their care, treatment and support. People's care was personalised to reflect their wishes and what was important to them.

A wide range of activities was provided that stimulated people's interests, enabling them to continue with their hobbies, create new ones and learn new skills.

People were actively encouraged to express their views and their feedback was sought and acted on.

People were enabled to experience a comfortable, dignified and pain-free death.

Complaints were addressed promptly and used to drive improvements in the service.

Is the service well-led?

Good

The service was well-led.

The service was led by a provider, a leadership team and a management team who placed people and staff at the heart of the service. When needs for improvement were identified, remedial action was taken to improve the quality of the service and care. Improvement plans were underway in regard to several aspects of the service.

People's feedback about how the service was run included, "Absolutely wonderful environment, well organised and managed, the best place to be."

Staff felt valued and supported by the service.

The service took a key role in the community. Current links were maintained through a series of trading shops and fundraising events. A person who volunteered in the hospice told us, "St Michael's hospice is the heart of the community."

St Michael's Hospice Hastings and Rother

Detailed findings

Background to this inspection

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

This inspection was carried out on 13 January 2017 by three inspectors, one pharmacist inspector 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. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people who approached the end of their lives.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. We also received a Provider Information Return (PIR) which the registered manager had completed prior to our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We looked at the premises and equipment. We looked at 12 sets of records that related to people's care and examined three people's medicines charts. We looked at people's assessments of needs and care plans and checked that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff recruitment, training and management, and records relevant to the storage, ordering and administration of medicines. We observed the administration of medicines. We looked at checks that were carried out in relation to the safety and quality of the service. We sampled the services' policies and procedures.

We spoke with four people who stayed in the In-Patient Unit (IPU), six of their relatives, two visitors and three volunteers. We also spoke with relatives of four people who received support from the community palliative

care service and the hospice at home service in the community.

We spoke with the provider's chief executive officer, the registered manager (who is also the community services manager), the head of clinical services, a hospice at home team leader, the day services manager, the education manager, the human resources manager, the counselling services manager, a matron who oversaw the IPU, three nurses, and five care workers.

We also spoke with two district nurses who oversaw people's care in the community, and a home manager whose service was supported by the hospice at home team. We obtained their feedback about their experience of the service.

Good

Is the service safe?

Our findings

People in the In-patient Unit (IPU) told us they felt safe living in the service. They said, "II feel safe for myself and my family because all the staff are welcoming, attentive and so helpful", "I feel safe because if I wake up in the middle of the night and ring the bell, they come at once" and, "They have special handrails in the corridors and nice surfaces so you don't fall; it is very safe and they are keen on fire drills." A relative told us, "There are always enough staff on duty; there is someone there when you feel low." A person who was supported by the hospice at home team told us, "They ring up and check everything."

The safeguarding policy reflected the guidance provided by the local authority and had been updated to reflect the Care Act 2014 and changes in legislation. It was clear and provided staff with guidance concerning the roles and responsibilities for staff members of all levels of seniority. Staff we spoke with were knowledgeable concerning how to identify abuse and potential abuse and they were clear about the need to take steps to report any concerns they may have.

Staff training records confirmed that training in the safeguarding of adults was part of the induction for all members of staff. This was complemented by annual training and refresher courses which were up to date. Staff told us about their knowledge of the procedures for reporting any concerns, which included contacting local safeguarding authorities and knowledge of the whistle blowing policy.

There were sufficient numbers of staff on shift to meet the needs of people at the service. Staff confirmed that additional staffing was available when it was identified that there was a particular need. The registered manager adjusted the staffing levels according to people's needs and made sure enough staff were deployed throughout all areas. Staff reported they were always able to have additional support if required. One nurse told us 'We can flex up' in order to meet patients' needs. Another nurse told us "There's always someone there for the patients." There was an established team of bank nurses who had worked at the hospice over a number of years ready to step in to provide cover as and when required. Each ward that was open had two qualified nurses on shift; two health care assistants on shift in the mornings, and two nurses and one health care assistant in the afternoons. There would be one or two qualified nurses on shift overnight depending on the needs of people at the time.

We looked at the arrangements for managing medicines (including obtaining, prescribing, recording, handling, storing, and disposing) and found that some improvements were required, although there had not been a negative impact on people . A medicines policy was in place and was signed by staff indicating that they had read and understood the processes. Medicines were managed and administered to people by registered nurses. We saw some competency assessments of nurses to calculate doses of medicines and we were told that nurses received training updates every six months, including training on medicines and use of syringe drivers (a device used to administer medicines slowly). Although nurses confirmed they received regular training, there were no training records available to verify this.

People's own medicines were recorded on admission. However, there was no clear process on how these medicines were assessed as being suitable for use. The quantities that people brought into the hospice and

were discharged with were not recorded; this meant that there was no clear audit trail to check that people received their medicines as prescribed.

Controlled drugs (CD) were stored securely and CD records were kept according to legislation. However, some high strength injectable medicines were not segregated in the cabinet. National guidance recommends segregation of high strength injections from lower strengths to avoid incorrect selection and to reduce any risk to patients. In-house doctors prescribed medicines for people admitted to the hospice. We looked at drugs charts and found one person's chart, for medicines to be administered when required, did not include maximum daily doses. This meant that nurses could potentially administer doses that could exceed safe levels, although this had not happened. All medicines charts included details of patients' allergies, there were no missed doses and all prescribed items were signed and dated by the prescriber. A community pharmacy provided a weekly 'top-up' service for stock medicines. These were delivered to the hospice and checked in by the nurse. The hospice held regular medicines management meetings, attended by the pharmacist. The pharmacist had conducted a recent audit of medicines management and we saw that actions had been taken by hospice staff in response to their findings.

We discussed the shortfalls regarding the management of medicines that we identified with the head of clinical services who took immediate action on the day to address these. We recommend that the provider ensures these improvements are embedded in day to day practice and sustained over time.

Some training for healthcare assistants (HCAs) was being planned, to enable them to assist in the administration of medicines and we saw evidence that there had been a consultation with staff about the training and this was ready to be rolled out. Peoples' own medicines and stock medicines, including emergency medicines and oxygen, were stored safely. Stock medicines were within their expiry date and opened liquid medicines were all labelled with the date of opening. Medicines requiring refrigeration were monitored appropriately. Unwanted medicines were disposed of in line with waste regulations.

Medicine charts and blank prescriptions (FP10s) were stored securely and there was a system in place to track prescriptions to the prescriber which prevents any misuse of prescriptions. Medicines errors and near misses (errors that are identified before the medicine reaches the patient) were reported by staff. There was evidence that errors were investigated and discussed at team meetings. The hospice provided care for people in their own homes and through a day care service. There were appropriate arrangements in place for administration or self-administration of medicines.

Safe recruitment procedures were followed to ensure that staff were suitable to work at the hospice. There was a detailed recruitment and selection policy in place that provided clear guidance concerning the process for employing new staff in order to ensure that they were suitable for the role. Disclosure and Barring Service (DBS) checks had been completed before staff started working. These checks also applied to volunteers and therapists. 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 employers. Regular checks of staff professional registration were carried out to ensure had not expired. Staff had provided evidence to confirm their qualifications and training.

There were policies in place relating to diversity and equality and dignity at work. They provided guidance concerning how issues would be resolved and how staff would be protected from harassment or unfair treatment at work.

Disciplinary procedures were in place to ensure staff practice was safe. Although there was no current

disciplinary action being taken against staff, a manager we spoke with was able to give an example of how the disciplinary procedure had been used in the past to address issues. There was a detailed process in place to manage staff performance issues. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual. These included clear control measures that would reduce any identified hazard and were completed as part of the admission process. Risks were identified as 'problems' in the computerised system that was used for care planning. A person's problem was, 'Suffering with nausea and/or vomiting'. Twelve control measures to minimise the risks and ensure the goals were achieved were listed in a care plan dedicated to 'Nausea and vomiting' which contained instructions for staff about the medicine to use, and how to relieve the person's discomfort with specific steps that were tailored to the person's needs and preferences. Staff were aware of the risks that related to each person.

When people were at risk of a fall, staff were made aware of this through the use of an oak leaf symbol on their door. It was identified during the admission process that one person was at risk of falls. Their risk assessment included actions to be taken by staff to reduce the risk such as ensuring they had had their glasses nearby and that they were wearing appropriate footwear. Pictures of forget-me-not flowers on doors were used to signify that the patient may be experiencing confusion. This meant that they were arrangements in place to help protect people from harm because staff were made aware of the individual risks people faced.

Risk assessments in regard to the environment were carried out with advice from the health and safety advisor as appropriate. The hospice had worked closely with the East Sussex Fire and Rescue Service to ensure that robust fire risk assessments were in place and these were fully embedded. The fire safety officer had spoken with staff as part of their visit in November 2016 to ensure that they had appropriate knowledge of what was expected of them in the event of a fire.

There was detailed information available to guide staff concerning how to evacuate the building if this was necessary. This included personal emergency evacuation plans and general emergency evacuation plans. Suitable equipment was available to assist with evacuating people in an emergency such as an evacuation chair. Fire safety equipment that included smoke and heat detection, fire alarm, fire blankets, and fire extinguishers were routinely checked. Staff completed fire drills and additional training on fire safety had been put in place as part of the 'welcome home' training that staff had completed when they moved back into the building, following on from refurbishment after a fire at the service.

There was a robust system in place to monitor accidents and incidents. An analysis of trends was carried out to ensure that where possible actions were taken to reduce the number of accidents and incidents. Accidents and incidents were discussed in management meetings to ensure that actions would be taken forward where it was identified that it may be possible to take preventative measures. It was noted in minutes from the Board of Trustees meeting in July 2016 that incidents relating to security had not been problematic since the introduction of a fob entry system. This showed that the hospice was addressing issues and putting systems in place to lessen incidents.

There was an effective system in place to ensure people remained as safe as possible from the risk of acquiring an infection. Staff were trained in infection control and were aware of who the infection control lead was, should they need further advice. There were robust infection control policies in place that included cleaning, staff protection and the management of infectious diseases. Audits were carried out in relation to infection control in order to identify any areas where steps needed to be taken to protect patients

from the risk of infection.

The premises were cleaned to a high standard and records were kept to evidence frequent cleaning throughout the day. Staff who worked within the housekeeping team took pride in their work and it was evident that they were a valued part of the hospice staff team. A member of the housekeeping team told us "We're hot on infection control" and they were able to describe in detail the steps that would be taken to protect patients if there was an outbreak of infection. There was an appropriate supply of personal protective equipment such as gloves and aprons and we observed that staff used this equipment as and when required.

Staff washed their hands appropriately, and guidance about hand washing was on display throughout the service. Alcohol gel was available outside every room and used by staff and visitors. Systems in place for the segregation of laundry and the management of waste were implemented appropriately. These measures helped protect people and reduced the risks of acquiring an infection while in the service.

The service was in the process of developing an appropriate business contingency plan that addressed possible emergencies such as fire, power outage, IT failure, data loss, building security breach, pandemic and infection in clinical areas. This included clear guidance for staff to follow. The development of the plan was being led by the provider's chief executive with appropriate input from a number of other professionals to ensure that the plan was robust and effective. The hospice maintained a 'what if' folder that provided staff with information concerning how to manage in case of an emergency.

Equipment in the hospice such as hoists and lifts were newly commissioned and had yet to be serviced but schedules were in place to ensure that they would be serviced at appropriate intervals. There was a maintenance team in place at the hospice who attended to repairs. Requests were logged and we saw that repairs were completed in a timely manner. There was a health and safety advisor who worked to ensure that the environment was safe and checks were made regularly.

Good

Is the service effective?

Our findings

People said they were very satisfied about the way staff gave them the care they needed. They told us, "The staff are very accommodating and tell me to move every day because they know I need to keep myself mobile", "They [staff] know what they are doing, they are extremely professional in everything they do" and, "The staff are so kind and considerate they can anticipate what you want and provide it before you know what you want yourself." The people, visitors and volunteers we spoke with told us the food was "Excellent", "So good", and "Superb."

There was an effective system in place to ensure people received care and support as soon as possible. The hospice at home team received referrals from GPs, district nurses, community staff nurses, clinical specialist nurses at hospitals and other health care professionals. The team leader made contact with referred people the same day, to discuss their expectations and ascertain whether they would like a visit at their home. The hospice at home team provided 24 hour service including a night sitting service. Following a visit, all information was inputted in a computerised system and a support plan was formulated. When people received care from district nurses, care workers liaised closely with them to ensure they complemented this to benefit people. Effective support was provided by the service to residential homes staff. The team leader told us, "We have a current case load of 17 people in residential homes and 61 in nursing homes who we also support; we set up syringe drivers and loan equipment." A home manager whose service was supported by the hospice at home team told us, "They are marvellous, always available to come at short notice and giving precious advice."

Staff were well supported in their developmental needs by the service. A robust induction programme was completed by newly recruited staff within six months. Workbooks were given to all new clinical staff, and care workers had a separate workbook based on the care certificate standards. These were appropriately monitored until completion. New staff members had a three and a six month probation review. Staff received monthly one to one supervision sessions with their line manager and were scheduled to undertake an annual appraisal of their performance. Staff in the IPU reported that they felt well supported by the matron. They felt that the matron offered them practical support and would cover the wards as and when required.

Staff received appropriate training. We viewed the training matrix that indicated a wide range of training was available to all staff such as safeguarding adults, Deprivation of Liberty Safeguards (DoLS) and food hygiene. In addition there were supplementary training courses for staff such as fire marshal training, venepuncture (obtaining intravenous access for the purpose of intravenous therapy or for blood sampling), and clinical audit training. The training team managed all training for hospice staff and also palliative training for the community team. There was a service level agreement with a local university, the local authority and Health Education England. All staff were offered grief and loss training and all clinical staff were expected to attend this training which was run by the counselling services manager. The hospice was running at approximately 85% completion rate for all staff having completed all allocated training in the financial year. A care worker told us, "The training is very thorough; we are well supported with a strong training programme".

Staff were able to apply for additional specific training. We saw an example of a request where an occupational therapist had requested and been granted a place at a rehabilitative palliative care conference. Another staff member from the hospice's lottery team had requested and attended dementia awareness training and two doctors had been booked to attend a specialist course on supporting children with the death of a significant adult. The medical director had been booked to attend the Royal College of Physicians end of life care update conference.

Volunteers in the hospice neighbours service received end of life care, health and safety, safeguarding and equality and diversity training. The voluntary services manager delivered the training. The education manager set up the programme and gave the learning materials for the training to be delivered at a level appropriate for volunteers.

The hospice used a specialist software system to allow them to track staff training needs. Care workers attended a day and a half training programme on medicines and end of life care skills. There was a signing sheet for each training course and the names from the signing sheet were entered in a computerised database. This enabled the training manager to check which staff member had outstanding training. Staff we spoke with told us that they received e-mail reminders whenever they had a development need.

External providers were used for certain training courses such as fire marshal training, basic life support skills and moving and handling. There were competency and awareness trainings, for example syringe driver training was delivered by the manufacturer who assessed people's competency. In-house training was underpinned by the 'Skills For Health Care Skills Training Framework'. The education manager told us, "We look at this for content and it makes specific recommendations for competencies of the trainer: this is why we moved the moving and handling training to an out of house trainer." The hospice used the local authority for their safeguarding adults training.

Following a fire in July 2015, the service had offered and provided additional support for staff. Additional supervision had been made available to staff who had been affected by the fire and its aftermath. The education department had set training for all staff to attend a special one day training on health and safety to cover all safety aspects prior to them coming back in to the building. Staff had to complete workbooks and display their understanding of key areas around health and safety, infection control, hazard spotting, fire safety and evacuation. There were infection control leads and learning disability champions that staff could consult. The education manager told us they were developing fire evacuation champions.

The education department arranged a clinical drop in session to provide an opportunity for learning needs. For example a doctor had delivered training on pacemakers; a locum consultant had held a session on a synthetic opiate used as substitute for heroin in the treatment of heroin addiction, to reflect changes in its use. The nurse educators or doctors identified either an observed trend in people (such as an increase of a certain condition) or a need in the clinical staff training and submitted a training plan.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and 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.

Consent was sought, obtained and recorded when appropriate before any aspect of people's care and treatment was carried out. When people declined, this was respected and documented. A person had chosen not to be woken up in the mornings and this was respected. A relative told us, "All the staff listen to the patients and they always ask for consent, they wouldn't dream not to." Sixty one out of 92 staff had completed scheduled training in mental capacity and DoLS and 31 people had been scheduled for training courses before end of March 2017. The head of clinical services had updated the service's policy in mental capacity to reflect a clear process of assessment and of decisions to be made in people's best interests. They told us staff awareness of how to apply the processes in practice will be included in the training scheduled in April 2017. In the meantime, an appropriate template for mental capacity assessments was in use and staff knew how to consult the local authority if they were in any doubt about people's mental capacity, in the service and in the community. No one was subject to a DoLS authorisation at the time of our inspection.

The head chef showed us menus that were planned on a six week cycle. They were varied, well-balanced and offered multiple choice. Alternatives were available such as baked potatoes, omelettes, salads, soups, sandwiches. In the afternoon people were asked what they wanted for the following day on menu cards. The menu cards were collated and checked by the nurses on each ward who completed a food order sheet stating whether people were diabetic or on a soft or pureed diet. The nurses also indicated if people needed smaller or larger portions than normal. Dietary requirements and allergies were recorded clearly on the menu cards and the chef was aware of people's dietary requirements. They told us that they often fortified people's food with fresh cream and butter in order to get as many calories as possible into people who were receiving palliative care. When the kitchen staff prepared food they had the menu cards on a shelf and placed the person's plate on top of the card and then plated up the specified food. The plates were then placed on hot trollies and taken to the wards. This effective system ensured that people's dietary requirements and preferences were accurately met.

Should people fancy a dish that did not feature on the menu, this was provided. One person said they could not eat 'wraps' so these were taken off the menu for that person. A hot breakfast was offered every day with a choice of all the usual full English variants such as bacon, sausage, eggs and toast. The chef attended a quarterly nutritional focus group where kitchen staff, clinicians, and people met up and could state their likes/dislikes. People told us, "The food is marvellous."

A locum physiotherapist who provided treatment for people told us, "Food for patients is very good and we can order it. There's a set menu that rotates and it's really good. I've never been in a room where there's not a drink on people's tables; there's always normally two or three drinks; I make sure people drink after therapy and I've never had to go and get a drink." Volunteers helped to make drinks for people and their visitors.

People were referred to health care professionals when necessary and their advice was sought and acted on. Staff enabled people to access a physiotherapist, social workers, the Sara Lee Trust (an independent charity organisation based in the hospice that provided complementary therapies and counselling), and were referred appropriately to doctors, MacMillan nurses, and specialist nurses. One district nurse told us, "All the staff seem to be very knowledgeable and compassionate, they refer quickly when needed, they are very professional and they follow our recommendations."

The premises had been adapted to meet people's needs effectively. Extensive refurbishment of the premises had taken place and some renovation and restoring works were still in progress. There was a large and welcoming reception area as people entered the building. Within the ground floor there were facilities for day services and four counselling suites as well as a chapel and a multi-faith room. There was a main kitchen as well as a smaller kitchen area that people could use to prepare drinks. People could spend time

in a chapel that was welcoming and equipped with handrails to help people move around. There was a doctors' office and a nurse's station. There were 11 en-suite bedrooms on the ground floor as well as additional bathrooms and storage space. On the first floor there were 15 en-suite bedrooms as well as a family room, guest bedroom and facilities for cleaning, and staff facilities such as a shower room. All bedrooms were equipped with a telephone, a nurse call system, a television, a wardrobe secured to the wall, a refrigerator and a safe. A staff rest room was located on the second floor. Administration services such as human resources and education and training services were located on the second and third floor. The hospice was in the process of developing a gym area that would be used as part of a re-enablement programme. There was attractive artwork on display throughout the hospice. The hospice grounds were attractive and welcoming, providing people and their visitors with private areas. A palliative care library of books and journals was accessed by all staff and bereavement volunteers.

Good

Is the service caring?

Our findings

All the people we spoke with, their relatives, visitors and health care professionals told us how they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were very positive in regard to all staff across the service. People told us, "Yesterday they [staff] gave me a bath and washed my hair; they didn't do it because they have to but because they care", "No one ever rushes you", "They [staff] are very considerate in the way they give the care; my partner does not want any information about his condition but my daughter worries and wants to know everything; they explained everything, in private, to us" and, "I am always treated with dignity and respect because they speak to you and not at you." A person told us, "The care is excellent and professional because they don't invade your space and yet you do not feel isolated." A person who received support in the community told us, "They are angels." A member of staff told us, "This isn't a job – it's a community."

Staff told us and we observed that there was a calm atmosphere on the wards and we saw positive interactions between staff and patients throughout the day of our inspection. Staff were smiling and engaging; they stopped to listen to people and responded to them with apparent genuine interest. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they conversed with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully. One nurse we spoke with told us "It's like we sprinkle fairy dust on them – we make them feel calm and relaxed."

Staff used appropriate touch when needed such as gently stroking a person's arm while they experienced some discomfort. They always checked to assess whether such gestures of empathy were welcomed by people. They offered companionship to people who stayed in their bedrooms when they considered that people may not wish to be on their own. The staff responded quickly to people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected, updated in their care plans, and staff communicated the updates to each other.

People were supported to express their views and staff were skilled at giving people face to face information and explanations they needed and the time to make decisions. One person told us, "They are very straight-talking, when I wanted clear explanations they gave it the way I wanted them to, although they had to repeat them quite a few times before all could sink in, they are very understanding and patient." With such an approach people could be confident that they could be fully informed to make any decisions.

People's preferred names were displayed on the doors to their rooms so that staff were aware of how they would like to be addressed. Each department in the service provided a wealth of information to describe what they could provide for people. The IPU offered a leaflet that included explanations about the admission process; day services offered a leaflet that detailed opening hours, their team and the activities available; the hospice neighbours services, a leaflet about how volunteers could help people in their own homes. The bereavement services provided an information pack that included brochures and leaflets about 'When someone has died: what you need to do and who can help' and, 'Your Bereavement -Living through it' that acknowledged people's feelings and emotions and signposted to other external services. In that

information pack, the service acknowledged how distressing unsolicited mail could be to people while they were bereaved and signposted them to a specialised website. This enabled people to ensure their information would be secure and not disclosed to mailing organisations they did not wish to subscribe to.

A comprehensive booklet titled, 'Patient and Family Information Handbook' presented a summary of this information, such as, what to expect when staying in the hospice, the menus and meal times; how to identify staff by their uniform; individual hospice services; the facilities and activities they could partake in. The hospice website was comprehensive, regularly updated and easy to navigate. It contained testimonies and four videos that showcased the hospice and provided an insight into the variety of services available. The service produced a monthly information bulletin that provided people and staff with updates about the renovation of the premises, social events, volunteers' news, actions taken by the board of trustees, and outcomes resulting from recent senior management team meetings.

People's individual communication needs were met by staff who understood them. Communication difficulties were explained in people's care plans. A person's difficulty had been identified as, 'Unable to communicate effectively due to..' and the associated goal to attain was, 'For [X] to feel that they are understood both physically and psychologically.' The recommendations to ensure the goals were achieved were listed in a communication care plan, such as, 'using special adaptations' and, 'Look for non-verbal signs of distress or happiness, to aid communication.' A relative told us, "The staff know how to talk to my husband; they know they have to lift his spirits before he gets a shower in the morning; they get him to laugh which is so lovely to hear."

People who were supported in their homes told us how they valued their relationships with the staff team, describing the staff as, "Caring", "Respectful" and, "Brilliant." One relative told us, "My dad didn't want anyone to help but after only one week he really appreciated the difference that good and kind carers from the hospice could make; he sees the same regular faces which helps a lot; he has grown to be quite fond of them and I am sure they are also very fond of him, they even take care of his dog when they come because they know it matters to him." As a result of this attentive approach from staff members, people felt genuinely cared for and that they mattered.

The relationships between staff and people receiving support consistently demonstrated that people's dignity was upheld. A relative told us, "They [staff] understand how hard it is when you can't remain dignified, they are very respectful." In the IPU, bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. Staff knocked gently on people's bedroom doors, and waited before entering to respect their privacy.

Visitors were welcome at any time in the service although were requested to abstain for two hours in the day so people could have a rest period. A relative told us, "They make an exception if my husband wants me to stay of course." Pets and children were welcome at the discretion of the senior nurse and there was no limit to the number of visitors at any one time. There were facilities available within the hospice so that family members could stay with their relative during their final days and hours.

The service took account of people's cultural, religious and linguistic needs. Services for people of all faith or none took place in the hospice's chapel. The day services manager told us how 'culture days' were organised where people could show their traditional dress and food.

The provider ensured that bereavement support was provided to people and their families according to their individual needs. The head of clinical services told us, "Our bereavement service is offered to all residents of Hastings and Rother regardless as to whether the patient was known to the hospice or not."

Staff referred people to an external Trust situated on the premises for pre-bereavement needs and the service provided post-bereavement counselling for families in the service and in the community. Children and young people up to 18 years of age were referred to an external organisation for pre and post bereavement services.

The counselling services manager told us, "We provide one to one counselling sessions; social support in the way of a monthly group meeting; 'walks and talks' which are monthly walks in a local park where people can meet and share their experiences with each other while walking." The counselling services team included 30 trained volunteers who received regular one to one supervision. The counselling services manager was a qualified psychotherapist who supported people with more complex needs.

The option of a quarterly 'Bereavement Therapeutic Group' over an eight week programme was offered to people who preferred a self-help environment as an alternative to one to one support. On-going bereavement support was tailored to individual needs and could be extended to respond to people's needs. Therefore the service provided emotional support for families that was continual, beyond the provision of care for people.

Good

Is the service responsive?

Our findings

All the people, their relatives and visitors we spoke with described in positive terms the way staff responded to people's needs. People told us, "Nothing is too much trouble; they do everything that is needed and more; you wouldn't get that treatment anywhere else" and, "I have never had such wonderful treatment; I get lots of attentive care and they have really good equipment." People were invited to input their comments in a social media site and we noted recent comments were also very positive, including, "Thank you for all the work you do to help and support everyone suffering the savage effects of Cancer."

People were able to self-refer to the service or via their GP and their needs were assessed as soon as they came into the IPU for supported care or a longer stay. Newly referred people met with a member of the clinical team so that their individual needs could be understood. In the community, when people's needs were urgent, the team made contact with them the same day and visited them as soon as possible to make sure people could be helped without delay. People were referred and signposted to appropriate services in order to respond quickly to their needs, such as the counselling services, day services, the volunteers' services or external organisations.

People underwent a holistic assessment that took account of their social history, physiological history, psychological and spiritual needs, any pain they may experience, food and dietary needs, and wishes regarding advance care planning. These assessments informed a comprehensive care plan and a management plan was written by doctors upon admission, in regard to their health care needs or symptoms. Additional care plans were written when necessary, such as a fall care plan, a wound care plan, or an anxiety care plan. A nurse told us, "Our patients have a multitude of conditions and we have to treat each as an individual. For example, some people with complicated wound care have special plans tailored to their needs."

People were given support when making decisions about their care and treatment and were fully involved with all relevant planning, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in 'advance care plans'. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they wished to be their legal representative.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Staff remained with people when they approached the end of their life, if this is what the person wanted. A member of staff told us, "We find out what the person wants, many have families with them, and a few may not; we get to know exactly what they want and we document this." Therefore people's needs in the last hours of their life were met by well-informed staff who were knowledgeable about people's individual needs. Staff anticipated how people felt when planning their care and support. A team leader told us how they sat with people in their home, enabling them to spend as much time as they needed, encouraging them to ask

questions, discuss their options and reflect upon them. As people and staff worked as a team to ensure each care plan was unique and responded to specific needs, people felt valued and understood.

People's care plans were personalised to reflect what they liked, disliked and the way they preferred to be cared for or supported. For example, care plans included a person's wishes to have their pillows arranged in a certain way; a person's wish to bathe several times a day; another person's wish to wear day or night clothes; people's preferred food such as porridge or noodles with a particular sauce. A person's care plan instructed staff to liaise with the medical team daily so that regular medicines could be reviewed to match the frequency and changing levels of their needs. In the community, the hospice at home team liaised closely with GPs and district nurses and followed up to check that new medicines had relieved people's symptoms to relieve their discomfort.

The head of clinical services informed us, "The IPU model is slightly different in that we offer Continuing Health Care and Continuing Specialist Palliative Care beds which mean some patients stay under our in-patient care for longer than is the case in many hospices. We believe this allows our services to be highly compassionate and highly responsive to patient needs."

Staff responded in a pro-active way to people when specific issues arose. For example, when a person who was unwell in the IPU had wished to attend their child's funerals, staff had explored ways of making this possible and had enabled the person to attend through a video call. Staff had also requested a vicar to visit the person and had spent time with the person to enable them to express their grief. Because staff members' approach was responsive to people's needs, people could be confident that staff understood what was important to them.

The day services team included a manager, a trained activities coordinator, a nurse, two care workers, and one support worker. The services were supported by 60 volunteers selected for their appropriate and relevant skills. At times, occupational therapy students came to the day services to support the team and complement their studies. The day services provided activities and outings to approximately 60 people. People were invited for a tester day, during which they underwent a full medical assessment by a nurse to ensure their medical needs could be met during suitable activities.

Activities were provided in people's preferred places, such as in the IPU, in the day services area, in their own homes, a social club or a café. The manager told us, "We find out what each person wants to achieve here, whether they may prefer working in small or larger groups, or in one to one; we have not had a request yet that we have not been able to fill." When a person had wished to produce art work with paint, pastels and clay, an art therapist had been contracted. The activities coordinator had helped a person practice calligraphy in their home at their request.

Every month, people participated in an activities survey and the results informed the next schedule of activities. These had included memory work, advance care planning, photography works and the creation of an audio photo album. People were supported to continue the pursuit of their hobbies and provided with suitable equipment to enable them to do so. For example, tables and easels that could be raised or lowered, or adapted paint brushes. A person with a neurological condition who had restricted hand movement had been equipped with a 'mouse paint brush' to enable them to paint via a computer. People were invited to access an external organisation located on the premises that offered complementary therapies such as massages, aromatherapy and acupuncture. People were encouraged to acquire new skills. A person learned how to operate a computer and 'skyped' their children who lived abroad; a person had learned to do quilting; another to create wooden toys, models and a doll house for their grandchildren; another had made a handbag. Staff in the Day Services including the re-enablement and fitness service logged people's

progress in the computerised system that was shared by care and medical staff. This ensured that vital information about people's wellbeing, interests and achievements could be shared for their benefit.

Interactive entertainment was provided in the day services such as music and dance therapy. Trips had been organised for people to see a pantomime, a theatre play, visit open gardens and enjoy meals out in restaurants and cafés. Window boxes had been purchased for people who had left their home and gardens when their circumstances had changed, to enable them to continue gardening. The day services manager described how, "Usually there will be a furry pet visiting the hospice every day, we check their temperament and assess any risks, and if appropriate we ask people in the IPU if they would like to see them and if so we take the pets to the wards." Events were organised for people to enjoy, such as Easter fair, a Halloween party, Christmas fair and a strawberry fair.

Feedback was obtained from people, relatives, visitors, health care professionals and staff. Satisfaction surveys were regularly carried out in the IPU, in the day services, sent to people who received support from the hospice at home team, to referrers and to people who had lost their loved ones four months hence. The results were analysed to inform the management team of any improvements that needed to be made. People, visitors and staff used 'suggestion books' that were displayed in the hospice. As a result of a suggestion, a coffee machine had been purchased for the reception area. People were actively encouraged to give their views and raise concerns or complaints. Complaints and commendations were analysed twice yearly by the provider's chief executive who presented a report to the board of trustees. Complaints were addressed promptly according to the service's policy and to a satisfactory outcome. A person told us, "If there were any problems I would tell the sister, doctor or matron, I know they'd sort it out for me."

Good

Is the service well-led?

Our findings

St Michael's hospice is a well-established hospice which is embedded in the community it serves. There was an open and positive culture which focussed on people and placed them at the heart of the service. Comments that people had sent to the service included, "I believe you have the service spot on", "Absolutely brilliant; the hard work and dedication of all involved to achieve all this and have staff and patients back in 14 months is outstanding", " I cannot suggest any way in which your service could be improved", "Great care; nothing too much trouble; great understanding of patients' needs" and, "Absolutely wonderful environment, well organised and managed, the best place to be."

The senior management team was well structured. A board of ten trustees (the provider) and the Chief Executive Officer (CEO) ensured the responsibility for the overall running of the service. For support services, the CEO oversaw the head of fundraising, the head of marketing, the head of voluntary services, the head of human resource and education and the head of finances and IT. Each head managed their department. For clinical services, the CEO oversaw the medical team and the head of clinical services. The registered manager for the service was also the community services manager. A new head of clinical services had started in their post nine days before our inspection and has, since our inspection, applied to become the new registered manager. The registered manager intended to concentrate on the development of the community services and become de-registered as the manager of the service. The registered manager and the head of clinical services worked in close collaboration to ensure a smooth transition and continuity of service. The head of clinical services oversaw the IPU, the day services, the community services, the counselling services, the spiritual care lead and the business support coordinator.

The senior management team met regularly to discuss the running of the service and a series of meetings took place across all departments. These meetings were appropriately minuted. Clinical services managers met every six weeks; the CEO met with the board of trustees and with all managers monthly, as well as with the HR and education manager and supervisors. The matron met ward staff bi-monthly. An overarching clinical governance committee, chaired by the head of clinical services, was scheduled to meet ten times a year, bringing together all heads of services, a trustee representative, an external quality manager and a staff representative. A medical management meeting was held every two months that included clinical managers, the medical team, the pharmacist and staff representatives. Each clinical manager met with their staff regularly, and quarterly staff forums took place to gather staff views and suggestions.

Staff were actively consulted about the running of the service. Staff told us that morale was good and they felt that their ideas were listened to when they made suggestions. They had been thoroughly consulted about the renovation and design of the premises. For example, they had suggested a toilet facility for relatives to be included on the first floor, and this had been taken into account in design changes. Staff were optimistic and positive about working with the new head of clinical services. They told us the head had impressed them with their willingness to engage "With what happens at ward level."

There was a system in place to maintain and monitor the quality of the service. Several needs for improvements in the service had been identified and these were being implemented. For example, ad-hoc

audits were completed in infection control, pressure ulcers, care documentation, and medicines. When shortfalls were identified, remedial action was taken as a result. The head of clinical services had plans to formalise the auditing system to render it more effective, and to reinstate a clinical audit and research group to scrutinise all audit plans and audits outcomes.

The board of trustees carried out quarterly inspection visits, to check the standards of the service in several areas. They issued a report of their findings that was discussed at senior management team meetings. The last inspection report had focused on how people felt about returning to the building. Issues about the size and layout of nurse stations; air conditioning; volunteers morale; staff competence in using the new computerised system and the provision of hot water were explained and an action plan had been written as a result. Actions were monitored from one inspection report to the next to ensure satisfactory completion.

A working group had been meeting to work on the National Institute for Health and Care Excellence (NICE) guidelines on care in the last few days of life. A need to provide focused training for nurses to identify the dying phase had been identified and this training plan was to be included for the next financial year. There were plans to introduce dementia and learning disability champions.

Not all the service's policies had been reviewed as intended. For example, the policies on 'Violence in the Workplace', 'Dignity at work' and 'Equality and Diversity' had been scheduled for a review in August 2015 and had not been reviewed. However, the service had experienced a major disruption and a relocation over several months. The head of clinical services who had been in post for nine days had already started to review the service's policies and had updated the policies on safeguarding, mental capacity and DoLS. They had identified the need for additional policies and procedures during their review. As a result, they had formulated a clinical policy register with review dates highlighted three months prior to the expiration date and had included policies and guidelines to be a standing item at clinical governance meetings.

The head of clinical services had written a clinical improvement plan that addressed the management of medicines and included the steps that had been taken during our inspection; and the writing of an updated business continuity plan taking into account current circumstances. They told us, "We are experienced with business continuity as a team; given our experience of the fire. We have a lot of learning which needs to be incorporated within the refreshed plan. As we have moved back into the building we have continued to add to the document in order to capture the implications of the changing layout and the facilities as they emerge." The improvement plan also acknowledged a need for staff to be re-trained in the mental capacity assessment processes to support them in practice; for adding a 'This is me' element to the computerised system so as to record more evidently people's life history; and for developing a process to establish and monitor a clearer documented link between complaints, audits, and how practice may have changed as a result. Completion dates in the improvement plan showed that action had been taken or was scheduled to be taken by April 2017.

The service was in process of using a new electronic system that crossed over all services to link all information together in a cohesive manner. Staff told us they experienced difficulties while using the new electronic records system. They told us, "It takes far too long to navigate this; we need more training before we can use it properly." The registered manager had designated a team leader who had been coaching staff over a period of three months; however staff felt they needed additional training to help them to use this system effectively. We discussed this with the registered manager who told us that additional training was being considered.

Comments and suggestions were welcome and these were taken into account to drive improvements. All satisfaction surveys and services annual review reports were analysed by the CEO who discussed their

findings and shared any suggestions for improvement with the board of trustees and relevant departments' staff. A hospice at home satisfaction survey had led to an improvement such as a quicker response to out of hours contact; an IPU satisfaction survey had led to an improvement of the provision of hot water and nurse call pendants; and an annual review of the night sitting service had led to an improvement in raising awareness of this service when staff attended community nursing team meetings and Gold Standard Framework (GSF) meetings.

The CEO was closely involved in the operation of the hospice and was leading and managing the development of effective business continuity plans for the hospice. Staff we spoke with felt they were able to approach the CEO, the registered manager and the new head of clinical services if they needed to go to them. The CEO talked to us about the service's values which were, 'Honesty and respect; innovation and excellence; community; compassion.' They told us, "Involving staff from all areas has contributed to these core values and these underpin all that we do and strive to do. These values were selected by all staff over the course of six workshops."

The registered manager told us, "The devastation of the fire that occurred in 2015 was overwhelming and it has been a really challenging 18 months but now is the right time to look at the future of the hospice and it feels very exciting. Whatever we do is for the benefit of patients, relatives and carers." The head of clinical services told us, "We want to make people less scared of the building, focus on enablement and empowerment to support people make informed choice regarding their place of death; to grow relations with GPs and referrers early enough to make a real difference for people."

Three new services had been, or were being developed by the service to meet people's needs. A rapid discharge service has been developed to expedite discharge from hospital to home if a patient was approaching the end of their life. The service offered up to four visits per day for up to 72 hours and offered support to people and their families to enable them to remain at home if that was their preferred place of care. A separate mobile phone number was available for referrers to refer to the rapid discharge service. The hospice at home team leader attended weekly meetings with hospital staff, to remain visible in the hospital environment and make people and staff aware of what services the hospice offered. This included accompanying people back to their home and ensuring they had what they needed. A separate phone line had been created to enable hospital patients to call the hospice at home team. A team of three clinical nurse specialists were being recruited to provide a community specialist palliative care service in the community. This service was intended to support people with complex needs in the community, such as those with uncontrolled pain. Once the situation was managed and contained, the clinical nurse specialists would refer people back to the hospice at home for continuity of support. The service had set up a new 'Re-enablement And Fitness Service' (RAFS) as part of their day services, to include gym-based exercises; physiotherapy, a weekly breathlessness clinic, a community sports programme and occupational therapy services. RAFS had been introduced between January and May 2016 and the gymnasium was due to be opened a few days after our inspection. There were plans to create a weekly young persons' group, and a 'creative Saturday' for families.

The service took a key role in the community. Current links were maintained through a series of trading shops and fundraising events. Fundraisers worked tirelessly to organise events and challenges that captured the heart of the local community and inspired people of all ages to get involved. Current diarised events included bingo afternoons, tea dances, coffee mornings and Bazaars, sewing groups, and an annual awareness day where people were invited to dress in one colour. The service had involved the community through a 'Phoenix Appeal', launched at the beginning of the year to help fund the re-building of the hospice following the fire in 2015, which had generated the funds to rebuild part of the hospice. A person who volunteered in the hospice told us, "This is the heart of the community."

All records relevant to the running of the service that we saw were well organised, kept securely and confidentially. An effective electronic record system had been introduced to store and update data about people's care. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.