The Myton Hospices

Warwick Myton Hospice

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 and 15 September 2016 and was unannounced.

Warwick Myton Hospice provides care and treatment to people over the age of 18 with life limiting conditions who require specialist palliative care in the 24 bedded inpatient unit, day service and hospice at home service. (Palliative care is comprehensive treatment of the discomfort, symptoms and stress of serious illnesses). At the time of our inspection 10 people were using the inpatient service. Initially people attend the day hospice for one day per week over a 12 week period and on the day of this inspection visit five people attended the day hospice. People were able to access a range of care and support which included, children and family support, occupational therapy, physiotherapy, chaplaincy, counselling and bereavement support.

There was a registered manager in post who was also the director of nursing, care and education. 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.

People were protected from harm and abuse due to the arrangements in place to make sure risks to people were reduced. Where people were at risk due to their health and physical needs these had been identified with measures put in place to help people to manage and reduce any known risks. Staff and volunteers had been suitably recruited and there were sufficient staff with a variety of skills to meet people's individual needs and to respond flexibly to changes.

Staff received the training and support they needed and were highly motivated to perform their roles and deliver sustained high quality care. This included staff having the skills to effectively manage people's medicines so these were available and administered safely to people.

People were extremely confident and positive about the abilities of staff to meet their individual needs in the right way and at the right time for them. The leadership team supported staff to undertake relevant training and career development. This was one area the leadership team had focused on to ensure improvements in care when required so that it remained effective in meeting people's palliative and clinical needs with best practice shared in end of life care.

People told us they were supported with their nutritional needs with the assistance of the catering team who actively sought and welcomed people's feedback. There was a shared commitment between all members of the staff team to sharing how meals remained nutritious and people enjoyed these in comfort. Staff were also aware of people's reduced appetite's towards the end of their lives to make sure changes in people's dietary needs could be effectively catered for and creatively met in different ways which included fruit smoothies.

Staff were kind and thoughtful to people which reflected the positive comments we received from people about how their experiences felt listened to and were valued. People told us staff spent time listening to them, did not rush them, and did all they could to meet people's individual wishes and requests whether this was in their own homes, the day hospice and/or as inpatients. This supported people who used the hospice services and their families to make special memories which were of a comfort to both people and families especially towards the end of their lives.

People's individual needs were assessed and staff always encouraged people to make their own choices about their care and treatment which were written down to help people's wishes to be followed in life and death. Where this was not possible issues of consent and decisions were made in people's best interests by people who had the authority to do this.

People were treated as individuals and staff were motivated and committed to providing people with the best possible palliative and end of life care. Staff enjoyed their work and believed the ethos of the hospice movement was about spending quality time with people. This was reflected in staff practices as they had assisted people to overcome obstacles so they could aim for their goals in life.

People were supported to receive end of life care in their preferred place of choice which met with their needs and wishes and to achieve a private, dignified and pain free death. People, their family members and staff were able to access the emotional, psychological, spiritual and bereavement support they needed.

People were at the centre of the leadership and staff teams core values of personalised palliative and end of life care aimed to provide quality of care and life to all people. To achieve this the registered manager led by example since they came into post to raise the profile and reputation of the hospice services in the local community. Close partnerships with external professionals, educators and national organisations involved with palliative and end of life care were being sought and partnerships formed. This helped to ensure people received the right care at the right time and knowledge was appropriately shared and used to influence best practice for people's care. This included care and treatment planning which looked towards the future to make sure it was inclusive to meet the diverse and changing care needs of the local population.

People and their family members, staff, board of trustees were actively informed and involved in developing the service. There was an open culture where every person was encouraged to share their experiences of the care and treatment the different hospice services provided. This included making complaints which were fully investigated and responded to, with evidence of the leadership team using them as a learning opportunity in order to make improvements to the hospice services. The registered manager showed they were dedicated to the continual development of the hospice services so all people received palliative and end of life care which was inclusive to all and of a high quality.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe because there were sufficient staff to meet people's assessed needs and who knew how to protect people from abuse.

Risks to people's individual health and welfare were assessed and managed in partnership with people.

People medicines were stored, made available and administered by staff whose competencies were regularly checked to ensure people received their medicines safely.

Is the service effective?

Good

The service was effective.

People's choices were respected and they were involved in decisions about their care and treatment and preferred place of death wherever this was possible.

Staff had training and support to provide them with the knowledge and skills in order to understand and meet people's needs effectively.

People's food preferences and any requirements around being supported to eat and drink was provided in a personalised way to meet people's end of life needs.

People were supported to access healthcare services promptly when needed to promote their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were supported in a caring way with dignity, respect and kindness.

People were supported to have choice and to be involved in all aspects of their care.

People were treated with the utmost care and compassion and received dignified and pain free end of life care and support.

Is the service responsive?

Good

The service was responsive.

People were enabled and encouraged to express their views and shape their support to reflect their own individuality.

Effective partnership working meant people's care and treatment was inclusive, consistent, flexible and responsive to their needs.

People's experiences, concerns and complaints were routinely listened to and used to learn lessons and drive improvements in the hospice services offered.

Is the service well-led?

Good

The service was well led.

People believed the service was well managed and they received high quality care which effectively met their palliative and end of life care needs.

The leadership and staff team shared strong values and beliefs centred on offering a personalised service to each person to fulfil their wishes.

The registered manager gave strong and effective leadership and was focused on continual improvement and long term development of the hospice services.

Warwick Myton 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 201

This inspection took place on 12 and 15 September 2016. The first day was unannounced. The inspection team on day one consisted of an inspector, a specialist advisor who is a nurse with experience of palliative and end of life care and an expert by experience with knowledge of 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. The inspector returned to the hospice on the second day and provided feedback to the registered manager.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The previous registered manager had submitted the information as we requested in January 2016. We took this information into account when we made the judgements in this report.

We checked the information we held about the service and the provider including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We sought information about the quality of service from the clinical commissioning group (CCG). We also asked Healthwatch for their views. Heathwatch is an independent consumer champion who promotes the views and experiences of people who use health and social care.

We spent time with people who were inpatients and with people who attended the day hospice on the day of this inspection and saw the care and support offered. We spoke with four people who were inpatients, two people attending the day hospice and two relatives about the care they received. We sampled the care records of five people and daily records to see how their care and treatment was planned and delivered. Consideration was given to how medicines were managed which meant we looked at medicine charts and administration records. We were present at a meeting with medical and nursing staff who met daily to share information and make recommendations about people's treatment and care needs.

We spoke with two people and one relative by telephone about their experiences of the care they received in their own homes from staff who were part of the hospice at home team.

We spoke with the registered manager and a range of 20 staff across the inpatient, day hospice and hospice at home services. These included the day hospice sister, ward manager, doctor, sister from Myton at home, receptionist, audit and compliance manager, nurses, health care assistant, volunteers, catering manager, chaplain, art therapist and hairdresser.

We looked at a selection of documentation about the management and running of the hospice services. These included the provider's recruitment procedures, staffing arrangements, complaints and compliments received, incident reporting and results of the provider's quality monitoring systems to see what actions had been taken and plans for the future. The leadership team also sent further information to us as part of the inspection.

Good

Is the service safe?

Our findings

Every person spoke confidently about how they were reassured by staff's abilities to keep them safe when they used the hospice services. People consistently told us they felt safe because of the care staff provided. One person told us, "There are always people around to check on me" which, made them feel safe. Two people spoke about the volunteers who drove them to the day hospice and how they felt safe because the volunteers, "Drive carefully." Another person who received a hospice at home service said, "Absolutely safe and comfortable, they (staff) have shown nothing but kindness to me." Relatives were also positive in their views about their family member's safety and felt reassured when their family members were at the hospice when they could not be there. A relative commented, "I'm an ex-nurse and I don't worry when I leave him."

Staff understood their responsibilities in keeping people safe from the risks of avoidable harm and abuse. Staff we spoke with had a good understanding of the signs of potential abuse and how to report this so people felt safe when at the hospice and in their own homes. For example staff said they would observe changes in people's behaviour, signs of emotional distress or of neglect which could indicate people were at risk of harm. Staff knew from their training and the organisations procedures how to report their concerns to ensure people were protected from abuse and avoidable harm.

We saw a wide range of possible risks to each person's wellbeing had been considered and assessed, for example people's physical abilities, emotional, nutritional and skin care needs. People's care records detailed the action to be taken to prevent any identified risks and staff spoken with knew how to manage the risks to people. For example, as part of reducing the risks of falls they had noted a person required their call alarm to be given to them. We saw this person had their call alarm and they told us staff readily came when they required pain relief so they were not at risk from discomfort. Staff told us they had access to equipment to meet people's different needs, such as mattresses and chair cushions to help relieve the pressure on people's skin area when people were at risk of pressure ulcers.

Staff we spoke with were able to provide examples of how they assessed and balanced the risks associated with what people wanted to achieve in their lives. At the meeting where people's needs were discussed we heard staff shared their different thoughts about how people's goals could be achieved. For example, a discussion took place about how the practical aspects of a person's life could be assessed so any risks could be identified to make sure they were not placed at avoidable harm when they returned home. The person's wish was to return home and they told us their needs were being assessed to ensure they had care in place to enable them to go home. Another person's physical abilities were impacted upon when they became tired which had the potential to increase the risk of falling. Staff knew how to assist the person so risks to their safety were reduced and had referred the person to the occupational therapist as one way of assisting the person to retain their own levels of independence. A further person told us how the care they received from the hospice at home team had supported them to feel safe and to fulfil their wishes to be at home.

The hospice environment supported people to meet their individual lifestyles so people were not discriminated against whilst risks were reduced for other people. For example, there was a dedicated room for smoking so this did not compromise other people's needs and wellbeing.

People we spoke with did not have any concerns about the availability of staff. One person told us, "When I need staff they are here immediately, I never have to wait which is what I need when I am in pain or need support to use the toilet." Staff told us they felt there were sufficient staff to care for people in the way people needed and at times they preferred. We saw people's needs were met in a timely way to ensure their safety and wellbeing was not compromised. One example was when a person's syringe driver was bleeping a nurse promptly checked this so any problems could be identified and action taken to maintain the person's safety. Syringe drivers are used to provide people with a continuous supply of medicines to aid their comfort. Another example was when the emergency alarm sounded we saw the nursing team immediately responded.

The registered manager regularly assessed and reviewed staffing levels to ensure people's safety and wellbeing. In the Provider Information Return [PIR] an example was given to show where the leadership team had previously reduced the numbers of people receiving care as inpatients. This was because of low staffing resources at the time and showed the registered manager's commitment to making sure the services provided to people remained flexible, responsive and safe.

The leadership team made sure their recruitment arrangements were responsive to people's safety and wellbeing needs. These included completing criminal checks through the Disclosure and Barring Service (DBS) and staff and volunteers had not started working with people until it had been established they were suitable to work with people. We asked staff about their experiences of being recruited into their various roles. One staff member confirmed, "Before I started here my suitability to work with patients was checked." Another staff member said nurse's registration was checked to confirm they were safe to provide nursing care to people.

People we spoke with confirmed they received their medicines when they needed them. One person said, "The nurses come round regularly with our tablets, they have helped me get on top of my pain." Another person told us they only needed to, "Press the buzzer and they bring me pain relief." For a further person staff showed they knew where the person was feeling pain and when the person asked for pain relief this was administered immediately to ensure the person's comfort.

We also found syringe drivers which were used to administer medicines had been checked to make sure they were in good order to use which included checking the date of the next service. We saw medicines prepared in a syringe driver for one person had been checked and records signed by two nurses to show the correct amount of medicine were given to the person.

Medicines were stored and disposed of securely with access only to authorised clinical staff. Accurate records were kept of medicines prescribed for and given to people. These showed how people were supported to take their medicines and at the times they needed these. However we found for one person the support they had to take one of their specific medicines was not accurately recorded on their medicine chart to ensure consistency of nurse's practices. The registered manager acknowledged this and assured us action would be taken immediately to ensure the medicine chart accurately reflected staff practices.

The PIR was clear in the provider's commitment to having, 'A clear Incident reporting and risk management process in place supported by an 'open, no blame culture' which encourages the immediate reporting of errors or incidents.' We found this was the case when we looked at the reporting and actions taken in response to incidents. For example, we saw trends and patterns following medicine administration errors and medicine storage issues were highlighted and specific actions were put into practice. These included the restrictions which had been put in place to limit the amount of nursing staff in the room when preparing to administer people's medicines to reduce any distractions. We saw this rule was applied to nurse's

practices as they took time to check people's medicines. This practice showed how lessons were being learnt and new practices implemented to help ensure people's safety was maintained.

Good

Is the service effective?

Our findings

People were positive in their comments about the effectiveness of the care and treatment they received from staff as inpatients, whilst attending the day hospice or receiving care in their own homes. One person told us their experiences of receiving care and support which met their needs was a positive one since being at the hospice. Another person said, "All of the care I receive at home is excellent, the warmth of their smiles brighten my day as good as any tablets." A relative told us, "The care they (staff) give is absolutely perfect, they give me morale support as well. They all certainly know the ropes, I can't fault the care as they know how to make sure [person's name] feels comfortable."

The PIR told us all new staff had a thorough induction before they started work. As part of the induction programme new staff worked in addition to staff numbers shadowing more experienced staff until they could show they had attained the level of competency required for their role. Staff told us they had benefitted from this approach as they had a mentor who had assisted them in gaining knowledge and experience to fulfil their roles and meet people's specific needs. One staff member described how through their induction they were able to spend time across the organisations different hospice services. They said this had been an enlightening experience which had increased their confidence to provide effective care.

Volunteers told us they had received an induction and training opportunities which had been worthwhile and supported the knowledge they needed within their different roles. We saw volunteers used their training to support people in the day hospice. One person told us the volunteers always brightened their day and another person said volunteers were, "Very warm and friendly" which helped them on good and bad days to cope.

There was a strong commitment by the registered manager to support staff to gain the knowledge and skills they required and to develop themselves by acquiring nationally recognised qualifications. Staff we spoke were appreciative of this approach and told us they had opportunities to improve their skills through ongoing training. One staff member told us they had been supported to undertake an end of life course at university to further enhance their knowledge. Another staff member described how they needed some assistance with using the computers to access the e-learning training which was readily offered by staff at the hospice. They told us how proud they were of their achievement in doing the e-learning courses. Staff member's comments about their learning opportunities included, "Everyone is so different but what we learn helps us to help patients in the best possible way for them" and "Education is so important to me."

We heard many examples from staff about how people's needs directed additional training to enhance their knowledge this was readily sought and learning shared to promote best practices. For example, staff had link roles for specific conditions, such as, tissue viability (specialists in people's skin care needs) and lymphoedema. Lymphoedema is a long term condition that causes swelling in the body's tissues, usually affecting the arms and legs. A staff member told us how their knowledge around the subject of lymphoedema had assisted a person to regain their physical abilities to walk. They said all staff worked as a team and knowledge was shared between them to ensure people were provided with the best possible care. Another staff member described how they had gained further knowledge about caring for people's skin.

They told us how by completing a course and going to conferences they felt confident in making sure people's skin care needs were met and they were as comfortable as they could be.

Staff we spoke with told us they were provided with regular support to be able to fulfil their different roles. One staff member said, "Since I started to work here I have found the support I have received to be exceptional both from colleagues and the managers." Another staff member told us they were well supported in their role, "[Name of person] is my line manager and she is very approachable." This person also said complementary therapy, counselling and psychology support were available when they needed any of these. Information sharing meetings at the end and beginning of shifts, a communications noticeboard, written notes and regular staff meetings were used to ensure staff kept up to date with changes in people's care needs and any important events.

The whole staff team worked collaboratively with a mixture of professionals to make sure people's healthcare needs were effectively treated and met. This included the occupational therapist and physiotherapist who worked across the provider's three hospice locations. We heard examples from staff of how both therapists supported people to become educated in their own health conditions so they were able to better manage these. For example, they provided people with support to maximise their health by visiting people's homes before and after discharge to ensure they had the right equipment to meet their individual needs effectively.

We heard from staff who were part of the hospice at home team how they worked in partnership with healthcare professionals in the community to meet people's healthcare needs. We were given examples of how people were able to return home from hospital to receive end of life care as their preferred place of dying due to health and social care professionals all working together. One relative told us the staff were very knowledgeable about how to keep their family member's skin from becoming sore. For example knowing where to apply the cream so this effective in reducing the risk of sore skin. Another relative said staff worked with the district nurses to ensure their family member was, "As comfortable and free from pain as possible."

People we spoke with told us they enjoyed the food at the hospice and they appreciated the varied and flexible menu. One person told us the food was "Wonderful" and another person said there was "An excellent choice of food." People's nutritional needs were assessed and monitored to ensure staff could identify concerns with people's nutrition, or provide dietary needs, such as reduced sugar and or gluten free diets. One staff member told us when a person had a reduced appetite or difficulty eating and drinking they were encouraged and supported to eat 'little and often.' We saw staff had the skills to request specialist support from a dietician or speech and language therapist if a person's eating and drinking deteriorated. Staff told us any concerns about people's eating and drinking or distressing symptoms this might cause towards the end of a person's life were fully discussed as a multidisciplinary team, (a group of mixed professionals) and the person's family. We saw people had access to drinks in appropriate cups to meet their needs and these were within easy physical reach. One person told us the staff, "Always pour out the water before they go."

The catering manager told us the chef had direct contact with people on a daily basis as they speak individually to each person about the food so they are able to change anything they are unhappy with. We saw there was information held in the kitchen area about people's dietary needs so there could be consistently followed by all staff. The catering manager knew how their role could benefit people in meeting their eating and drinking needs. They provided examples of how they made ice lollies and fruit smoothies and added oats and milk powder to meals to boost their nutritional value.

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 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. Staff spoken with knew about their responsibilities to make applications to the supervisory body for people who did not have the mental capacity to agree to any restrictions placed on them in order to promote their safety and wellbeing. At the time of our inspection people using the service had capacity and did not require any DoLS. People were encouraged to make decisions and choices for themselves and their consent to care was obtained and noted in their care plan. We did find one person had consented to aspects of their care but there was no indication to show the reason they had not signed this alongside the nurse's signature. The registered manager was made aware of this and would ensure nurses practices were strengthened in this area in line with the MCA.

Staff we spoke with were able to tell us how their training had helped them to understand the importance of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) in their roles. Staff told us people's consent to their care and treatment was always sought and we saw this was the case. Where this was not possible this was done in people's best interests with people who knew them well and were authorised to do this. One person we spoke with told us staff had involved them in the decisions about their care and treatment. We saw staff gained people's consent during the day of this inspection visit about their everyday decisions, such as, asking about medicines for pain relief and what to eat and drink.

We saw people had been supported to make advance decisions about their future care in the event of them not being able to make that decision at that time. For example, legal documentation was in place which provided information about people's wishes in events, such as; if their heart were to stop of they were to stop breathing. We saw in people's records and staff told us these important decisions were discussed alongside people's changes in needs during multidisciplinary meetings.

Good

Is the service caring?

Our findings

People told us that staff were caring. One person said, "We joke and have a laugh together. They're all lovely." Another person told us, "They're lovely. They always talk to us and can't do enough for us. They help you as much as they can." A relative said, the staff who came into their home had "Gone above and beyond" to make sure their family member was as comfortable as they could be. We saw compliments from people also described their care as, 'tremendous,' 'absolutely marvellous' and 'wonderful.'

We saw staff supported people in a warm and caring way. For example, we saw staff made time to sit with people and chat with them. One person told us about how impressed they were with staff practices that had supported them with many aspects of their care without making them feel embarrassed. They said staff, "Just helped them with such understanding" and they felt they were treated me like a human being by all staff. All staff spoke positively about spending time with people and their family members having time to listen to people and respond to their wishes and not to be rushed. One staff member said, "We like to talk to patients to find out what makes them feel special. The best thing is being with the person and asking them about their journey." Another staff member said, "You are there to listen and build up trust, that's the key." We heard examples of how staff sat with people in the last few hours of their life to offer them comfort and support if they were on their own.

Relatives who visited the hospice were also very complimentary of the care received by their family member and felt staff involved them in their care. One relative said, "They seem very caring [person's name] is comfortable and content, they would say if not." Another relative told us, "They know her here and tell me if she's had a bad day or hasn't eaten" which they valued. We saw several examples of the provider's commitment to supporting people's relatives. For instance, there were two flats, free of charge, for relatives who wanted to spend as much time as possible with their family member who was nearing the end of their life. Families also valued the accommodation if they had travelled a long distance.

Staff placed people at the centre of their care and champions had been created in various roles, such as privacy and dignity to ensure best practices were shared. We heard examples positive examples from people about how staff practices had valued their dignity and privacy. For example, one person described how staff had assisted them to unpack on their first day at the hospice. They said, "I felt like I was treated with dignity. They (staff) were careful with my things." In addition to this the person told us one evening they had ran out of a specific item they used and how a staff member drove to the shops to buy exactly the items she wanted. They went on to tell us, "I feel like they (staff) don't just do things to me, because they have to, they are always checking that things are okay before they do them. In the hospital they just shut the curtains. Here they ask me, "would you like the curtains open or shut?" Through these positive experiences the person thought the staff, "Really do care" and they felt, "Listened to."

People's diverse needs were considered by implementation of aids, equipment and new initiatives to ensure their needs were responded to and no one was disadvantaged. The management and staff team had a number of initiatives in place to show how they cared about equality for everyone. One example was a voice amplifier they provided for people who due to their health conditions had difficulties in projecting their

voice. Another example were the whiteboards used by the hospice at home team to support people's sensory impairment needs. Staff told us they used the whiteboards to write on as another method to assist people in expressing their particular needs. One staff member said the different methods they used to communicate with people kept, "People at the heart of their care by supporting them to be involved in all their care."

We saw and staff from the hospice at home team told us they had provided people and relatives with examples of how they could use fortified supplements in different meals. This initiative had been developed because staff had found for some people the taste of fortified supplements was not always to their liking. This caring and creative approach by staff helped support people in overcoming obstacles so their particular needs were met. We saw a lot of thought had gone into providing menus with pictures for people who liked to not only read the menus but see the meals.

Additionally we saw children were very much part of the hospice ethos which was reflected in the PIR as, 'Patients and their families are central to everything we do.' We saw many examples of where this was reflected in practice and appreciated by people. One person told us their grandchild visited and, "Feels at home" at the hospice. They spoke about how staff provided their grandchild with colouring books and crayons, commenting, "It's nice that they (staff) go the extra mile to satisfy the children." Another person said the children, "Makes (the hospice) seem normal." We saw children had access to a family/play room and there was a variety of toys for them to enjoy. We also heard how there was a counselling service for children to support them in expressing their feelings and emotions in a variety of ways which included one to one support and group activities.

We saw evidence of the registered manager and staff team's commitment to giving people as much choice and control as possible. For example, people were consulted about how they would like to receive their end of life care and how they were supported with their symptoms of pain so people were as comfortable as they could be. One person told us, "They (staff) really help me with any pain I feel but they always give me choices and I feel in control which is of a great relief to me." The PIR stated, 'Family pets are frequent visitors to patients on our inpatient unit.' We heard from staff people's pets could stay with them at the hospice and we saw this happened on the day of this inspection visit as a dog shared time with their owner. Staff told us other people have had cats staying with them and on one occasion staff arranged for a person's horse to visit them.

People received their end of life care in accordance with their care preferences. One staff member told us, "We offer holistic, individualised end of life care". This was reflected in the different care and support people told us they received. Advance care plans were followed which recorded people's personal preferences and choices. One staff member said, "These care plans empower people to get the end of life care they want." Additionally, people's emotional and spiritual needs were shown in their care records which were reviewed with each person whilst they stayed at the hospice. One person told us, "I am always asked about every aspect; what I say is taken seriously, in a respectful and sympathetic manner."

People and their family members could access a range of support services across the hospice and community setting to suit people's preferences and needs. For example, art and complementary therapist support and bereavement support. People were able to access a chaplain so that they could gain spiritual and bereavement care and support. We saw there was a sanctuary room for people to use for reflection and to meet their cultural and spiritual needs, One person told us they knew they could see a chaplain if they wished whilst they stayed at the hospice and knew about the sanctuary room. We saw relatives had accessed this room to put messages of remembrance on the tree like structure as a way of reflecting their memories of family members who had died.

Systems and guidance were in place for staff to follow for the protection, handling and processing of personal confidential information relating to people's care. Staff recognised and understood these.

Good

Is the service responsive?

Our findings

People told us the service staff delivered was very responsive to their needs. People and relatives from the inpatient unit, day hospice and hospice at home service appreciated that staff involved them in regular reviews of their care. They kept all the agencies involved and up to date with regards to people`s needs who used the hospice at home service. One person told us, "Staff keep me in the loop and talk to my GP if there is a need for it. This is a huge help for me." Another person said, "We are definitely fully consulted about planning care and what happens next." One relative said, "They [staff] care for you by doing it with you rather than doing it to you."

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the inpatient unit, day hospice and when people received support from the hospice at the home service, staff sat with people, enabling them to spend as much time as they needed and encouraged them to ask questions, discuss their options and reflect upon them. As people and staff worked as a team to ensure each support plan was unique and responded to specific needs, people felt valued and understood. People were encouraged and helped to complete advance care plans to record their wishes regarding how and where they wanted their end of life care to be managed.

Staff were able to tell us about the individual needs of people who were using the hospice services, such as, how their mental or physical health might affect the way they provided care. One staff member said by talking with a person and supporting them to write down their feelings had eased their physical pain. We saw staff used their communication skills effectively whilst they supported one person to meet their needs and this person told us staff always made them feel better. Another person told us about a specific part of their health condition which had caused them distress. They praised the staff as they had worked,"Tirelessly" to find the right solution for them which had been successful in responding to their particular needs and easing their feelings of distress. A relative said the staff who provided care to their family member at home had answered any queries they had about their family member's needs which had helped them to feel less anxious about the future.

Staff and volunteers showed they cared about people's feelings and we saw how people really mattered by the responsive actions of the staff team. For example, the art therapist showed us the plaster cast of a man and woman's hands which had just been made by two people using the hospice service. One person gave us an example of how staff had valued their own specific ways of keeping their hair styled as they preferred to in their room as they would have done at home. The chaplain described to us how a blessing ceremony had been held in a person's room. Both people had wanted to have a ceremony beside a river but the person using the hospice service was too unwell to fulfil this at the time. The chaplain therefore made a cloth river with crocheted ducks beside it which was then set up in the person's room to enable both people to share some special memories of their day.

People also were complimentary and valued the support provided. One person told us, "I can have my hair done which I really value." We spoke with the hairdresser who said, "I let the clients dictate what I'm doing".

A barber service was also offered which meant both men and women had equal access to the facility. We saw how staff and volunteers naturally approached people when they noticed they were quiet or looked unhappy. We heard how they checked with people whether they were feeling comfortable and how they had been. We saw any activities which took place in the day service valued people's different abilities and were of social therapeutic benefit for people. From people's facial expressions and body language we saw this enabled people to feel a sense of pride with what they had achieved. There was lots of chatting and laughs between people, staff and volunteers.

We saw examples of this when we attended a meeting with different staff members where they discussed people's individual needs and goals. The staff team showed a detailed knowledge of the health, physical and emotional needs of people whose care and treatment they had been involved in. There was a strong shared sense of purpose around making sure any issues were followed up promptly by the right members of the staff team. For example, a staff member explained how they had noticed something about one person's health and this was responded to by the doctor stating they would assess this. Staff also discussed how to respond to someone's needs so these could be met effectively in their own home so their individual goals could be achieved.

People's wishes were at the centre of their care planning. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. People`s constantly changing needs were assessed and discussed by staff on a daily basis or more frequently in order to address them appropriately. Staff we spoke with told us, "Thorough handovers" were provided at the beginning of their shift. Each person was discussed in depth including care needs, changes to treatment and care plans and medicine requirements to make sure care remained responsive.

The leadership team were committed to engage with the local community to improve the quality of care and to meet the unmet needs of the local people. There was a strong motivation to want to continue to be responsive to people and their families by always striving to improve the range of services offered. One example was the extension of the hospice at home service to be able to respond to people's care and support needs at night. One staff member told us recruitment to the posts to enable this to become a reality had taken place and they were enthusiastic about how this would really make a difference to people whose last wishes were to be in their own homes at the time of their death. Another example was the specialist lympheodema service where people could be offered a limb massager machine on short term loan basis. The loan of this machine supported people to carry out treatments in their own homes which responded to people's needs whilst maintaining their independence.

People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life. There was an annual 'Light up your life' which was a remembrance service for people so families had continual emotional support beyond the provision of care for people. We heard from staff how people's families were appreciative of the care they were offered and showed this through their fund raising achievements for the hospice services.

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People who we spoke with told us if they had any concerns they were comfortable to raise these with the management and/or staff team. This was also confirmed to us by people who received a service at home and their relatives also told us staff who provided care were approachable and were confident action would be taken to resolve any complaints and/or concerns they had. The registered manager had systems in place to review any complaints received. We saw where complaints had been received these were investigated and responded to promptly. For example, one complaint made was about the communication between the inpatient staff and the day hospice staff. The registered manager met with the person and apologised. Action had also been taken to ensure future communications between all staff when meeting people's

needs was as good as it could be. This showed lessons were learnt so staff and the services people received would develop further.

Good

Is the service well-led?

Our findings

Throughout this inspection we saw there was an open and welcoming atmosphere in the hospice. People told us how highly they thought of the staff team which included the management. One person said, "To me it is very well managed. The standard of care is second to none and when I am here they all help me to live each day."

We saw people who used the hospice services has opportunities of sharing their experiences of the care and treatment they received. For example, through responding to surveys, speaking with staff and writing down in letters and thank you cards their appreciation of the care provided by staff and volunteers. We found the comments received praised the standard of care and what it meant for people. Comments we read included, 'The hospice at home nurses were caring, professional and delightful and helped enliven [person's name] day as well as taking away some of the burden of caring from him.' 'Dying is the thing many fear the most in life, and they made watching the dying process okay, what an amazing gift to have. We saw the feedback from people was shared between the leadership and staff team to extend best practice across the services people received. Staff told us this helped to promote good staff morale as they were able to see how well they were doing in their caring roles.

There was a defined structure to the organisation with a board of trustees and layers of managers, staff and support services. Staff we spoke with told us there had been a lot of changes in the senior management team which included an appointment to the chief executive and registered manager's role over the last year. They told us the registered manager was approachable and had a regular presence at the hospice. The registered manager led by example and was open with us about their vision to ensure the services were continually well led with on-going improvements made. One example provided was the review which had been undertaken of the day hospice service to ensure it met the diverse needs of the local population now and in the future.

All the managers we spoke with showed they had an excellent understanding of the care provided which showed they had regular contact with staff and people who used the service. The registered manager was aware of their role and responsibilities and was able to tell us about all the changes which had taken place since they came into post. The registered manager showed they were passionate about promoting Myton hospice services. They gave us examples of how they were reaching out to the local community to raise the profile of the hospice to wider groups of people and continuing to promote its reputation for quality palliative and end of life care for all people.

The registered manager shared with us that although the management and staff team had come a long way improvements continued to be on-going. The registered manager showed they were knowledgeable about the areas where work needed to be progressed. For example, continuing the joint working with the local hospitals to achieve best practice for people with life limiting and life threatening illnesses. The registered manager also showed they had an open and responsive style to any areas we saw or heard which could be focused upon. For example, two people did not like the new duvet covers. One person described them as similar to, "Lying like a pancake on your legs, it's impossible to tuck it in." The registered manager

immediately spoke about the actions they would take to ensure the duvets were to each person's tastes. Another example was the action taken to ensure the sanctuary space was visually inclusive to all as we saw three crosses on display without other artefacts to reflect different cultures and/or religions.

Staff we spoke with were aware of the roles of the management team at the hospice which included the chief executive. Staff told us the chief executive was visible around the hospice. Staff and volunteers told us they liked working in the various hospice services and were motivated to provide a good standard of care and treatment to people. One staff member said they were proud of how all the staff worked together as a team and how they all made a difference to people's lives, such as the "Fabulous kitchen staff" who made sure people's meals were personalised. Another staff member said they had been a lot of changes in the staff team in the inpatient unit but it was more stable now and believed the staff morale had improved. A further staff member told us, the registered manager was eager to provide opportunities for staff to lead on different projects and share their ideas for the benefit of people who used the hospice services. The registered manager had recruited to the post of practice facilitator to continue to develop staff knowledge and skills to ensure care remained personalised and of a high quality.

The leadership team promoted the values of the organisation. These were used when discussing their expectations of staff during meetings and how improvements could be made to the quality of the care and treatment people received. There was a culture which the registered manager had developed since they came into post where suggestions and concerns raised by staff were taken seriously and acted upon. Staff were also aware of the organisations whistle blowing procedures which they told us they would not hesitate to use if they felt their concerns were not addressed by the leadership team.

Information following investigations were used to aid learning and drive quality across the services people received. Staff spoken with told us about the daily team briefings they had and how meetings were also used as time to reflect on their own standards of practice and make suggestions. The registered manager confirmed meetings were also used for reflecting on the emotional parts of the work staff did at the hospice. For example, if a person's death particularly touched a staff member in some way. One staff member told us they felt there were a variety of support networks for them to access, such as the chaplain and psychological support.

A range of audits was completed regularly to review and measure the performance of the hospice services people received and included care and clinical treatment. The audit checks were seen by all the leadership team, heads of department, staff and reported to the board of trustees. We saw action had been taken to address any issues highlighted in these audits. For example, following trend from recent medicine audits, changes to staff practices were put in place to enable them to develop their learning and apply this to their practices. Another example were the discussions around clinical incidents, such as pressure ulcers where staff had strengthened their own learning and a guide had been developed in preventing pressure ulcers.

The registered manager, staff and volunteers reflected in their work the values of the organisation. These were noted in the PIR as 'Respect and dignity for all - Value every individual and ourselves - One Myton, One Team, One Goal – Professionalism in all that we do.' We heard how these values had been put into action as recently the hospice had closed to enable some major works to be undertaken. Staff provided examples of how they had worked across the provider's other inpatient hospice to enable people to continue to receive the care they required. We consistently heard how all staff worked as one large team which had been successful. There had been no evidence of disruption to the care and treatment people received during the short closure of the hospice. We also heard from one staff member how the, 'Can do' culture of the hospice at home team had supported a person who had made the wrong choice about returning home from hospital. Within hours staff made contact with the person's doctor and the person went to live in another

setting as they wished. People's comments consistently echoed the value placed upon the standards of care adopted by the leadership and staff team such as 'The comfort you provided with the squeeze of his hand, the care you gave, always with a smile of the feeling of living these last few weeks, an afternoon lying in the sun, a whizz in his wheelchair and a tipple of brandy.'