

Marie Curie

Marie Curie Hospice Newcastle

Inspection report

Marie Curie Drive
Elswick
Newcastle Upon Tyne
Tyne and Wear
NE4 6SS

Tel: 01912191000

Website: www.mariecurie.org.uk/en-gb/nurses-hospices/our-hospices/newcastle

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14 June 2016

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

The inspection took place on 13 and 14 June 2016 and was announced. We last inspected the hospice on 21 November 2013. The provider met the requirements of the regulations we inspected during this inspection.

The Marie Curie Hospice, Newcastle provides specialist care for people with cancer and other life-limiting illnesses. The Newcastle hospice provides in-patient care, day care, out-patient support and short breaks. The hospice is registered for 22 people with 20 people receiving treatment when we visited.

The hospice had a registered manager. 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.

The hospice excelled at providing people with person-centred care that met all of their needs, physically, emotionally and spiritually. Dedicated, committed and compassionate staff provided care that maintained people's dignity and respect. One person told us, "Its Brilliant, [I am] happy to be here and staff are happy to help." Another person said, "I am having an absolutely marvellous time, I came in a week ago and wanted to crawl into a hole. This week I feel so much better."

We found numerous examples where staff had gone the extra mile to meet people's wishes and create special memories for relatives. For example, arranging weddings, other celebrations and supporting people to attend events or fulfil their wishes.

People told us they were totally in control of decisions about their care. Staff supported people creatively to express their views and make choices. Bereavement support and support for families and children was a priority for staff at the hospice.

There was a strong focus on rehabilitation and promoting people's independence for as long as possible.

The provider's values put people at the heart of the care delivered at the hospice. Staff understood the values and how they translated into people's care.

The hospice had an open, transparent culture which encouraged involvement from people and staff. The hospice actively looked for new ways of working and delivering on-going improvements for the benefit of people.

Exceptionally strong governance arrangements were in place to ensure the hospice was safe and providing the best care. People gave positive feedback about the leadership and management of the hospice. One person commented, "It must be well led, as it is brilliant."

The hospice was keen to not be a stand-alone service and had developed strong partnerships with other organisations. They also took part in research projects to help advance palliative care.

People and staff told us the hospice was safe. One person commented, "I feel safe, it is brilliant."

Staff had a good understanding of safeguarding and the service's whistle-blowing policy, including how to report concerns. All staff members said they would raise any concerns straightaway. One staff member said, "I would be the first to speak up if I saw anything."

People were assessed to help keep them safe from potential risks, such as the risk of poor nutrition, skin damage and falls. Where a potential risk had been identified measures were in place to help minimise harm to people, such as providing specialist equipment to prevent people from falling.

Medicines records, systems and processes supported the safe management of medicines.

There were sufficient staff to ensure people's needs, choices and preferences were met promptly. People, relatives and staff all confirmed staffing levels on the ward were good.

Effective recruitment processes, including pre-employment checks, ensured prospective new staff had the relevant skills and attributes and were suitable to provide person-centred care.

There were plans in place to deal with emergency situations. Health and safety checks helped keep the hospice safe.

Staff were very well supported and had the training they needed to be effective in their role. Staff took ownership of the supervision process and agreed the frequency of their supervisions jointly with their line manager. Emotional support was available for staff if they required it.

Where people lacked capacity the provider acted in accordance with the Mental Capacity Act (MCA). Deprivation of Liberty Safeguards (DoLS) had been authorised where required. Staff used a variety of methods to support people with decision making and making choices.

People were supported to ensure their nutritional needs were met in line with their preferences. The hospice was able to cater for a wide range of cultural and dietary requirements. People's views about the meals provided were actively sought to improve people's experiences.

A multi-disciplinary team of health and social care professionals provided people's care. People had access to a doctor 24 hours a day through the on-call system.

People's needs had been assessed and personalised care plans developed. People had discussed their preferences with staff on admission to help ensure they received the care they wanted.

Staff were responsive to people's pain management needs. The provider was developing a more effective pain management tool.

Daily handover meetings and the weekly multi-disciplinary team (MDT) meeting ensured all people were discussed in-depth by a range of professionals. Care and treatment was evaluated every day to reflect people's changing needs.

People knew how to make a complaint if they were unhappy with their care or treatment. One person commented, "Yes I know how [to make a complaint], not had the need." Two formal complaints received during 2015 had been fully investigated and action taken to address the issues.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Staff knew how to recognise and respond to safeguarding concerns.

Staffing levels were good with enough staff on duty to provide safe, person-centred care.

Risks were managed with appropriate action taken to minimise harm to people.

Medicines were managed safely.

Good 

Is the service effective?

The service was particularly effective.

Staff were highly skilled, knowledgeable and well-trained.

Staff received good support and had regular opportunities for professional development.

The provider followed the Mental Capacity Act so that people were not unlawfully deprived of their liberty and supported to make decisions.

People's nutritional needs were met well including preferences and special dietary requirements.

A Multi-disciplinary team of health and social care professionals was available to care for people.

Outstanding 

Is the service caring?

The service was extremely caring.

People and relatives told us about the "brilliant" and "marvellous" experience they had whilst staying at the hospice. They said they had been treated with great care, kindness and respect.

Staff were committed to doing as much as they possibly could to enhance people's physical, emotional and spiritual wellbeing.

Outstanding 

People felt in control and were actively involved, where possible, in all decisions about their care and treatment.

There was a strong focus on rehabilitation to ensure people could be as independent as possible.

Is the service responsive?

Good ●

The service was responsive. People were in total control of their care and treatment and were consulted about their care plans.

Care was evaluated daily to keep up with people's changing needs.

Care was person-centred and people were supported to make choices about how they spent their day.

The small number of complaints received had been dealt with professionally.

Is the service well-led?

Outstanding ☆

The service was especially well led. The registered manager and the management team provided strong, robust leadership. This helped ensure care was provided in a culture of honesty, compassion and respect.

People and staff particularly commented on the effective management of the hospice. People confirmed they were valued and their views listened to and acted on.

The hospice had developed effective and successful partnerships with a range of organisations and regularly took part in research to improve palliative care for people both in the hospice and the wider community.

The provider proactively monitored, evaluated and improved the quality of people's care. Staff were highly motivated and committed to improving people's care.

Marie Curie Hospice Newcastle

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 June 2016 and was announced. The provider was given 48 hours' notice so as not to disrupt the day to day running of the service and to enable nursing staff, who were caring for very unwell people, to be available to speak with us.

On the first day of the inspection there were two adult social care inspectors, a specialist advisor with experience of end of life and palliative care, 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. On the second day of the inspection there were two adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the information in the PIR as well as all the information we held about the service, this included notifications of significant changes or events.

During our inspection we spoke with four people receiving medical treatment, two relatives and a visitor. We also viewed the consistently excellent feedback received from 44 people and relatives, received during April and May 2016.

We also spoke with 22 staff including the registered manager, the medical director, the lead nurse, the nurse manager, the facilities manager, the lead allied health professional, a pharmacist, the head chef, the administration supervisor, the hospice manager's PA, the chaplain, the patient services clerk, an advanced

nurse practitioner, the practice development facilitator, an in-patient unit sister, three staff nurses, three health care assistants and the dietitian. Prior to the inspection we contacted external health care professionals and commissioners of the service from the Clinical Commissioning Group (CCG) by email. We received a response from two commissioners who provided positive feedback about the hospice.

We reviewed a range of records including five people's medical records, two care plans and medicines records. We also reviewed staff files, including staff recruitment, training, supervision and appraisal records, records relating to the management of the hospice, quality assurance checks and a range of policies and procedures.

Is the service safe?

Our findings

People told us they felt very safe receiving care at the service. One person commented, "If you are going to be bad [unwell], it's the place to be." Another person told us, "I feel safe, it is brilliant." All of the staff we spoke with said the hospice was a safe place for people to be.

The provider had a safeguarding policy and procedure. Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns, and were fully aware of the service's 'whistle-blowing' (exposing bad practice) policy. All staff said they had not needed to use the whistle blowing procedure but would not hesitate in raising any concerns they had. One staff member said, "I would report it [concern] to a team leader. I haven't but I would definitely raise concerns. Team leaders are always upfront and friendly, everyone would just knock on their door." Another staff member commented, "I have never had to use it [whistle blowing procedure]. It is there if I needed. I would go to the ward manager, she is very understanding. All managers deal with things very well. They would deal with it in the right manner." A third staff member told us, "I would be the first to speak up if I saw anything."

People's safety within the hospice setting was clearly a priority. We saw a range of assessments had been carried out to help protect people from potential risks. This included assessments relating to the use of bed rails, nutrition, skin damage and falls. We observed safe handling practices whilst spending time in the 'in-patient unit'. People identified as at risk of falling were provided with specialist equipment to help keep them safe. For example, sensor mats to alert staff when they were out of bed. We also saw one person had a crash mat in use in their room to protect them if they fell out of bed.

We looked at the way medicines were managed within the hospice. We found people were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines. People told us they received their medicines correctly. One person commented their medicines were "spot on". Another person told us they received their medicines "like clockwork".

We looked at how medicines were handled on the ward. We saw appropriate arrangements were in place for checking and confirming people's medicines on first admission to the hospice. When people were discharged, we saw they had been given detailed information about their current medicines, including changes made during their stay at the hospice. This ensured up to date information about people's medicines would be available to their GP if required.

There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management.

We saw a lockable cabinet was located in each room for the secure storage of medicines. Staff told us no one was managing their own medicines.

Appropriate arrangements were in place for the recording of medicines. The medicines records we checked showed people received their medicines as prescribed. For a medicine that was administered as a patch, a

system was in place for recording the application and removal of the patch. This was not fully completed for one person we looked at.

Medicines were kept safely. Medicines were kept securely and only accessible to staff authorised to handle medicines. Medicines were stored at the correct temperature and therefore were suitable for use. There was a system in place for checking expiry dates of medicines. Controlled drugs were ordered, received, stored, checked and disposed of in accordance with the required legislation.

Nursing staff told us that they received training in medicines management and also specialist equipment such as syringe drivers. Their competency for administering medicines was assessed at regular intervals.

Arrangements were in place to ensure medicines incidents were reported and fully investigated. We found there was an open culture around reporting medicine errors. All the staff members we spoke with were aware of how to report any medicines incidents. We saw that a recent medication error had been fully investigated and additional medication training had been undertaken and changes to procedures had been introduced promptly to reduce the risk of reoccurrence.

We asked about the arrangements for auditing medicines handling and storage in the hospice. We saw controlled drugs were checked frequently. We were also told the pharmacist completed a full audit of all medicine charts. These checks helped to identify any issues in order to learn and prevent the errors happening. There was also a system to receive and act upon national drug safety alerts.

We spoke to the registered manager about staffing. We were advised staffing levels had been reviewed two years ago and had been increased. The registered manager advised the service generally operated on a ratio of three people to one nurse. The registered manager told us staffing was based on dependency but that generally on an early shift there would be eight or nine staff members which comprised of five or six nurses and three health care assistants. On a night there were two nurses and two health care assistants and a twilight shift had recently been introduced with an additional nurse working until 11pm. From our observations around the service and our discussions with staff, people and relatives we concluded staffing levels were appropriate. One person said, "Yes, every time I need help they are there. There are lots of hands to help." Another person commented, "More than enough [staff]. Three or more [staff] will come when required." Staff told us staffing levels were excellent. One staff member commented, "We are well staffed, fantastic. We sit down and have a chat with people."

Robust systems were in place for the employment of new staff members. Potential staff members were asked to complete an application form which covered areas such as their previous experience and qualifications, a full employment history and details of two referees. Staff members were asked to account for any gaps in their employment history and appropriate checks were undertaken to establish whether staff members had a criminal record. References were sought and applicants' right to work in the UK was also checked. Checks were also completed regarding professional registration and qualifications.

The service had a business continuity plan which covered the actions to be taken in order to continue the service in the event of an emergency. This plan set out the roles and responsibilities of individual staff members in responding to incidents which occurred both during and outside of normal business hours. Individual action plans had been created for possible emergencies such as explosion, resource failures such as the loss of gas supply and the loss of staff resource due to sickness, for example though a pandemic influenza outbreak. Regular health and safety checks were undertaken by the facilities team to ensure the service was as safe as possible for people.

We spoke with the facilities manager in relation to health and safety and the management of general risks in relation to the service. A number of these audits were completed by external agencies and we found the service had received positive ratings in all recent audits completed. The provider evidenced consistent good practice as year on year they had been awarded a 5 star rating for health and safety from different external consultants. A 5 star rating showed the provider was 'meeting best practice' based on the gradings the consultants used. We found areas for improvement identified during audits were captured on an action plan and action taken to address these. For example, the health and safety audit highlighted the provision of challenging behaviour training for staff as an area for improvement. Training in challenging behaviour had been delivered to staff responsible for delivering training to others within the service. Sessions had started to be scheduled to provide this training to all staff.

We found the service regularly completed exercises to test and review the effectiveness of health and safety procedures. Learning from these exercises was used to improve the services response to emergencies. For example, we noted a live test was completed on 8 July 2015 to assess the response to a fire within the hospice. A review of this exercise highlighted concerns that staff had initially presumed the alarm was a test and had therefore not immediately evacuated. People had also stopped to collect personal belongings before leaving the premises. Following the test, feedback was provided to all staff members via email, reminding them of the importance of responding to the fire alarm promptly and reminding them that they should not stop to collect personal belongings. All staff were also asked to re-familiarise themselves with the evacuation plan for the service. This was then monitored to ensure completion of the actions.

We viewed the provider's file containing details of events and incidents that had been reported to external bodies such as the Local Authority and the CQC. We found an incident reporting form was completed for all incidents. This provided an overview of the incident and any remedial actions that had been put in place.

Is the service effective?

Our findings

The staff team had an extremely high level of knowledge and skills. One person told us, "Everyone knows their role." People and relatives described staff as compassionate, understanding, wonderful and a lifeline. One relative described how they had been "helped through a difficult time." Another relative commented the "professional dedication of staff is beyond words."

The service worked in partnership with other organisations to make sure staff were fully trained and able to deliver outstanding care which met people's needs and was based on best practice. For example, certain staff had recently worked with a local university to complete a specific training module related to care and compassion in care. Staff had reflected on their current practice to improve how they communicated with people. All staff members were encouraged and supported to undertake additional qualifications. A number of senior staff members either had or were working towards degrees in palliative care. Health care assistants had also completed vocational qualifications in palliative care. One qualified staff member told us working towards academic qualifications had helped to improve people's care. They said, "Patients have benefitted hugely. We looked at symptom control and what is important to patients when they have a palliative care diagnosis. We can bring this learning back to benefit patients."

There were champions within the hospice who supported staff to develop their skills and knowledge so that people experienced good healthcare outcomes. This included dementia awareness, tissue viability, dignity, blood transfusion and infection control. Six members of staff had been designated as dementia champions to provide additional support to the staff team. The provider had invested in raising staff awareness of dementia to ensure staff had the knowledge to support people living with dementia or experiencing confusion due to their illness appropriately. All staff had completed dementia awareness training and had signed up as dementia friends. Staff had also followed through on their dementia promise by raising awareness of dementia on social media. The registered manager told us, "Dementia awareness had much improved across the hospice."

Staff had used their enhanced knowledge and understanding of dementia to make a difference to the lives of the people they cared for. One health care assistant told us, "I have learnt a lot about dementia and I use it on the ward." For example, staff knew how much one person enjoyed looking at specific pictures. They did this whenever they attended to the person. A relative had commented their family member had been seen as a "whole person again". A resource box was placed on the in-patient unit, which included hand-made 'fiddle muffs' and knitted dolls to support distraction and calming when people became anxious. Staff had engaged people in reminiscence and singing to promote and enhance memory recall. One staff member said they felt a huge sense of achievement when a person began to sing the words back to them; this had been the person's only response for a long time.

All new staff members received a role specific induction consisting of classroom based training, e-learning and practical hands on training. This variation in training methods allowed the provider to accommodate staff members' different learning styles. The Practice Development Facilitator advised us they met with all new staff members within their first couple of days to discuss their induction with them and to determine

any specific training requirements. This ensured training was personalised to the individual learning needs of staff. Following completion of their initial induction, all new care staff underwent a number of clinical observations to confirm their competency in carrying out tasks key to their role. Staff members were only able to complete tasks unassisted once they had been signed off as competent to do so. Staff told us the provider promoted good educational opportunities and career progression.

We reviewed the service's training matrix. We saw essential training was in place which all staff had attended. Clinical observations and competency checks were conducted of staff members' practice as part of this process. One staff member said, "I would say training is very good." The training programme and delivery was thorough in that it not only checked staff member's knowledge but their practice in how care was delivered.

All staff, both clinical and non-clinical, had completed a communication course called 'Sage and Thyme.' This was training to support staff with communicating with people who were distressed. The registered manager told us this was important as any of the staff team could encounter a distressed person during the day or night. They went on to tell us completing this training should give staff the confidence to start a conversation with the person. We found the course had been evaluated and positive feedback given. For example, staff comments included: "I am a member of the non-clinical staff but was still able to use the Sage and Thyme model whilst having a discussion with two relatives at the reception area. I found working through the model helped me steer the conversation"; and, "A recently bereaved relative was in the reception area very distressed. I was able to confidently approach and resolve some of [the relative's] problems. I felt like my Sage and Thyme training helped me to do this."

The process of revalidation for nursing staff was already embedded within the Hospice. Revalidation is the process which nurses must undergo to maintain their registration with the Nursing and Midwifery Council (NMC). The lead nurse was responsible for this and was supported by the practice education lead.

Staff felt well supported and confirmed they received regular supervisions and appraisal. They said they were encouraged and empowered to develop their own solutions to challenges they faced. One staff member told us, "We have plenty of options [for support]. The chaplain is here, a psychologist and even your own colleagues. We all help each other." Another staff member commented, "There are plenty of people I could go to, we support each other. We really get on with each other, we are very lucky." A third staff member said, "I feel very much part of the nursing team. I am well supported by manager. We all work towards the best care for the patient."

The medical director talked to us about the use of the nationally recognised practice of 'Schwartz' rounds to allow staff to reflect on their own feelings in a safe and supportive environment. Schwartz rounds provided staff from all backgrounds with the opportunity to talk openly and share experiences about the emotional challenges of caring for people. Previous topics discussed included 'The patient that stayed with me'; and, 'Christmas at the hospice.' Staff fed back they found the sessions useful in building confidence and support. Their comments included: 'It had given me food for thought, not on the technical aspects of my work but the emotional'; and, 'Gives a feeling of togetherness as a larger team, as many different staff attended. Boosts morale by sharing.'

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 so that they can 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 and hospitals 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.

The registered manager was aware of the service's responsibility to ensure no person was deprived of their liberty unlawfully. We reviewed the records for Deprivation of Liberty Safeguards (DoLS) submitted by the service and found the service had acted appropriately. We reviewed the 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) document of a person who lacked capacity; there was evidence of a mental capacity assessment and the use of best interests planning for their future care and placement. Staff showed a very good understanding of the MCA including how to support people with making decisions and choices.

Effective communication to enable people to express their views and make decisions was a priority. Staff clearly understood the importance of adapting their communication to meet people's individual needs. They told us about one person who had lost the ability to communicate verbally. Staff followed the person's choice to communicate through writing notes. Additional resources were available at the hospice to help with communication, such as laminated boards with symbols and iPads. Staff told us these were used regularly although they weren't required for the people using the service at the time of our visits. There were also excellent links with the speech and language therapy service to provide additional specialist advice and guidance to support people's communication. Staff told us they would always get consent before proceeding with any care or treatment. Written information could be made available in any format when required to meet a person's needs.

There was a strong emphasis on the importance of eating and drinking well. People and relatives told us staff went out of their way to ensure preferences were met, they had choices and they had enough to eat. One person commented, "It's like a 5 star hotel." Another person told us, "It is very nice." A third person told us, "You can choose to eat in your room, the restaurant or TV room, which I did so I could watch the football the other day." A fourth person said, "The chef will come and see you." One relative said, "The food looks absolutely delicious." Another relative told us, "It's brilliant. They encourage [my relative] to eat, by giving [my relative] choices. Once they brought [my relative] five different sweets [puddings] to choose from."

The provider was keen to promote choice so that people and relatives could have a positive dining experience. The provider had opened up the Garden Café to enable people to have their meals in a café environment whilst enjoying the social aspects of eating and having time away from the ward environment. One person had been supported to host a family Christmas in the Garden Café as they were too poorly to do this in their own home. The in-patient unit had been re-designed to include a large fridge for people's use to store items of food they purchased themselves. Fresh fruit was available throughout the day, as well as homemade (by the chef and volunteers) cakes and biscuits as a mid afternoon snack.

Positive staff relationships encouraged people who were reluctant to eat or drink. One of the hospice's chefs met with all new people to explain the menu and discuss any dietary requirements the person had. Outside of the normal catering times (7am to 6.30pm daily), nursing staff could prepare hot snacks. Following feedback from people a cold cabinet had been provided which held sandwiches and drinks to increase the choices available to people and relatives. The hospice had 28 different menus which were rotated every four weeks to offer a wide variety of meals, always including healthy options. People could either choose from the menus or specifically ask for anything else not on the menu. One person said, "If it's not on the menu they will make it especially for you."

There was regular interaction between the chef and people. For example, if people's menu choices weren't returned or their meal uneaten, the chef would speak with the person to find out if there were any further improvements or changes they would like. Where meal choices had been made by relatives the chef said they still checked with people to ensure they were getting the choice and food they liked. People were encouraged to give immediate feedback about their meals by leaving comments on the back of their menu. In this way adjustments to their meals could be made quickly. People could also request a visit from the Head Chef to discuss any aspects of the meal or give any further comments.

The hospice was able to cater for all special dietary requirements, such as pureed meals, vegetarian, gluten free and other allergens. For example, for one person on a blended diet, who had previously used the hospice, the chef creatively used a piping bag to present food to resemble restaurant standard meals. The hospice was also able to cater for any cultural dietary needs. For example, locally sourced, certified Halal food and locally sourced and specially prepared Kosher meals. People could also choose small, medium and large meals or a specified size of the person's choosing so as not to overwhelm people with small appetites. One person commented, "You have a choice of a small, medium or larger meal."

There were excellent links with dietetic professionals ensuring a high level of nutritional expertise was available at all times. The Newcastle hospice was the first in the group to directly employ session time from a dietitian. As well as providing advice and guidance to staff and people on an individual basis, the dietitian delivered a training session on nutrition for every nurse and healthcare assistant. The dietitian had also had some input into ensuring menus were nutritionally balanced. The dietitian confirmed staff at the hospice were "very good" at following advice and recommendations. For example, knowing when to make adjustments for people on a percutaneous endoscopic gastrostomy (PEG) feed. A PEG is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

The dietitian worked creatively with staff to use supplements in food and drinks to ensure people had an appropriate dietary intake. For example, a nurse made up frozen lollies using fortisips (a nutritional supplement) as this helped a person to have a calorific ice lolly that was soothing and met their preferences. We also noted the care of another person who was clearly advanced in their illness and had become dehydrated. The person had been admitted to the hospice for rehydration. The staff went above and beyond to encourage hydration, making the person 'mocktails' (alcohol free cocktails) to encourage them to drink through offering refreshing flavours. Staff promoted oral care through using a variety of liquids in line with people's personal preferences, such as water, tea, coffee and alcoholic drinks.

Discussions with people and staff showed links with health and social care professionals were excellent. The provider had redesigned care delivery to focus on people receiving holistic care that met all of their physical and psychological needs. For example, each multi-disciplinary 'in-patient team' for seven people was led by a consultant with support from other medical and nursing staff, health care assistants and a social worker. On-call arrangements ensured people had access to medical staff 24 hours a day. One person told us that if they became unwell "the doctor would come and see me". Where the hospice did not directly employ a particular service, such as speech and language therapy, there were good partnership links in place to ensure people received the care they needed.

People accessed a range of complementary therapies from directly employed therapists, such as massage and acupuncture. One person told us about how having a massage had "really helped them to relax". We heard during the daily admissions meeting one person, who was being discharged, wanted to have acupuncture before going home. We saw staff made sure this was done before the person left the hospice later that day. This showed people valued the complementary therapies on offer.

Careful consideration had been given to the adaptation, design and decoration of the hospice. The hospice environment was calm and relaxing with quiet spaces for contemplation and reflection, such as the multi-faith reflection room. We overheard a person about to return home following a weeks respite care. They thanked staff and said they were "over the moon" with their care, particularly as the garden area was accessible for their wheelchair. Another two people told us about the enjoyment they found from sitting in the gardens watching the wildlife.

The hospice recognised the importance of families having the space to spend private time together. The provider redeveloped part of the hospice into the 'Lindisfarne Suite.' This was a self-contained space for a family to stay at the hospice together. One nurse said, "It is very rarely empty. We can give them space to be a family. That is what we are all about, giving patients choices. Our values are all about that." The provider organised opportunities for families to spend quality social time together. For example, pizza nights for families staying together in the Lindisfarne Suite. Staff had also set-up a cinema experience in the hospice for another person who was too poorly to go out to the cinema. This enabled them to have one to one with their child watching a favourite movie. There was also a family room containing a wide variety of toys, games and electronic equipment, such as a PlayStation and a DVD player.

Is the service caring?

Our findings

Without exception, people and relatives described to us having received excellent care and treatment at the hospice. One person told us, "Its Brilliant, [I am] happy to be here and staff are happy to help." Another person said, "I am having an absolutely marvellous time, I came in a week ago and wanted to crawl into a hole. This week I feel so much better." A third person commented, "It's 100%." A fourth person told us, "I am treated like royalty." One relative commented, "[My relative] is getting the best care, staff are very, very friendly." Another relative said, "[My relative] feels better when [my relative] comes here and I feel at ease when I come over."

As well as the positive feedback we received directly from people, we viewed the many comments and compliments the hospice had recently received praising people's care. 44 compliments had been received during April and May 2016 alone. Relatives described the care provided at the hospice as fantastic, loving, fabulous and overwhelming. They commented staff were wonderful, angels and the kindest people. Other comments made referred to the great care and attention people received and the dignity with which they were treated.

People and their relatives told us staff were extremely kind, caring and compassionate. One person told us, "They are lovely people." Another person commented, "Staff take time to listen, so endearing in a nice way which keeps you smiling." A third person said, "Staff always have time for you." A fourth person commented, "They will help with absolutely anything." One relative told us, "Staff are great with [my relative]." Another relative said, "They are very kind and caring, staff look after [my relative] very well." A newly appointed staff nurse told us they were "actively encouraged to spend time with families". They went on to reflect on a person who had recently died, whereby the family had fed back they felt extremely supported and well cared for.

We found numerous examples during our inspection of staff 'going the extra mile' to make people feel special and help fulfil their wishes. One staff member commented, "Staff go out of their way to meet patients' needs. There is nothing we wouldn't do for a patient." Another staff member said, "We go the extra mile for the patients." All of the staff we spoke with told us about a wedding which had very recently taken place at the hospice. The chaplain told us an archbishop's special licence had been required in order for the wedding to take place. Staff had been required to obtain and send documentation to London on the person's behalf in order to obtain the licence. The chaplain told us how the staff had come together to organise and conduct the wedding in line with the person's wishes. We saw staff had the wedding certificate framed as a special memento of the special day.

We found staff at the hospice had been involved in arranging celebrations for many weddings and anniversaries. Staff supported a person to attend a concert in Leeds to see a favourite singer. One staff member commented, "It was an amazing achievement to get [the person] there really. It was also one of [relative's] last memories." Staff also supported another person to attend a famous sporting event. We found other examples including: providing Christmas dinner in the restaurant for a person and their extended family; a nurse coming into the hospice in their own time to help a person complete life story work

before they passed away as it was important to them to finish it; and, staff helping to prepare people's own homes to enable them to return home to their preferred place of death. One staff member told us about a time when a person wanted their hair dyed a particular colour. They said, "We met [the person's] needs. It is the little things that matter."

Relatives had written to the hospice to especially thank staff for taking the time to make their family member feel special. They commented staff had made their relatives last days memorable, pain free, peaceful, calm and comfortable.

Staff were passionately committed to ensuring people's wellbeing was enhanced. People and their relatives we spoke with told us being in the hospice had a positive effect on their emotional wellbeing, helping them to feel better about their situation. One person said, "My spirits are kept up in here and my mood is as good as it can be." Another person commented, "Genuinely, they want to help you, when you have a down day." One relative told us, "I have been offered support; I know it's there if I need it." Another relative commented, "I can sleep now." One staff member said, "Families are having a tough time. We pride ourselves in not just looking after the patient but everyone involved."

We heard from people about how staff went out of their way to try and relieve some of their emotional and physical distress. One person told us, "They all know their jobs, if you need painkillers they will get the nurse." Another person said, "Yes they help me with the pain." The registered manager gave us examples of other occasions when staff had helped people. For instance, on one occasion staff arranged to move a piano into the in-patient unit to help a person who was experiencing psychological distress. Over time this helped the person to relax and also regain a lost skill. Staff assisted another person who felt she had lost her independence to host a garden party for their family at the hospice. The provider told us this restored the person's sense of self, resulting in a very positive influence on their psychological wellbeing.

We spoke with the newly appointed chaplain about how the service met people's spiritual needs. They advised a spiritual care assessment was completed on admission to ensure people had an informed choice about the spiritual support available. The chaplain informed us they regularly sought feedback from people, relatives and staff about how they could improve the service they offered. The chaplain told us they were currently establishing links with other religious groups in the local area to enable them to better cater for people with a variety of religious beliefs. For example, they had been to visit a local Sikh temple to learn more about the local Sikh community and to raise awareness of the role and services provided at the hospice. The chaplain advised, "We were able to ask lots of questions about Sikh customs and practice as regards to illness and end of life issues." Further staff visits had been planned as well as teaching sessions for hospice staff. Following the initial visit a Sikh book of writings had been donated for the hospice's reflection room. A faith leader contact had been established to call upon for people using the service from the Sikh community if needed. The provider hoped these initiatives would encourage the recruitment of additional staff members and volunteers from different faith groups. The chaplain also offered support to staff and they met with new staff members when they first joined the service. They also offered a confidential listening service to staff on the proviso that any safeguarding concerns would have to be reported.

Currently none of the people using the service required an advocate. The registered manager told us if this was required they would contact an Independent Mental Capacity Advocate (IMCA). The role of the IMCA is to support and represent people at times when critical decisions are being made about their health or social care. They are involved when the person lacks capacity to make these decisions themselves and mainly when they do not have family or friends who can represent them. Advocacy was always discussed when completing a DoLS application and a best interests decision to ensure people were supported appropriately.

All of the people we spoke with said they were completely in control of their care and treatment. One person told us, "I have total control." Another person said, "Yes I guide them, until they get to know me." A third person commented they were "definitely" in control. People also confirmed they were consulted and involved in making all care and treatment decisions, both clinical and non-clinical. One person told us, "Yes they see you all the time, they ask what you think and are given options." Another person said they were "always told what plans are being put in place". A third person commented, "I have been asked by doctors and nurses how I feel, I said they can't do anymore." A fourth person said, "A special worker asked I how feel." Two people said they had been consulted and involved with decisions about medicines dose changes. Another person told us they had been invited to a meeting to discuss their treatment. They said they had declined but staff had gathered their opinions anyway.

An excellent approach to privacy and dignity was embedded throughout the hospice. There was an option for people to have a single room or share a four bedded bay with curtains. This allowed people to choose whether they would like the company of other people or their own personal space. All of which were conducive to a positive experience and good care. People said they were always treated with dignity and respect. One person said, "Yes, my personal care is respected." We viewed the many thank you cards on display at the hospice. Promoting people's dignity and respect was a recurring theme throughout the comments. For example, comments included: 'Words cannot express how much it meant to us to see the compassion, dignity and respect shown to [person]'; "[My relative] was always treated with kindness and respect as a person not just another patient"; and, "[My relative] was a very proud and dignified [person] and was allowed to remain so throughout [my relative's] time at the hospice". Staff spoke clearly about how they aimed to provide care in a respectful and dignified way.

The hospice had a strong focus on rehabilitation, as well as promoting independence. People had access to the hospice's physiotherapist and occupational therapist when required. All people told us the physiotherapist had visited them to assess their needs. The hospice had its own well equipped gym. One person with very limited mobility told us the physiotherapist had encouraged and supported them to attend the hospice gym. They said, "I wouldn't of thought of going to the gym, it's unbelievable. I have been to the gym, I feel safe and I have been offered by the physio to go again, which I really want to do. It helps me both physically and mentally." The registered manager told us following discharge people with an exercise plan were free to drop in at any time without an appointment to use the gym facilities. We observed this happening during our inspection. This focus on rehabilitation was also apparent in the recently redeveloped day centre. People attending the day centre were offered the opportunity of developing skills to enhance their independence. For example, some of the day centre activities involved cooking and baking skills in the centre's fully equipped kitchen. The kitchen had also been specially adapted for rehabilitation and to meet the needs of wheelchair users. This enabled patients to attend weekly cookery and baking sessions to build their confidence in food preparation.

We discussed the process for making clinical decisions regarding treatment with the medical director. They told us day to day decisions, such as changes to 'when required' medicines would be made with the person and relatives if appropriate. More significant decisions would be a joint decision with the person and the medical team. Consideration would be given to mental capacity, the support required for the family, the legal position and support for the medical team. Of the medical notes that were reviewed all people had active do not attempt cardio pulmonary resuscitation (DNACPR) documents, one of which had been completed just three days before the person died. One nurse told us, "We prepare the way before the patient dies so that it is not traumatic, but peaceful."

Advance care planning and decision making was well established. The medical director described a proactive approach to empowering people to make their future wishes known. The medical director was

making changes in this area. For example, supporting the day care team to begin advance discussions whilst people had the capacity to do so. They told us they believed this "up-stream approach" would benefit everyone involved in the future. We viewed one person's medical records and found they had a self-written signed advance statement and had been commenced on a care plan which reflected their wishes.

A comprehensive bereavement support service was available for all relatives consisting of either one to one, group and telephone support depending on the needs and preferences of individual relatives. The hospice had received positive feedback from relatives about the support they had received after their family member had died. Words used to describe the bereavement service included, fantastic service, exceeded expectations and went the extra mile.

All families had the option of having a memorial service for their loved one if they wish. The hospice also held an annual 'Lights to Remember Service' at the cathedral to celebrate and reflect on the lives lost, to which all bereaved families were made welcome. The hospice had received lots of positive feedback about the memorial service. Words used by family members to describe the service included: 'a beautiful remembrance of loved ones'; and, 'a lovely service.'

The hospice had a dedicated 'Patient and Family Support Team' which staff told us was integral to the caring nature of the hospice. The team consisted of social workers, the chaplain, the children and young person counsellor and support by specially trained volunteers. We viewed the feedback from children who had been supported by the service. This described how they had been helped with stress, encouraged to feel comfortable and open up made to feel better when feeling sad. One parent described the counsellor as 'amazing'. Whilst others fed back about how the support they received had allowed them to 'continue and still be a family.'

Is the service responsive?

Our findings

People were admitted to the hospice following a referral from recognised health professionals, such as a GP, nurse, consultant or other health and social care professionals. Referrers were encouraged to use a specified referral form, which had been developed jointly between Marie Curie, a neighbouring hospice and referrers. This allowed a consistent and streamlined approach to the referral process. People could be admitted 24 hours a day, seven days a week. One of the hospice's four Advanced Nurse Practitioners could visit new people prior to admission. This allowed them to prepare the person for the hospice environment and have care plans "ready to go" on admission. Following admission, people spent time with a doctor and nurse to discuss the reason for their referral and the outcome they wanted from their stay. People's choices and preferences for their care and treatment were discussed during the assessment.

All of the people we spoke with told us their needs had been assessed and they had been actively involved in developing their care plans. They said staff were very responsive to their needs. They went on to say staff often asked them how they were and if they needed anything. People had signed their care plans to show they agreed with the contents of the plan. The registered manager told us if people were unable to sign care plans a nurse would sign to confirm they had discussed the plan with the person. The 'This is Me' document was used within the hospice to enable staff to gather a better understanding of people in their care. Staff said this had proven to be a huge help in getting to know people's preferences, such as their likes, dislikes, family members and what was important to them.

Care planning had evolved to move away from generic core care plans to an individualised approach. Care plans we viewed covered key areas, such as communication, pain, skin integrity, spirituality and emotional care. We saw care plans were left at each person's bed sides to enable them to have ownership of the plans. There was space in care plans for a person centred statement and personalised goals depending on what was important for each person. Care plans were evaluated daily to ensure they were always up to date with the person's changing needs.

The provider was keen to promote the role of health care assistants to build their confidence and empower them to populate care plans with any interventions they had been involved with. Care records we viewed were usually completed accurately. We found some minor inconsistencies with daily recordings. For example, we found an inconsistency for one person between their daily records and their care plan with regard to bowel habits.

People told us staff took the time to help them manage their pain. One person replied, "Everyone would come and help." Another person commented, "This happened to me and I got pain killers." A third person told us, "The doctor would come and see me." The hospice team were leading on developing a new assessment tool as they felt the current tool was limited in its usefulness. The medical director told us the hospice had tried all of the recognised pain assessment tools but found they had limitations in how well people were able to describe their pain. The hospice was evaluating a new tool which was intended to be a wider than giving a score to consider whether the intervention provided had improved things for the person.

A multidisciplinary handover meeting took place daily involving a social worker, physiotherapist, pharmacist, nursing staff and doctors. There was a recorded message from the night duty nursing sister on each of the units covering each person. There was also a verbal follow up of anything additional that had happened that actual morning since the voice recording had been made. The handover included detailed information for each person, such as changes to medicines, reported pain, use of 'when required' medicines overnight, eating, sleep and sickness. A detailed discussion took place about plans for treatment. It also included a detailed discussion about any plans for admission, discharge and referrals received. We saw there was good interaction and staff were encouraged to engage and ask questions.

People were evaluated every day to ensure they received the best care and treatment to meet their needs. One staff member told us people's needs were discussed every day. They said, "Care needs change daily. We treat them [people] as an individual. We need to change the care provided to what patients need on that day."

As well as the daily handover meeting each person's care and treatment was fully discussed during the weekly multi-disciplinary team (MDT) meeting. The lead nurse told us the MDT meeting was a full afternoon and comprised of looking at each person's current placement, their future planning needs and the person's wishes and goals, including discharge from the hospice. The MDT was made up of nursing staff, the chaplain, medical staff, a nurse practitioner allied health professionals, such as a social worker, occupational therapist and physiotherapist.

People were asked how they wanted to spend their day and their choices were respected. One person told us about how they had spent time with a friend in the pub the previous day. People had the opportunity to attend the day service. One person who was returning home on the day of our inspection told us staff at the hospice had already made arrangements for them to attend the day service. One staff member said, "We go round and ask patients what they want to do that day. We give them their choices every day." Another staff member told us some people liked their hair and nails done or to have a makeover. They commented this helped people "to feel better about themselves, to feel amazing and that is what is important".

All the people we spoke with knew how to make a complaint. For example, talking to a member of staff or completing a complaint form. They all told us though they did not have any reason to make a complaint. One person commented, "Yes I know how, not had the need." Another person said, "I know I could fill in a form."

The service had a complaints management policy which provided details of the procedure to be followed when responding to complaints. We reviewed the service's complaints log and associated folder and found the service had received six complaints during 2015. Of these, two were formal and four were informal. The complaints register provided a brief overview of each complaint including the date the complaint was received, the date it was acknowledged, an outline of the complaint and details of the outcome and any action taken as a result of the complaint. We found all complaints had been thoroughly investigated and where appropriate an outcome letter had been sent to the complainant. Action was taken to address any issues identified during the investigation. Where complaints related to the conduct of staff members, we saw evidence this as addressed with them directly.

Is the service well-led?

Our findings

The hospice had a registered manager who had been registered since October 2012. The registered manager had 15 years previous experience as an oncology (cancer) and palliative care nurse and relevant academic qualifications in nursing and management. They were fully aware of their legal responsibilities and were proactive in submitting statutory notifications to the Care Quality Commission. We found the service was making appropriate referrals to external bodies such as the Local Authority. The registered manager understood the challenges facing the hospice and articulated a clear vision for moving forward.

All of the people and relatives we spoke with gave exceptionally positive feedback about the service and the leadership and management displayed throughout the hospice. One person commented, "It must be well led, as it is brilliant." Another person told us the hospice was, "Absolutely well-led." One relative described how they had "dreaded" visiting the hospice as they knew nothing about hospices. However, they found the experience a "pleasure" and had felt "most welcome". Other words people and relatives used to describe the hospice were loving, calm, peaceful and comfortable.

The hospice's values were inclusive and person-centred making sure that people were at the heart of the service. These included; "Always compassionate"; "Making things happen"; "Leading in our field" and "People at our heart." The vision and values were driven by the excellent leadership of both the registered manager and provider. The values were consistent across all Marie Curie services and had been developed with input from the 'Expert Voices Group' (the group within Marie Curie which represents the voice of people and carers). Throughout our inspection we found excellent examples of staff putting these values into practice. For example, we identified many examples where staff had gone out of their way to meet people's holistic needs, choices and preferences in the most caring and compassionate way. All staff we spoke with, without exception knew what the values were and their importance in promoting excellent care for people. Staff described to us what the values meant for them. One staff member said, "The values are about patient-centred care, making sure we do everything for the patient and learning from the patient."

We found the hospice had a culture of openness and transparency. Staff demonstrated they were knowledgeable, dedicated and committed to providing people with the best possible care. They all fully understood their role and how this supported person centred care. One staff member told us the hospice team was supportive of each other and worked well together. They said there was a culture of 'no such thing as a silly question'. Another staff member described to us the "open and honest ethos of the hospice". In order to help break down barriers all staff used their first name and wore badges which stated 'hello my name is [first name]'. The medical director said the staff team "all had different strengths and it works well". In order to promote transparency, all minutes from meetings were shared with the staff team.

All staff described clearly and consistently the culture of positive leadership within the hospice. They were enthusiastic, motivated and welcoming throughout the inspection process. One staff member told us about how their role had flourished due to the positivity of the leadership and management team. They went on to say they had been very supported in their advanced practice and prescribing role, with clinical supervision every four to six weeks. Another staff member commented, "Honestly, it is the best job I have ever had. I just

love it." A third staff member said, "I really like it here. It is a lovely place to work. The staff are lovely, managers are lovely. It is probably the best nursing job I have had. It is all about patient choice." A fourth staff member said, "The senior management team work really well together, they all have different strengths."

The service used inclusive ways to enable people to be empowered and voice their opinions. Feedback was then used to deliver real improvements to people's care. The hospice had an iPad based satisfaction survey and comment cards were available to fill in anytime. These were reviewed in real time to make immediate improvements from any suggestions or issues raised. One person commented, "I have done the survey twice and I put 10, 10, 10." Another person told us, "I was asked if I would come back and I said of course I would." One relative said, "They ask us if there is anything wrong, if they can do anything to help." We viewed the feedback received from 84 people received between January 2016 and May 2016. The feedback was consistently excellent. For example, 100% of people said they were always treated with dignity and respect and welcomed when they came to the hospice. When asked how they would rate their overall experience, 94% of people gave the highest possible rating of 'very good' with the remaining 6% rating the service as 'good'.

There were opportunities for people and relatives to influence the work of Marie Curie more widely. The 'Expert Voices Group' involved people and relatives both locally and nationally. They had been involved in developing the strategic plan and the content and tone of the new information resources for people and families. People and relatives had been consulted about the appropriateness of the provider's priorities which had been set for the following year. In addition, The Expert Voices Group had been involved in developing the methodology for the provider's own compliance visits, particularly about how to gather meaningful feedback from people. The group had representatives on the Clinical Governance Trustees Committee to help ensure that the provider remained focussed on the needs of people and families in delivering care.

There was also a local Newcastle User Group which aimed to ensure people's voices were clearly heard throughout the hospice's governance structures. The group fed directly into the overarching clinical governance meeting in the hospice. The group was responsible for reviewing all feedback, reviewing actions and suggestions resulting from feedback and encouraging teams across the hospice to involve people and their families in all aspects of the hospice's work. Minutes from previous meetings confirmed the group met bi-monthly.

Feedback from people had been an integral part of the re-design of the day centre, along with best practice recommendations from hospice UK. Details of other improvements made following feedback were displayed around the hospice so people could see their views were taken seriously, listened to and acted upon. The registered manager provided us with details of the many improvements that had been made following people's feedback. These included ordering additional Wi-Fi, new id badges for staff, new flooring and a new desk in a communal area suitable for wheelchair use. We were shown a copy of a leaflet that was being produced to better advertise the hospice services available to people. This had been created as a result of feedback from people. Feedback from people who had previously used the service had been gathered to help inform the plans for the redevelopment of the day centre.

Staff also told us their views were actively encouraged and valued. They told us they were consulted about all changes before they were implemented. One staff member told us staff meetings were well run and organised. They went on to say they "are always listened to". Staff also said they were encouraged to make suggestions and communicate their ideas. One staff member told us about a time when they had suggested the Multi-disciplinary team boards in the nurses' office could be improved. They said, "I spoke to the ward

manager. We all had our bit input and they were changed." Another staff member commented, "We put views forward, you are listened to." A third staff member said, "We are encouraged to talk to management. We are always asked our opinion before things are rolled out. Curtains, bed covers and the new Kardex system."

There were strong and robust governance arrangements in place to ensure the hospice was well run and continuously improving. The registered manager and clinical director had undertaken a fundamental review of governance. The registered manager commented, "Governance was a big thing, we went back to basics. We are both [registered manager and medical director] proud of governance in the hospice."

The provider had a comprehensive action plan for improving and developing the service. The plan had clear links with other internal and external audits and people's feedback. For example, actions identified following a recent external Marie Curie compliance review had been added to the action plan to ensure timely completion of the actions. All actions on the plan had been completed or were progressing towards completion. Improvements already delivered and logged on the action plan included toiletry bags for people for overnight stays and additional staff posts, such as a new consultant and a chaplain.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high quality service. They had developed extremely strong links and partnerships with a range of organisations to promote and improve palliative care for people and relatives. For instance, a partnership arrangement with the coroner to develop a more streamlined process for the verification of 'expected deaths'. This provided a more seamless and less burdensome process for families. The hospice had also developed positive relationships with the acute trust. For example, joint work around incurable lung disease and developing links with Motor Neurone Disease groups. Both of these partnership arrangements had resulted in greater numbers of referrals for palliative and respite care from people with a non-cancer diagnosis. There were also strong links with the North East Ambulance Service with reciprocal arrangements in place to provide placements for new paramedics and nursing staff. This led to a greater understanding of each other's roles to improve services for people. The provider was also involved in work to develop a dedicated palliative care ambulance. Marie Curie Newcastle had strong links with a neighbouring hospice and had engaged in joint working to develop a referral form to streamline the admissions process.

One local commissioner told us about their successful working partnership with the hospice since 2013. They said they had jointly developed palliative care to make it "safer, more effective and more responsive". This included the joint funding of a Modern Matron in palliative care, a community based Palliative Care Rapid Response team and the expansion of a Hospital Liaison Team to work across the clinical commissioning group area. The commissioner told us the provider had wholly funded a service manager post to 'manage and support the Marie Curie staff working in these teams'. The new and enhanced services were aimed at improving responsiveness, in line with local and national policies. The commissioner said feedback from people, their families, ward staff, consultants, GPs, community nurses and care services had been extremely positive. They told us, "The new and enhanced services are proving to be highly effective in that they aim to ensure that the complex needs of palliative patients are being met in hospital and in the community, both in and out of hours." They went on to tell us, "The services are meeting a previously unmet need and had highlighted improvements in integration of services, continuity of care and pathway streamlining. All of which provided a much better overall experience for patients."

Staff described to us positive partnership working with the local community. There were good links with nursing homes following discharge to help ensure people were discharged appropriately. Staff told us if they felt discharges were potentially 'risky', the hospice would keep the person's bed available for up to 48 hours

as a safety net. Staff members also said there was effective public involvement with the hospice and "excellent" support from local volunteers in terms of transport and support for people.

The provider aimed to be an excellent role model amongst other health and social care professionals and services through proactively sharing knowledge and expertise of palliative care. The registered manager told us they did not want the hospice to be a "stand alone service" but part of the wider local health pathways. For example, some of the medical staff had other clinical roles within the NHS. This encouraged good communication, sharing of information and a close working relationship. Other staff also had teaching roles with academic institutions. The hospice provided training placements for more junior doctors, as well as nursing, occupational therapy, physiotherapy and social work students. The medical director told us some of medical staff had gone on to become consultants which benefitted people locally. The hospice ran student nurse and district nurse education programmes.

There was a strong emphasis on striving for excellence through actively engaging with and taking part in research projects to advance palliative care for people at the hospice and wider across healthcare. A number of research projects were on-going at the time of our inspection. These included a memorialisation (remembering people after death) project with Hull University, an environmental research project examining how hospice design promotes person centred care, improving communication during end of life care and a project looking at spiritual care.

There was a culture of continuous learning and reflective practice in order to learn from previous incidents to provide a high quality, progressive service. The registered manager described to us a service that was, "happy to learn and happy to change" and an attitude of "let's try that, it's okay". They went on to say, "There is always learning we don't stand still, we always challenge ourselves. We are always having new ideas. The team are driving things forward now and for the better." This message was echoed by all of the staff we spoke with. One staff member said, "We are moving ahead all of the time, trying to improve." Another staff member told us, "If something is not working it is done in a different way. I feel proud; we are very much hitting the values. It is a really special place." A third staff member commented, "If anything does come up it gets looked at and gets changed if it needs to be changed." One commissioner for the hospice told us the provider was "very responsive to suggestions to improve and change practices. They commented, "Marie Curie also have a reflective practice process in place for members of staff to reflect upon incidents, learn from them, and suggest any changes to improve practice." Another commissioner commented, "The staff have proved themselves to be proactive, eager to learn and very caring."

The provider completed a root cause analysis to investigate and learn from incidents. We viewed many examples where this had been done in a thorough and robust manner. For example, one person had been admitted to the hospice with existing pressure damage. Following a comprehensive root cause analysis this was found to have been unavoidable. The provider identified a number of actions to take forward to try and prevent any recurrence and benefit all people. This included ensuring all care staff were aware of the responsibility to record and fully plan care to prevent pressure damage. We were able to clearly see the effective monitoring of these investigations from the various governance groups through to the overarching clinical governance group to ensure completion of any actions. A commissioner told us about one person who was discharged from hospital with incorrect medicines. They said this could have had "catastrophic" results had the provider not identified and dealt with the error through their robust checks on admission to the hospice.

The hospice had a clear vision and strategy for its future development focused on continuous improvements. The strategy, developed with input from people with a life limiting illness and their families, acknowledged the current challenges in caring for people at the end of their lives. Objectives had been set to

reach out to more people and families living with a terminal illness, improving care and efficient and effective management. Staff had been given their own specially adapted personal copy of the strategy with space in which to reflect on the strategy and the provider's vision and values. Marie Curie Newcastle had also developed a local strategy to reflect the specific challenges facing the hospice. Immediate plans for 2016/17 included a joint training initiative with a local university to develop a new assistant practitioner role within the hospice and developing a business case to develop a hospice at home service.