

North Devon Hospice

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

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 19, 21 and 22 January 2016 and was unannounced. The service was last inspected in December 2013 and no breaches of legal requirements were found.

North Devon Hospice headquarters is in Barnstaple, it is set on a hill and has beautiful views of the surrounding area and a well-kept themed garden. It provides a service for adults with life-limiting illnesses and advanced progressive conditions, such as, motor neurone disease. About 130 people were receiving a palliative care service across North Devon when we visited. The service includes an inpatient unit (known as the bedded unit) with seven beds, a day hospice at the same location and a newly built hospice outreach centre in Holsworthy, known as The Long House, which opened in September 2015. Most people receiving palliative and end of life care in North Devon preferred to remain at home and have support in the community, wherever possible. This was in line with national findings.

The day hospice in Barnstaple opened four days a week, and included a drop in service on Fridays. The Long House opened three days a week including a drop in service on Wednesdays. This new service provided a service closer to home for people in a very rural part of North Devon.

The hospice team included specialist palliative care medical and nursing staff, an occupational therapist, physiotherapist, a team of healthcare assistants and support staff. The hospice had a supportive care team, which included complementary therapists, counsellors, bereavement care, and a chaplain. A specialist community nursing palliative care team provided physical, emotional and social support for people thought to be in their last year of life and those close to them. They also provided specialist advice to GP's, district nursing and other staff. Local GP's and consultants in the NHS referred most people to hospice services, and a few people referred themselves. People accessed the service in a variety of ways, via the community nurse specialist, day hospice, bedded unit or the hospice to home team.

The hospice to home service is comprised of registered nurses and healthcare assistants, who provide personal care and support to people at home approaching the end of their life. Healthcare assistants in the hospice to home team were employed by the hospice but worked under the direction of the district nurses. District nurses assessed people's individual needs and provided care plans to inform hospice to home staff about their care. The hospice to home service was available day and night, and was flexible. This meant it could respond to people's rapidly changing needs and provided respite for carers. The team worked closely with Marie Curie, a charity for people with terminal illness, who also provided some night sitting services for people in the area.

The hospice had about 550 volunteers who were involved in all aspects of the service such as fund raising, working in the bedded unit, day hospice, in shops, and as volunteer drivers and gardeners. They offered befriending services to people and provided respite for carers. Some volunteers also had professional qualifications and offered counselling and complementary therapies.

The service had a registered manager, who is the director of care at North Devon Hospice. 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.

Staff supported people with poor appetites who needed help and encouragement to eat and drink. People praised the food available at the hospice, although some staff had concerns about people in the bedded unit being able to have food of a consistent standard whenever they wanted it during the day. Suggested reasons for this varied but included concerns about staffing levels in the kitchen, competing demands from the restaurant and a lack of staff training about preparing and presenting small amounts of nutritious food suitable for a person at the end of their life. There was ongoing work between departments to try and address this but further steps were needed.

People received their medicines on time and in a safe way, their pain relief and symptoms were well managed and they were kept comfortable. However, some improvements were needed in the prescription charts used and in assessing staff competencies in medicines management.

Comprehensive individual and environmental risks assessments were in place, which showed actions being taken to minimise risk. We identified some risks in relation to the use of convector heaters, which were hot to touch, and needed to be risk assessed.

People received effective care, based on evidence based practice, from staff that had the knowledge and skills needed to carry out their role. Staff had regular training and updating to maintain and increase their knowledge. However, greater clarity was needed about how the clinical competencies of staff were assessed and monitored to carry out their roles.

People had a high standard of end of life care which enabled them experience a comfortable, dignified and pain-free death. People and relatives consistently described amazing care from hospice staff. We received overwhelmingly positive feedback and comments about how staff treated people with the utmost kindness, dignity and respect. People described the hospice as a happy place, in which they felt supported and cared for. The service had received numerous compliments about the quality of care and the support staff provided. For example, one person said, "The minute you walk in the door everyone smiles, and immediately you feel comfortable." A relative said, "A hospice to most people means death, but it's not, it's a big comfort blanket, they wrap you up and make you feel better."

Each person was supported to complete an advanced care plan which captured their wishes about their end of life care. This meant staff were able to carry out each person's wishes, even when the person was no longer able to communicate them. The person and those important to them were involved in decisions about their care. Care plans gave detailed information about people's needs and wishes and were reviewed and updated regularly.

The service worked in partnership with local health professionals to identify people likely to be in the last 12 months of life, so they could be offered hospice services. People and professionals had 24 hour access to specialist end of life care and treatment to manage their pain and physical symptoms from staff at the hospice.

There were sufficient numbers of suitably skilled staff on duty at all times to keep people safe, meet their needs and to provide skilled support. A robust recruitment process was in place to make sure people were

cared for by suitable staff and volunteers.

People said they felt safe being at the hospice and steps were taken to protect them from potential abuse and avoidable harm. Staff were aware of potential signs of abuse and knew how to report concerns, and any concerns reported were investigated.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty safeguards (DoLs). Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA.

People knew how to raise concerns and were confident any concerns raised would be listened and responded to. Any complaints received were thoroughly investigated and included following up any competency or attitudinal concerns about individual staff. Response letters sent were honest about any failings, they acknowledged and apologised where any deficiencies in care were identified and outlined actions being taken to improve.

The environment of the hospice was bright and welcoming, and was in good decorative order. It was clean and hygienic, with measures in place to prevent cross infection, such as good hand hygiene practices. All areas were well equipped and maintained, with good quality fabrics and furnishings.

People, relatives, staff and external professionals said the service was organised and well run. There was a culture of care, comfort and compassion for people and those important to them. Senior staff acted as role models to support staff to achieve high standards of care. Staff used local information to identify unmet needs and developed services to meet them. For example, the creation of a hospice to home team and the development of a hospice outreach centre in Holsworthy. Staff said they worked well as a team and felt supported and valued for their work.

There were a range of quality monitoring systems in place, which were well established. There was evidence of making continuous improvements in response to people's feedback, the findings of audits, and of learning lessons through reflecting on practice, in response to feedback, complaints, accidents and incidents.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People received their medicines on time and in a safe way, but improvements in the prescription charts used were needed.

People felt safe at the service. Individual risks were assessed and reduced as much as possible, but some environmental risks needed addressing.

People were protected because staff and volunteers understood signs of potential abuse and were confident any concerns reported were investigated and dealt with.

People were supported by enough staff so they could receive care and support flexibly at a time and pace convenient for them.

Robust recruitment checks were undertaken before staff and volunteers began to work for the service to ensure they were suitable to work with people.

Accidents and incidents were reported and actions taken to reduce the risks of recurrence.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People were complementary about the food but some staff identified inconsistent standards in catering. Further steps were needed to ensure people always had access to high quality food and drink, for as long as they were able and wished to.

People received effective care because staff had the knowledge, training and skills to provide good quality end of life care. However, there was a lack of evidence of how the competencies of clinical staff were assessed and monitored.

Staff received training and supervision which enabled them to feel confident in meeting people's needs, and identify changes in their health. They sought medical and nursing advice

Requires Improvement ●

appropriately.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good ●

The service was caring.

The ethos of the service was individualised and person centred. Staff communicated effectively with people and treated them with utmost kindness, compassion and respect.

People mattered, staff were sensitive and responded to people's changing needs and wishes and respected their privacy and dignity.

People's physical and emotional needs were supported by staff with excellent communication skills. Staff comforted, reassured and empathised with people and families who faced challenges and uncertainties.

People experienced a high standard of end of life care which enabled them experience a comfortable, dignified and pain-free death. They were consulted and involved in decision making about their care.

People valued their relationships with staff who often performed beyond the scope of their duties to meet a person's needs and wishes.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care that met their needs, and staff cared for them as individuals.

Care plans were person-centred and guided staff about how to care for them, and were reviewed regularly as their needs changed.

People knew how to raise a concern or complaint. Any complaints raised were thoroughly investigated and lessons learned.

Is the service well-led?

Good ●

The service was well led.

The culture of the hospice was open, friendly and welcoming. Staff worked as a team to support people.

People, relatives and staff expressed confidence in the senior management team and said the service was well organised and run.

People, relatives and staff views were sought and taken into account in how the service was run and their suggestions were implemented.

The provider had a range of systems for monitoring the quality of care and made continuous improvements in response to their findings.

The service used local information to identify unmet needs and developed services to meet them.

North Devon 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 checked 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 19, 21 and 22 January 2016 and was unannounced. The inspection team included two inspectors, one of whom was a pharmacist, a specialist advisor in palliative and end of life care and an expert by experience. 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. Prior to the inspection, we reviewed the PIR, previous inspection reports, notifications and all contacts we had about the service. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We spoke with 12 people who used the service and with six relatives to get their feedback. We observed staff interactions with people in different parts of the hospice. We looked at the care records of six people which included electronic, paper and medicine records.

We spoke with 44 staff and looked at 10 staff records. Staff we spoke with included the chief executive, registered manager, trustees, nursing staff, healthcare assistants, clerical, catering, housekeeping and facilities staff and volunteers. We joined daily staff discussions in the bedded unit about individual's people's care and attended a weekly multidisciplinary meeting. This meeting included medical and nursing staff, a GP, community nurse specialists, nursing staff, an occupational therapist, physiotherapist, chaplain and other therapists, who discussed the ongoing care of five people being cared for in the bedded unit.

We contacted a range of health and social care professionals that regularly worked with the hospice such as GP's, district nursing staff, commissioners and other agencies and received responses from six of them.

Is the service safe?

Our findings

People felt safe and supported at the hospice, they said they felt relaxed, and at ease. One person described their visit to the hospice as, "A change of scenery and faces, you're in safe hands" and another said, "I feel really chilled out here." Another described how staff put their mind at rest about using the hospice for end of life care. A staff member said, "People say over and over again that they feel safe here... they feel held and safe and can make their peace with God and people on earth."

People received their medicines on time, which helped them to manage their pain and symptoms. When a person was first admitted to the hospice, a doctor checked their current medicines, and made a record of them in their electronic records, along with any changes. (This is known as medicines reconciliation). This made sure the person would continue to receive the correct medicines. Staff had access to up to date information, policies and procedures on the safe use of medicines, although these did not include instructions for staff on medicines reconciliation.

Some prescribed medicines were given by injection via a syringe driver and staff had information for their safe use. A syringe driver helps control symptoms by delivering a steady flow of liquid medication through a continuous injection under the skin. Staff made regular checks of each syringe driver to make sure the equipment was operating correctly and documented these checks. The syringe driver policy said staff should be trained and competent, but did not specify how often they should have update training or how their competency should be assessed. Some staff said they did yearly e-learning updates on syringe drivers, although others said they had not had any syringe driver training update for some time. The registered manager confirmed all staff had completed e-learning syringe driver training annually. In addition, a practical update training session for staff was arranged for 2016.

Healthcare assistants supported registered nurses by checking some of the medicines. This was so people received their medicines more quickly, and so the nurse did not have to wait for another nurse to be available. Although healthcare assistants said they had informal training for this role from nursing staff, there were no records of any training or assessments of competencies in relation to medicines management. This could increase the risk of medicines errors.

We recommend the service ensure all staff checking medicines have been trained and assessed as competent to do so.

Doctors prescribed people's medicines on specifically designed prescription and administration charts. Staff recorded the medicines they had given or used a code to record the reason, if they had not given a medicine. Prescription charts included a list of 'as required' medicines which the doctor had agreed nursing staff could give when needed. However, the prescription charts in use did not have space for the doctor to record the date of prescribing or the frequency of doses of the 'when required' medicines. This could increase the risk of people receiving those medicines at the wrong frequency, although staff told us there was always a doctor available to consult if they needed to give another dose.

We recommend the service consider current guidance from a reputable source for the design of in-patient prescription charts to ensure they follow best practice, with regard to prescribing 'when required' medicines.

Effective systems were in place for obtaining medicines. Staff ordered medicines from a nearby NHS trust hospital pharmacy. A pharmacist from the supplying hospital visited the hospice once a month. Staff told us if they needed advice about medicines they were always able to contact the hospital. This helped to ensure that staff managed medicines safely. There was a twice daily delivery service Monday to Friday. Staff told us the system worked well and they could always go and collect medicines if they needed them urgently. This meant people could be confident their medicines would be available for them.

Medicines were stored safely within a secure treatment room, including some drugs, which need additional security because of their potential for abuse. However, the arrangements in place for disposing of controlled drugs did not meet the current waste disposal regulations. Since the inspection, staff have contacted us to outline the arrangements being made to address this.

People were able to self-administer their medicines if they wished to and if staff had assessed they were able to do so safely. No-one had chosen to do this at the time of our inspection. Some people were prescribed pain-relieving patches that lasted for more than one day. Staff regularly checked the patches were still in place. This helped to ensure that people received their medicines for pain relief effectively.

Staff reported any medicines errors, these were investigated and any action taken was documented. We looked at two medication incidents reported in the record of accidents, incidents and near misses during November 2015. The reviews of both incidents showed no further action was needed because of either incident.

A medicines refrigerator was available. Staff recorded the temperature daily to check it was in the safe range for storing medicines. Emergency drugs and equipment were available, which staff checked weekly. Suitable records were in place for these medicines to show they were looked after safely. Staff made regular checks of stocks to confirm this, including an annual check, last done in September 2015. The hospice had an accountable officer who investigated and reported any incidents involving controlled drugs and sent quarterly reports to the local controlled drugs intelligence network. There was a process in place for dealing with medicines alerts. Two examples were seen of alerts received, these were sent to heads of department and there was evidence of suitable action taken in response.

Staff carried out medicine audits to check the quality of their practice. A small number of improvements were identified and recommendations made to address these. This helped to ensure that ongoing safety improvements were made in relation to medicines management.

People were protected because risks for each person were identified and managed. Comprehensive risk assessments were completed for each person, such as in relation to their risk of falling, of developing pressure ulcers, of malnutrition and dehydration, pain and anxiety and moving and handling. Detailed care plans identified measures taken to reduce those risks as much as possible. For example, people assessed as at risk of developing pressure sores had suitable equipment in place to protect them such as pressure relieving mattresses and cushions. Staff used moving and handling aids such as slide sheets and hoisting equipment to reduce the risk of damage to people's fragile skin. A health professional said, "Having had several meetings with North Devon Hospice both in strategic groups and locally, discussions around patient safety is paramount. Each patient is risked assessed and supported by hospice staff in a safe way."

People were involved in any decisions about their risks and staff respected their wishes. For example, by providing facilities for people who wished to continue to smoke. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. For example, staff discussed a person with swallowing difficulties because of their increased choking risk. They agreed to try sips of fluid only and remain with the person to monitor they were swallowing safely.

There were sufficient numbers of staff to keep people safe and meet their needs at a time and pace convenient for them. People said staff were attentive, they popped in regularly to check on them and responded promptly to call bells. Staff could spend time with each person and with those close to them offering assistance, support, comfort and reassurance.

The hospice had previously used a dependency tool to establish recommended staffing levels. In the bedded unit there were two registered nurses and two care staff on duty in the morning, a registered nurse and two care staff in the afternoon and a registered nurse and care worker on night duty. Rotas were planned in advance and showed recommended staffing levels were maintained. Staff in the bedded unit said they no longer used the dependency tool because of the rapidly changing nature of people's needs. Instead staffing levels were reviewed daily, and increased, when needed, to ensure the service could meet people's individual needs. For example, if a person needed one to one care.

When we visited, there was a nursing and a healthcare assistant vacancy and some staff sickness in the bedded unit. A registered nurse was successfully recruited to during the inspection and plans were in place to recruit another registered nurse, following completion of their return to practice course. Meanwhile, the service had a large group of bank staff, some of whom had recently retired from the service. These staff covered any short term gaps in staffing and provided additional cover needed, which meant skilled and knowledgeable staff were available to provide care at all times. As a contingency, additional staff support could be obtained from the community specialist nursing team and the hospice to home team.

People were protected by staff and volunteers who were knowledgeable about the signs of potential abuse and had a good understanding of how to keep people safe. Staff attended a range of safeguarding training, dependent on their role which included raising awareness of protection of children. Appropriate safeguarding policies and contact details were available so staff knew how to report potential abuse internally to management and to outside agencies. No safeguarding notifications had been received from the service in the last 12 months.

Accidents and incidents were reported by staff and reviewed by the registered manager. We sampled accident and incident reports and saw examples of actions taken in response to reduce individual risks. In the PIR, the registered manager outlined that concerns, accidents and incidents were reviewed at 'Learning Points' and 'Significant Event' meetings to ensure hospice staff learned lessons when things went wrong. Staff told us about some of these and minutes confirmed issues were discussed and learning identified. A whistleblowing policy was in place so staff could raise concerns in good faith, in the knowledge they would be followed up and their confidentiality maintained. One staff member told about their positive experience of doing so, and of actions taken in response to address their concerns.

Environmental risks were assessed and actions taken to demonstrate how the premises and equipment were managed to keep people safe. Contingency plans were in place to ensure continuity of the service, for example in the event of the loss of electricity, heating or water or adverse weather conditions. However, when we visited, the main entrance to the reception area was out of use because of the exceptionally cold weather. This was to protect people waiting in that area from the cold, each time the main door was opened. Instead a temporary entrance was in use near the bedded unit. All visitors entered the building near

the bedded unit, which wasn't ideal because they had to ring the bell, and staff from the bedded unit had to respond to assist and direct visitors, which made this area busy and less private.

One person in the bedded unit said they sometimes felt cold, and staff had arranged for the person to have a convector heater in their room, for additional warmth. However, the heater was hot to touch, in excess of the 43 degree maximum surface temperature recommended by the health and safety executive, which could increase the risk of burns. There was no risk assessment in place about the safety of using this heater in a patient area. We followed up the effectiveness of the heating system with estates and maintenance staff. They said the underfloor heating system used was slow to respond in exceptional weather conditions. They told us about plans to replace the boilers in the next few months, which should help. However, we found the environmental temperatures in the bedded unit were not being monitored regularly, so staff were not alerted to changes in room temperatures. We discussed this with the senior management team, who undertook to take further steps to manage these risks.

In the PIR, the registered manager outlined how clinical, as well as health and safety risks were monitored and reviewed regularly through various committees, such as the health and safety committee. Each department had a risk register to identify any areas of increased risk, which showed actions being taking to minimise risks. Where significant risks were identified these were captured on an organisational risk register. This meant the board were aware, and were taking further steps to address and reduce them. For example, an increasing number of staff were approaching retirement age and there were difficulties reported in recruiting skilled and experienced nursing staff. Minutes demonstrated ongoing actions being taken to prevent and reduce those risks as much as possible, for example, by providing an in- house management development programme.

The registered manager received national patient safety alerts electronically. These were circulated to relevant staff who reported any action taken in response. The premises and equipment were well maintained. There were systems in place for external contractors to regularly service and test moving and handling and fire equipment, undertake gas, electrical testing and lift maintenance. There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the hospice. Staff highlighted repairs needed and faulty equipment, and these were completed in a timely way. Contracts were in place to service and maintain all clinical equipment.

People were cared for in a clean, hygienic environment. Housekeeping staff had suitable cleaning materials and equipment. Staff had access to hand washing facilities and used gloves and aprons appropriately. All equipment and rooms were cleaned between each use and the service used a sticker system to confirm when equipment and rooms were cleaned and were ready for use. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance. Daily, weekly and monthly cleaning schedules were maintained. The service had a designated infection control lead that monitored infection control practices. For example, by monitoring cleanliness and undertaking audits of staff handwashing practices. This reduced the risks of cross infection for people.

There were effective recruitment and selection processes in place to help ensure staff and volunteers were safe to work with people. Staff and volunteers completed application forms and interviews had been undertaken. Appropriate pre-employment checks were done, such as Disclosure and Barring Service (DBS) checks and obtaining references from previous employers. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people who use care and support services.

Is the service effective?

Our findings

People were supported to eat and drink enough for their health needs. Two people in the bedded unit confirmed they were offered a choice of main meal each day and were offered drinks and snacks of their choice. One person had difficulty swallowing food and said it took them a long time to eat, which sometimes meant their remaining food went cold. At mealtimes, people who needed equipment were provided with adapted cutlery, plate guards and beakers to enable them to eat independently. Where people needed assistance to eat and drink, staff and volunteers helped them.

Six staff, which included nursing, care and catering staff, identified a lack of consistency in the quality of food available to people in the bedded unit as an area for improvement. One said, "Everything used to be homemade but the time constraints mean this was not always the case, I don't want to see the patients going without...we need to sort things out differently." Another staff member said, "For people in the bedded unit, we need to feel food is fresh and appetising, and they can have it when they want it. I cannot tell you how many times we have brought this up." Other staff members said they thought food for people in the bedded unit "had gone downhill" compared to previously and one staff described it as, "A bit hit and miss." We asked staff how these issues affected people's mealtime experience and they said they didn't because they sent food back if it was not of an acceptable standard. However, this could mean delays while people waited for their food to be prepared again.

Staff suggested a variety of reasons for the inconsistencies in the quality of food for people in the bedded unit. They included low staffing levels in the kitchen at times, and staff sickness. Some staff identified the competing priorities of catering staff who also ran the restaurant and helped in the sandwich shop in the local town (a fundraising initiative). We followed this up with the registered manager who confirmed the sandwich shop was now fully staffed, so this issue has been resolved. Other suggested reasons included late orders for meals from bedded unit staff, a lack of planning, budgetary constraints and a lack of staff training on presenting people with small amounts of nutritious food in an appetising way.

This issue was also raised in a provider visit report carried out by two trustees in July 2015. We followed this up with senior staff to check what action had been taken in response. They outlined ongoing work to try and address the issue. For example, a nutritional working party had been set up, staff from the bedded unit had worked with catering staff to foster good relationships, improve communication and set expectations between both departments. Minutes of a team development day earlier in the month showed further discussions to address this issue. This included promoting an understanding of people's nutritional needs and emphasising the importance of being able to give people what they wanted, whenever they wanted it. The registered manager said a nutritional staff post was planned for the bedded unit. However, despite these measures, staff remained concerned about the quality of food for people in the bedded unit.

We recommend further steps are taken to ensure people have high quality food and drink when they want it, for as long as they are able and wish to.

Detailed information was available to catering staff about people's food preferences, likes and dislikes, any

restrictions relating to medical needs (such as diabetes) as well as any health or cultural preferences. Staff could access dietary and nutritional specialist advice to meet people's individual needs. Out of hours, staff and volunteers prepared people a variety of snacks such as soup, scrambled eggs, toast, rice, yogurt, jelly and ice cream. Ice pops were also available in the freezer which people found particularly soothing, when they were unable to eat or drink much. There were facilities for relatives to bring in people's favourite foods.

People attending the day hospice ate in a separate dining room, and the atmosphere was sociable, calm and relaxed. They were satisfied with the quality and choice of food, and said they enjoyed mealtimes and did not feel rushed. One person said, "Lovely....better than a hotel." Another person said, "This afternoon we will get tea and cake".

People received care from experienced staff that had the skills to support their complex needs. However, we identified some gaps in how the training and competencies of clinical staff were monitored. New staff and volunteers underwent a thorough induction, which gave them the skills and confidence to carry out their roles and responsibilities effectively. The hospice had an education department which provided a wide range of courses, training days and access to books, educational literature and other resources. The teaching programme included teaching communication skills, advance care planning, symptom management in palliative care, as well as managing breathlessness, confusion and agitation. The hospice had close links with North Devon Healthcare Trust who provided hospice staff with clinical training. This included medicines management, blood transfusion management, and dementia awareness training was planned for 2016.

Staff and volunteers confirmed they had good in house training and accessed external study days and courses. Two nurses on the bedded unit had completed palliative care degrees. Registered nurses were encouraged to attend a specialist pain management course and two care staff were doing a palliative care course run in association with a local college.

The PIR showed a recent review of the training needs of staff and volunteers had been completed for each department. A training matrix showed what essential training each staff group was required to undertake. For example, health and safety, safeguarding, food hygiene, communication skills, breaking bad news and managing challenging questions. The education department booked dates of essential training and sent reminders to staff and managers. Training records showed most staff were up to date with their essential training and were booked for further training.

Where staff attended clinical training at the trust, individual training certificates were provided. Training department staff said clinical competency assessments were completed in each department. However, as there was no formal monitoring of clinical training/competency assessments, we could not confirm whether or not each staff member had completed all the required clinical training and assessments.

For example, when we visited the bedded unit staff were discussing the care of a person whose swallowing reflex was variable because of their advanced illness. They discussed whether or not the person should continue to be offered food and fluids because of their increased choking risks. A staff member said they had done training on swallowing assessment and managing swallowing difficulties. However, when we asked for details about how many staff had completed this training, no records were kept, although the 2016 training needs assessment identified swallowing assessment training as desirable training for this staff group. This meant the provider could not be assured about whether staff were appropriately trained to manage these risks.

The PIR showed the hospice used an end of life care competency framework for nursing and care staff. The

framework used was developed by St Christopher's Hospice in response to the Department of Health End of Life Care Strategy (2008). When we asked staff in the bedded unit about this, some staff recalled receiving a competency folder but others did not. One staff member said, "It is new, no one has anything in it yet." Senior clinical staff explained the competency framework was introduced to the bedded unit during September and October 2015 following staff development days. They said each staff member had their own folder, and would gradually have their individual competencies assessed and signed off. However, as staff kept their individual records at home, there was no information available at the hospice on their progress. In the hospice to home team, we found care staff had completed their competency folders in 2014, although they had not been reviewed since then. The hospice to home manager and quality lead confirmed they had worked with all community care staff during 2015, to check and review their skills. This showed there was a lack of clarity and consistency about the use of staff competency assessments at the service.

We recommend the service clarifies how the competencies of clinical staff are assessed and monitored.

Staff and volunteers had access to a range of supervision and support. Most staff had a named supervisor they met with regularly for support. A range of other informal supervision opportunities were also available, through staff handover, weekly team meetings and meetings organised to review people's individual care. Some staff said they didn't access supervision, and others did. One staff member said their manager was supportive and encouraged clinical supervision, but it didn't always happen. Most staff said no written records of individual supervision were kept, and supervision uptake wasn't monitored. We followed this up with senior staff, who said the current supervision policy was being reviewed. They confirmed the updated policy would include the need to keep records of individual supervision and monitor uptake of supervision. Annual staff appraisals were carried out, during which staff received feedback on their performance and discussed any training and professional development needs for the forthcoming year. The hospice had an employee assistance programme via a confidential helpline, and figures showed this service was valued and well used by staff.

Hospice staff promoted improvements in end of life care for local people by providing a range of training and courses for health and social care staff working in the local community. For example, training on advance care planning, communication skills, care in the last days of life, and bereavement training. Feedback from local GP's showed they particularly appreciated the training and updating provided for them, and for junior doctors in training.

Staff told us about a pilot training programme for nursing homes, called 'The Six Steps End of Life Care' training programme run during 2015. This incorporated the five national priorities for care of the dying as well as the care of people with dementia. Two staff from each of six local nursing homes attended, who in turn championed and provided end of life training workshops for their staff. Feedback from nursing home staff was positive, they said it helped them improve the quality of end of life care provided for people living in their nursing home. The next programme was due to commence shortly and will be open to staff working in local nursing and residential care homes.

People received ongoing healthcare support and had access to specialist palliative care advice to manage their symptoms. Hospice staff used written criteria to determine and prioritise whether people needed to be admitted to the bedded unit, staff said they were very flexible about this, depending on individual circumstances. Admissions were usually for symptom control or to provide end of life care.

People, relatives, and external professionals gave us positive feedback about the quality of care and treatment received from hospice staff. One person said pain was an issue when they were first admitted to the bedded unit, but they were soon made comfortable and free from pain. Another person living with

cancer at home described how the community specialist nurse had helped them manage their symptoms. They said, "They have been fantastic, they transformed my life in 24 hrs." They went onto explain how the nurse had advised their GP about prescribing, arranged for them to visit the hospice and kept in regular touch with them at home. A third person said the advice they received meant they could now sleep in their bed at night, whereas previously they had slept in a chair because of their discomfort. A relative said the community specialist nurse had been a huge help and support for them. They said, "[Staff name] keeps in touch, weekly or fortnightly, she is always there on the phone if I need her, she is wonderful."

Health professionals said they could contact the inpatient unit anytime to speak to a doctor or specialist nurse and always received practical advice. A health professional said, "North Devon Hospice provides a great range of services, it's one of bright spots of North Devon healthcare." A community health professional said they appreciated when the consultant did a joint home visit with them to help them manage their patient.

Hospice staff worked in partnership with their staff at the local GP practice. The community palliative specialist nurse met with practice staff at the surgery monthly (known as the Gold Standard Framework (GSF) meeting). The GSF is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. Staff discussed the care of people already receiving end of life care and identified people likely to be reaching the last 12 months of life. GP feedback showed they particularly appreciated the community specialist palliative care nurses advice about prescribing. One said, "[Name of nurse] is excellent at providing physical, emotional and psychological support to our patients." They also provided informal training for practice staff about diagnosing changing stages of a person's illness, and managing symptoms such as breathlessness and restlessness.

People's consent to care and treatment was sought in line with legislation and guidance. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found they were.

The hospice had policies and procedures in place in relation to consent, assessing mental capacity and Deprivation of Liberty safeguards. Staff at the service had undertaken training in MCA 2005 and DoLS and demonstrated a good understanding of their responsibilities. The registered manager said, so far, staff had not needed to make any applications to deprive a person of their liberty. However, the policies and procedures were in place to do so, if needed.

Where people lacked capacity, there was evidence of consulting relatives, staff and other professionals in making 'best interest' decisions about the person's care and treatment. At the weekly multidisciplinary team meeting, each person's mental capacity to make their own decisions and consent to their care was reviewed. For example, staff discussed a recent case where a person was refusing personal care. However, staff judged the person had capacity to make that decision and it was respected, even though staff thought the person's choice unwise.

The environment met people's individual needs. The hospice was purpose built, and had facilities for people with disabilities such as wide corridors, an assisted bathroom and a wet room. The bedded unit had seven

single rooms with en-suite facilities. Some rooms had verandas so people could go outside on their bed, if they wished. There was a restaurant with a terrace visitors could use and food was available out of hours from chilled cabinet. In the gardens, all terrain buggies were available to enable people with mobility needs to access and spend time in the gardens.

In September 2015, North Devon Hospice opened The Long House, a new outreach centre in Holsworthy. This was because the service had recognised a need for enhanced services in a rural area. It was purpose built, with therapy rooms and facilities for one to one counselling and patient/carer groups as well as clinic space to see outpatients. Staff described it as very homely, light and airy. One person said, "Its lovely, all different things, lovely pictures, simple, but meaningful, I love it."

The facilities department worked in partnership with nursing, occupational therapy and physiotherapy staff to ensure all equipment purchased for the hospice was suitable for the needs of people who used it. For example, medical equipment such as syringe drivers, electric beds, chairs and moving and handling equipment. New furniture had recently been purchased for various communal areas of the hospice. A person in the day hospice looked very comfortable having an afternoon nap in a recently purchased recliner chair.

Is the service caring?

Our findings

Staff developed positive, caring and compassionate relationships with people using the service. People benefitted from getting to know staff in different parts of the hospice so they became familiar with the various services offered. For example, staff from the community specialist nurses, and hospice to home team kept in touch with people and families in the bedded unit, which people said they found very reassuring.

People described the hospice as a happy place, in which they felt supported and cared for. One person said, "The minute you walk in the door everyone smiles, and immediately you feel comfortable." Another said, "There is a sense of fun, everyone is in a bad way here, and they make the most of what they have got". One person described how staff went "over and above" to accommodate people's wishes. For example, they said recently staff had organised an early Christmas celebration for one person and their family and an early Burns night celebration for another person. This showed people and families mattered and staff supported their wishes.

Volunteers told us about the many ways they supported people in different aspects of their care. For example, a small team of volunteers worked with the community specialist palliative care nurses and provided social and befriending services for people. A volunteer from this service explained how they sat with a person at home, so their relative could go out for a few hours to have a break and attend a support group at the hospice. They had developed a rapport with the person, as they chatted about things of mutual interest. They said, "It was great, because I was able to do something to help." A volunteer driver transported a person to the hospice regularly and had become very fond of them. They said the person enjoyed the chat and company, and they felt they had brought a sense of "normality" for them. They said, "We have some good fun together and when she goes, I'll be sad."

People were treated with dignity and respect. In the bedded unit, each person was cared for in the privacy of a single room with en-suite facilities. Staff spoke knowledgeably about the people they cared for, their circumstances and what mattered to them. We saw many gentle, kind and calm interactions with people. A staff member gave a person their one to one attention, with good eye contact and spoke discreetly with them. In the day hospice, another staff member did a crossword puzzle with a group of people, there was lots of laughter and everyone joined in.

In the bedded unit, volunteers often helped to occupy children by playing with them and doing activities such as painting and drawing. They also chatted to people, offered them snacks and drinks and added personal touches, such as providing a fresh flower arrangement on each person's tray to accompany their meal.

Feedback from people, and relatives showed North Devon hospice staff treated people with the utmost kindness, dignity and respect. One person said, "Everybody is very down to earth, you can speak your mind, say what you want to say." Another person spoke of the trust and confidence they had in staff and said, "I'd trust [named member of staff] with my life." A relative commented, "A hospice to most people means death,

but it's not, it's a big comfort blanket, they wrap you up and make you feel better." Another relative said, "It takes a special person to do the job they do, they are always smiling and helpful." A person using the hospice to home service said, "I'm making the best of what I've got. I'm very pleased with the girls that come, they are lovely." A relative who received a night care service several times a month said, "If there are any problems I can talk them over, they are all brilliant because I can get some rest."

People and those close to them were consulted and involved in decisions about their care and treatment. A relative said, "They offer him options gently and sensitively, he is not pushed." The hospice had a range of information leaflets for people and families which provided them with practical information and helped them to explore decisions they needed to make about their future care and treatment.

People were asked about where and how they would like to be cared for when they reached the end of their life. In the last days and hours of life, staff sensitively involved the person and those important to them in decisions to the extent they wished to be involved, and followed their wishes, which were outlined in advanced care plans. A community staff member said, "I love my job, the best thing about it is being able to keep people at home and help them have as good a death as possible."

Staff were knowledgeable about how to meet their religious and cultural food preferences. A chaplain was employed by the service who attended the weekly team meeting to discuss people's care. A non-denominational room for quiet reflection was provided for all to use, and the hospice had developed links with other religious faiths in their local area. They said, "We don't separate spiritual care, it is just part of the person....we have a list of all the available denominations.....and I am authorised to give communion. We can connect people with any faith tradition, such as Mormon, Judaism." Speaking about people's faith the chaplain said, "We have to be fluid and sensitive to what people want...to explore their spirituality and give their life meaning. Spiritual support is integrated and this is most important."

Written feedback following people's death included; "The care we received was incredible"; and "Thanks for looking after [person's name] and making his final hours so peaceful and relaxed." Other comments included; "Thank you for all the love and care, we could not have asked for more," "They helped my mother to die with dignity;" "They made a difficult time much more bearable." Relatives and close family could spend time with their loved one shortly after their death. The chaplain conducted some people's funerals when asked, they said, "I give people the choice, I have the advantage of knowing the person and can bring this to the ceremony."

There were plenty of areas for people and relatives to chat, and have some privacy. A relative's room was available for family members to stay overnight when needed. A 'cool room' was available for families to spend time with their loved one in a quiet and private area after the person had died, should they wish to.

People and relatives appreciated the emotional and psychological support available from employed staff and qualified volunteers through the counselling services provided. For example, one person appreciated being able to talk to someone who was not emotionally involved, and said they were relieved they did not having to be strong, which they felt they had to be around family members. A relative who had received support following an earlier bereavement said, "I don't know how I would have managed, they were fantastic support."

Following death, the hospice provided bereavement support to relatives and family members. A relative described how much they valued receiving bereavement counselling, which had put them in touch with other people going through the same experiences. A volunteer counsellor said, "It can be a form of community bonding....it addresses loneliness and it lives on." The service had qualified volunteer

counsellors who specialised in working with children in schools and at home.

Is the service responsive?

Our findings

People received personalised care which responded to their needs. Staff worked with each person and those that mattered to them to develop care plans that reflected how each person wanted to receive their care, treatment and support. Individual care plans reflected information about the person's needs, wishes and preferences, as well as information about their family, life history and their interests and preferences.

Staff worked together to meet people's individual needs whether they were being cared for in the bedded unit, or at home. People said staff supported them with practical needs, such as equipment so they could remain at home. They also said staff made them aware of benefits they were entitled to and things that helped them retain their independence for longer, such as disabled parking badges.

People and those close to them were consulted and involved in decisions about their care and treatment. Staff supported each person, if they wanted to, to develop an advanced personalised care plan, which captured their wishes about end of life care. This also offered people the opportunity to identify and discuss any advance decisions to withdraw or refuse treatment and their views about resuscitation in the event of unexpected collapse. This meant the person's wishes were known and could be taken into account by staff, when the person was no longer well enough to communicate them.

People's care records included a range of assessment tools which helped staff to identify people's individual care needs. For example, a skin care assessment tool, a pain measurement scale, prompts for assessing people's personal care, nutrition and hydration as well as their oral hygiene needs. Most of the information about people's care was captured on an electronic care record system, which was updated daily, sometimes several times a day. Medical, nursing and therapy staff recorded all assessments and care decisions in an electronic care record, which meant changes in people's care needs were communicated quickly between the staff team. The electronic care plans gave staff detailed instructions on how to meet people's individual physical, psychological and emotional needs. Staff said a number of changes and improvements had recently been made to improve the electronic records system.

In each person's room in the bedded unit, there were also paper records such as printed care plans to instruct staff about repositioning, skin and mouth care. However, when we looked at these, we found they were not very meaningful. We were unable to tell from the information we saw which aspects of the person care individual entries related to and could not judge whether the care provided was effective. Staff said they were aware the current paper records were not ideal, they explained the codes used related to the electronic record. They told us about a working party in progress to improve them. They had plans to visit another hospice to look at their paper records, to see if these could be adapted for local use. This demonstrated there was work underway to improve the paper care records further.

People had 24 hour access to specialist care and treatment to manage their pain and physical symptoms from staff at the hospice. There was an advice line, which people and families, community nurses and GP's could use to speak to a nurse or doctor, about managing people's symptoms, comfort and pain control. If needed, the hospice to home team could provide support to the person and family members in their own

home, when the person was nearing the end of their life. People were referred via many different routes into the service. The hospice worked closely with the NHS continuing healthcare team so funding did not have to be in place for people to receive a service. This meant people approaching the end of their life, whose condition was deteriorating, could be referred rapidly to the service, and there were no delays in initiating specialist care.

People received consistent and co-ordinated care when they moved between different services by the professionals who were caring for them. One person said, "The staff know your name, and are obviously well briefed because you don't have to explain every time." Entries in the electronic care records showed staff liaised with relevant health and social care professionals and had robust arrangements to respond rapidly to people's changing needs. For example, with GP's and district nurses. The medical director at the hospice and the lead consultant for end of life care at the local NHS hospital trust worked closely together. The medical director provided specialist advice to the trust when the consultant was on leave.

A weekly multidisciplinary weekly team meeting was held, during which hospital and community based staff reviewed people's care and treatment. For example, they discussed the care of a person who was currently in the bedded unit for symptom control. At the meeting staff discussed what the person would need in order to return home. They arranged everything to enable them to return home. For example, equipment, pain relief, and support with personal care. This meant the person was able to return home, which was where they wished to spend their remaining time. Staff also discussed how to meet the health needs of another person in the bedded unit, whose condition had stabilised. The person had ongoing nursing needs which could not be met at home. Staff liaised with the person, their family, and relevant health and social care professionals to help them choose a suitable nursing home. They made plans for the person to be admitted and to continue to provide support to nursing home staff about the person's care.

People said they particularly valued meeting up with and speaking to others at the day hospice, who were going through similar experiences. One person said, "Most are in the same boat, we talk about how we manage, we are going through same experiences, and share tips." Another person said they were surprised at how much they appreciated attending the day hospice. They said, "I'm not normally a group sort of person, I'm not a knitter or arty but faced with a situation there's not that much you can do. I feel very at home there, I enjoy doing jigsaw puzzles, they spoil you, we sit around and talk." A staff member said, "It brings people together in the same situation, so they don't feel alone. One person told us they enjoyed the cookery sessions held sometimes. Another person said, "It is all informal...at Christmas...there was a pop-up hospice shop here, so we could do our Christmas shopping." A monthly 'Feel Good Day' offered hairdressing, manicures, and complementary therapies, there was a carers pamper day and a gent's event.

A team of volunteers transported people to and from the day hospice services. One person said, "A car comes and picks me up and I get away from the four walls of home." Another said, "It makes a big difference, I look forward to it every Wednesday. People there are so lovely, it's like walking into home, so friendly, I love going. There are lots of things on offer, you can just sit and talk, be on your own, have a massage, sometimes I do painting." One person said they sometimes found the day hospice session too noisy and tiring, which we made staff in charge aware of.

Staff supported people to maintain their interests and hobbies and to develop new ones. In the day hospice, a volunteer supported two people who were painting pictures in the art therapy room. A volunteer said, "It takes a lot to stop a patient coming to the day hospice ...they really want to come" and "It's great for carers who know the person will be looked after."

Both services provided a variety of groups for people and separate carer's groups. Staff said groups were

popular and on average, 15 people attended each group. They said, "For some people, the groups are right, whereas others want one to one support or information. We don't impose... we support the person and the whole family and that continues after their death." This showed staff tailored services to people's individual needs and wishes. One person with a progressive medical condition said, if possible, they would like a dedicated support group for people with their condition. They said "It would be good to be able to meet at the hospice, for mutual support and to share our experiences, even if it's only a cup of tea."

People and relatives feedback was sought in several ways. The hospice was a member of a national questionnaire 'I Want Great Care ' which they used to obtain feedback. The questionnaire asked respondents to rate their care using five key questions about dignity/respect, involvement, information, caring, support from staff and whether the person would recommend the service to others. North Devon Hospice had a top five star rating. There was also a comments book on the bedded unit and in the day hospice for people and relatives to use. Staff said where any feedback comments needed follow up they followed them up and took action to address them. The provider information return showed the service had received 238 compliments in the last 12 months.

People and relatives said they had no concerns or complaints about the hospice. They said if they had any concerns, they would feel happy to raise it with the staff or the registered manager and were confident it would be dealt with straightaway. They were given information about the complaints policy and procedure, when they first came in contact with the service. Reminder leaflets about how to complain were on display in communal areas.

The hospice had a complaints log and monitored any complaints received. Three complaints were received in the last 12 months. We found each complaint was thoroughly investigated with positive actions taken to address areas needing improvement. Written responses offered apologies where any aspect of care fell below the standard expected. Explanations were given about the investigation, its findings and actions being taken to address concerns. Staff were open and honest with people when things went wrong and committed to learning from people's experiences. Where concerns related to individual staff members, these were dealt with on an individual basis and monitored. Information about complaints was discussed at team and department meetings, so wider lessons could be learned to improve care. This showed the service had a robust system for investigating complaints.

Is the service well-led?

Our findings

The service had a positive culture, staff were open and friendly and focused on meeting people's individual needs and caring for those that mattered to them. People, relatives, staff and health professionals all described a "happy" atmosphere and warm welcome whenever they visited. One person said, "When I first went there I thought a celebrity had walked in but they were speaking to me." A health professional said, "It is well run and resourced" and, "All hospice staff ensure appropriate packages of care are in place to meet the patient's need at varying stages of their illness." A GP said, "As a practice we work amazingly well with them. Everyone is excellent, good leadership."

Staff and professional feedback showed the service was well led by the senior management team. Several staff and volunteers told us about the chief executive's vision sessions in which they outlined the future plans for the service. Each year, staff and volunteers had the opportunity for a one to one conversation with the chief executive. Some staff had done 'job shadowing' to increase their understanding of senior management roles. A volunteer said "Everyone is supported, it's very well organised".

North Devon hospice had a registered manager who was the director of care and was responsible for the bedded unit, hospice to home service, and the community nursing service. The registered manager was meeting their legal obligations such as submitting statutory notifications when certain events occurred, such as when a death or injury to a person occurred. They notified the CQC as required, and provided additional information promptly when requested and worked in line with their conditions of registration. In the bedded unit, there was a manager and deputy manager who led and supported the staff team. Senior staff acted as role models to support staff to achieve high standards of care.

There was a chief executive lead, a board of trustees and a senior management team with a broad range of knowledge, skills and experience to support the various aspects of the hospice work. The medical director was a consultant in palliative care and was the clinical lead for end of life care, clinical governance and audit. Members of the senior management team and trustees were members of various committees, such as finance and human resources, health and safety, the corporate governance committee, and a care quality working group. Each committee had clear terms of reference, which were regularly reviewed.

The hospice had a five year strategic plan which outlined the vision and commitment to provide end of care closer to people's homes. People, staff, volunteers, and local health professionals were consulted and involved in developing the strategy. The chief executive described work being done to reach people in need of end of life care and to make access to hospice services more equitable across North Devon. For example, they described how they had worked with local healthcare services, looked at information about local needs and at where services were provided. From this, they had identified and prioritised Holsworthy as the area where people needed a more local outreach service.

The hospice worked with local community and partnership organisations to open The Long House day outreach centre in Holsworthy. The League of Friends, local mayor, GP practices and other local businesses raised funds. Following the success of the first three months of The Long House, there were plans to extend

opening hours to provide a service Mondays and Fridays as well. This showed the service was meeting identified local needs.

The service had also established a hospice to home team in order to respond to the rapidly changing needs of people having end of life care at home and because of gaps identified in the local provision of personal care services. They co-ordinated care on behalf of Marie Curie to increase night sitting services in the area. Senior staff said they were making progress in making hospice services more accessible to people with non cancer related life limiting conditions, such as heart failure, chronic lung disease and motor neurone disease. This was confirmed by supporting data, speaking to GP's and from people with chronic conditions we spoke with. One person with a progressive medical condition said their community specialist palliative care nurse knew a lot about their condition. They said, "I'm so much better, managing my breathing better and eating better."

The GP out of hour's service confirmed they worked closely with North Devon Hospice through the community hospice at home service and specialist community nursing team. They said, clinicians utilised the 24 hour specialist palliative care advice line, which helped prevent avoidable admissions to hospital and ensured people at the end of their lives received safe and effective care.

Most staff and volunteers expressed high levels of satisfaction with working in the hospice. Staff said the hospice was a lovely place to work and many staff had worked there for a number of years. Staff said, "It is a really rewarding and a good place to work " and "This team is amazing." A volunteer said, "It is a really lovely place to work...responsive...people listen," and another said, "We are well cared for and respected."

A few hospice staff expressed some areas of dissatisfaction to us. This related to recent organisational changes which left some ancillary staff feeling unsettled. We discussed these with the senior management team, who were aware of this and told us about work underway to address them. An independent staff survey carried out in June/July 2015 showed a marked improvement in staff morale since the previous survey. Areas for further improvement included cross team communication and performance managing staff, and we saw evidence both of these areas were being addressed.

Staff and volunteers were consulted and involved in decisions made about hospice services. A staff consultative forum was in place and recent minutes showed a range of issues were discussed. They included the staff survey results, uniforms, staff training, and uptake of the employee assistance programme. A member of the staff forum said, "The staff consultative forum is strong, open and trusting."

Minutes seen showed regular staff and volunteer meetings were held, so information was communicated to staff, who could contribute ideas and suggestions. Staff received feedback on accidents/incidents, the findings of audits and complaints and compliments received, so lessons could be learned and good practice shared.

The provider had a clinical governance action plan which showed the framework used for continuously monitoring and improving the service to reflect best practice standards in end of life care. The quality monitoring systems included getting feedback from people and families, risk management, and professional development of staff. Ten key performance indicators were identified, which the service used to monitor the quality of care. These included referral and response times, staff training, sickness and turnover figures.

The service had a quality lead, who led on policies, audits and infection control. The PIR showed a comprehensive programme of clinical audits were undertaken, which included some regional and national

audits. Local audits included record keeping, medicines management and infection control audits. The findings of audits were used to make improvements to the service.

For example, a referral to response time audit was completed in 2015, and the results prompted a review of the referrals process. This was because the audit showed hospice staff needed to respond more rapidly to referrals received about people needing end of life care. Meetings with hospital staff and GP's practices were arranged to discuss referral criteria and referral rates. Expected response times were set, so the performance of hospice staff could be monitored. One GP said they found this really helpful, as the hospice had compiled detailed data about GP referrals. This prompted some GP's to review their practice which resulted in them referring more people at an earlier stage, which improved people's access to end of life care.

We sampled minutes from various committees such as the Care Quality Working Group, Clinical Governance Committee, Finance and Human Resources committee and board of trustees. These showed information about the quality of care was reviewed, any risks or areas needing improvement were identified and monitored to ensure they were being addressed. For example, in response to risks about increasing difficulties recruiting staff into senior posts. This resulted in developing an in-house management and leadership development programme so existing staff could be developed ready for more senior roles.

All policies developed, were reviewed and signed off by a corporate governance committee and board of trustees. We sampled some policies such as advanced care planning, consent, and medicines management, which were evidence based and were regularly updated. The hospice had sickness absence, capability and disciplinary policies and procedures in place. There was evidence that sickness absence and individual staff performance issues were managed, and monitored. Although some staff were concerned about sickness absence, the figures showed low overall sickness rates. The service had reviewed the recently published National Institute of Health and Care Excellence (NICE) end of life care guidelines against their current practice.

Accidents, incidents and near misses were reported and monitored to identify any themes or trends that needed addressing. Meetings between staff (known as significant event meetings) were held to discuss challenges that arose, such as suicide risks, and the assessment of nutrition and hydration. From these, areas for further improvement and staff training needs were identified. This showed the service was committed to making continuous improvements.

Health and safety systems were in place, to ensure safety checks were carried out on all equipment and services, although we found some quarterly departmental health and safety checks had not been completed.

Trustees did an unannounced hospice visit annually and spoke to people and relatives, with staff, line managers, and volunteers, to discuss the provision of care, highlight any areas of concern and areas for review. The report showed actions taken in response to areas identified for further improvement, such as equipment needs, although the issue trustees raised about the quality of food in the bedded unit in July 2015 was ongoing.

All records relevant to the running of the service were well organised and reviewed regularly. People's care records were kept securely and confidentially, and in accordance with the legislative requirements.