SPDNS Nurse Care Community Interest Company

Hospice at Home

Inspection report

St Luke's Hospice
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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

About the service
Hospice at Home is based at St Luke's Hospice and provides adult palliative care and specialist care. The service supports individuals in their wish to be cared for at home, facilitates rapid discharge from hospital and avoids unwanted hospital admission. At the time of our inspection, 34 people were accessing the service.

People's experience of using this service and what we found
People received exceptionally good palliative and end of life care and practical support, advice and emotional care from a dedicated staff team who were well trained and placed people and their families at the heart of the service. This support was also extended to people's families.

People and relatives were extremely complimentary about the service. People and relatives thought of their carers as being like family members and told us they were highly compassionate and caring and treated them with the utmost respect.

Staff were highly motivated, felt valued and enjoyed working at the service. They were passionate about providing outstanding person-centred care to people when they needed it. A holistic approach was taken to assessing, planning and delivering care and support. People were fully involved in how their care was to be provided.

The service had forged strong links with other professionals and worked collaboratively with them to ensure people's needs were met in a timely way and to ensure continuous improvements in end of life care. Feedback received from professionals was exceptional. One professional said, "The service is outstanding, demonstrating commendable resilience, responsiveness and commitment to all service users, patients, carers, families, and bereaved people, but also to St Luke's as a partner organisation. The team, from managers to admin support to nurses and carers, are genuine and dedicated. They show high levels of empathy, courage and caring in the face of a difficult and often emotive job/service."

Staff were safely recruited and well trained. The service had a rapid response team to enable them to respond quickly to any deterioration in people's health.

People were supported safely, and risks regarding their care were assessed and managed. Staff were aware of how to report any concerns about neglect or abuse and were confident they would be addressed.

Where required people were supported to take their medicines by staff who had been trained and assessed as competent.

Senior management were praised by staff, professionals and people receiving a service for their commitment and passion for care. The service's visions and values were fully embraced by staff and senior

management promoted a culture which was open and inclusive. Staff were aware of their roles and responsibilities and told us and they felt listened to. They also said the management team were caring and supportive.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Effective systems were in place to monitor and respond to any concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 17/08/2018 and this is the first inspection.

Why we inspected
This was a planned inspection.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Outstanding ☆

The service was exceptionally caring.

Details are in our caring findings below.

Is the service responsive?

Outstanding ☆

The service was exceptionally responsive.

Details are in our responsive findings below.

Is the service well-led?

Outstanding ☆

The service was exceptionally well led.

Details are in our well-led findings below.

Hospice at Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector, one assistant inspector and a specialist advisor. The specialist advisor had extensive experience of working in the field of palliative and end of life care.

Service and service type
This service is a domiciliary care agency. It provides personal and nursing care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 72 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 2 July 2019 and ended on 5 July 2019. We visited the office location on 2 July 2019.

What we did before the inspection
We reviewed information we had received about the service. We used this information to plan our inspection.

The provider was asked to complete a provider information return (PIR) prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. This information helps support our inspections. The deadline for submission of the PIR was shortly after the date of our inspection. We took this into account when we inspected the service and reviewed the PIR following our inspection..

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with 12 members of staff including the registered manager, head of community services, Hospice at Home and RADS manager and the quality audit and training coordinator.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We also reviewed feedback we had received from nine professionals about their experience of the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were safeguarded from abuse and neglect. Staff had received training and understood what actions to take to protect people. They told us they were confident to raise any concerns.
- Staff had access to daily surgeries which were chaired by senior managers on a rotational basis from the service and the hospice should they wish to discuss or raise concerns about safeguarding or health and safety.
- Safeguarding was an on-going agenda item at team meetings and weekly handover meetings.
- Senior management attended the provider's strategic safeguarding group and were part of the provider's safeguarding on call system.

Assessing risk, safety monitoring and management

- Support was delivered in ways that supported people's safety and welfare. Assessments were in place to identify risks from people's care, their home environment and healthcare conditions they were being supported with.
- Staff were made aware at their induction the importance of being aware of new and emerging health and safety issues; and that people receiving palliative care change condition and functional ability very quickly and manual handling needs to be reassessed at each visit to ensure people's safety.
- Staff were aware of how to report any changes to people's needs and could call for additional support from the office at any time. One member of staff told us, "We are the eyes and ears. Any concerns about a risk or if anything needs to be changed, we let the office know and they will update [care plan documentation]."
- Assessments, and any changes in people's needs were uploaded onto the service's electronic systems and circulated to staff via mobile phones so any new care instructions/updates on people's health were immediately available.
- The service had identified, and developed, a hospice wide pre-home visit risk assessment. This was kept centrally and ensured relevant information could be found efficiently and quickly and provided staff and other health care professionals with knowledge of potential risks before they visited people.
- Accidents and incidents were recorded and reported by care staff to the office. These were discussed at management meetings to identify any actions required to ensure the safety of people and staff.
- A healthcare professional told us, "All staff are very aware of patient safety issues and feel able to raise concerns. They have good training and senior support and understand risk assessment and safeguarding processes."

Staffing and recruitment

- There were sufficient numbers of staff who had been recruited safely.

● The service employed qualified nurses and healthcare assistants (HCAs).
● Systems were in place to monitor missed calls, including a full investigation.
● Staff were given autonomy to organise the timings of their call visits and to take as long as they needed when supporting people. One HCA described to us how this alleviated any pressure on them and enabled them to be completely focussed at each visit. People were notified if their call visits were going to be late.
● Senior management described to us the systems they had in place to ensure the service was flexible, enabling a rapid response team to support people should their health deteriorate rapidly. A professional said, "The needs and preferences of individuals are always their focus and they strive to alter rotas and care delivery as flexibly as possible in order to ensure changes in condition, circumstances and need are responded to in the most timely way possible."

Using medicines safely
● Where required, people were supported with the administration of their medicines.
● The service had clear processes in place to ensure the safe management of medicines. A health care professional said, "They direct enquiries to me, particularly around unavailability of key drugs, sourcing of unusual medicines and advice on complex regimes. Any medication incidents are all fed back to me, particularly where the hospital has failed to supply sufficient medicines for end of life care in the community, so I can investigate, and improve processes in the hospital."
● Carers who administered medicines were trained by the provider as part of their induction. They were supervised ten times before being able to give oral medicines unsupervised.
● Sub-cutaneous medication via a syringe driver was routinely managed by district nurses however HCAs had been trained to observe the site of the 'line' and syringe driver pump and knew who to report any issues to. In the event of an emergency, the qualified nurses would set up a syringe driver; these staff had yearly training.
● Both qualified nurses and HCAs followed the medicine administration records (MARs) process when administering medicines. MARs were reviewed monthly by a qualified nurse to ensure the medicines people received were being given safely and were still appropriate to meet their needs. Where there had been any medicine errors, these were fully investigated and, where necessary, action taken to mitigate reoccurrence.
● Any medication changes were discussed with GPs and updated onto 'system one', and people's MARs updated.

Preventing and controlling infection
● People were protected from the risk associated with infection control.
● The service had an emergency supply of equipment should this be needed. If emergency stock was used, these would be replaced by the external loans company.
● The service did not use any returned items until they had been cleaned and returned by the external loans company. This ensured people were protected from cross infection.
● Staff were aware of the infection control policy, had received training and provided with personal protective equipment (PPE).

Learning lessons when things go wrong
● All incidents were looked at by the management team. This helped to identify any trends and put measures in place to mitigate reoccurrence. Lessons learned were shared with staff to help improve the service provided.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were holistically assessed in accordance with best practice guidance. This included the use of recognised best practice assessment tools to measure people's palliative and end of life healthcare needs. The scores from these assessments were regularly reviewed, captured within people's care records, and presented at weekly handover meetings.

Staff support: induction, training, skills and experience
● New staff received a two-week induction which included working a day's shift at the hospice's inpatient unit. They were also required to complete the Care Certificate. The care certificate is a nationally recognised course in induction for care workers.
● People received care and support from staff who knew them well and understood how to support them. Staff received on-going training, observations of practice, supervision and appraisal to ensure the individual care and support needs of people were effectively met. A healthcare professional told us, "Staff are well trained which makes their service effective and keep the patients safe."
● Extended role training for HCA staff was being rolled out to enable them to undertake simple clinical observations such as blood glucose and urine testing, taking blood pressure and undertaking simple dressing changes. The purpose of this was to be able to respond to people's changing needs and enable HCAs to report real time information to other appropriate services.
● All staff had access to open learning forums that were often held in-house by the hospice. Annual team away days were also held, themed on specific relevant topics, to keep staff up to date with effective skills and knowledge, and to build on team relationships.
● Some nurses had qualifications in palliative care degrees. These skills were kept up to date through clinical practice, supervision and case load reviews.
● Nurses were supported by management with their revalidation with the Nursing and Midwifery Council.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Without exception, health care professionals were complimentary about the service, specifically about the way the service actively promoted integrated working.
● Accurate and up-to-date information about people's health was shared internally and externally with other healthcare professionals.
● Alongside its own systems, the service had access to an electronic system used by the hospice staff and NHS professionals; for example, GPs, hospital staff and district nurses. This ensured all relevant professionals had access to up to date information to help provide seamless, joined up care.
● Staff had access 24/7 to a clinical nurse specialist and a palliative medicine consultant for specialist

advice.
● A member of staff attended weekly palliative care multi-disciplinary team meetings held at Basildon Hospital to discuss people on palliative or end of life care who are known to several different services. People's nursing and medical care was discussed, and clinical decisions made as to the best plan of care, ensuring people's needs are managed in an efficient and timely manner by the most appropriate services. A number of referrals to the service were generated at this meeting.

Supporting people to eat and drink enough to maintain a balanced diet
● Where required, people were supported with their dietary needs.
● Nutritional assessments were undertaken to support end of life nutritional needs and to identify whether referrals to the speech and language team (SALT) were required.
● Staff used a nationally recognised tool to ensure they provided the correct texture of food, as directed by SALT.

Ensuring consent to care and treatment in line with law 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.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty.

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 had the appropriate legal authority and were being met.
● People's capacity was assessed and recorded.
● Staff had received MCA training and understood the principles of the MCA. They were able to give examples of when this was used and of their responsibility to report if they had any concerns that a person may be lacking capacity.
● A member of staff told us, "We did the training. We have people living with dementia and patients who lack capacity. It's difficult, they are going through big changes in their lives. People are assessed before we go [into their homes], but we see the deterioration and the families who cannot manage, then the specialist nurses come in."

Outstanding ☆

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were truly respected and valued as individuals; and empowered as partners in their care in an exceptional service.

Ensuring people are well treated and supported; respecting equality and diversity

● People received outstanding care. They and their relatives were respected and empowered as partners in their care, both practically and emotionally by an exceptional and distinctive service.

● Staff demonstrated they cared for people deeply, about their work, and the importance for them to give the best quality care possible. One member of staff spoke about going the extra mile for people. For example, on visiting one person at home, they wanted to sit out in the garden, so they set up the garden furniture and a parasol, so the person could get pleasure from enjoying their garden which was possibly their last summer. They went on to say, if people's animals needed feeding they would do this if people were struggling. Although these were simple examples, it demonstrated staff looked at people's needs holistically, rather than just meeting their clinical needs.

● Feedback from people, relatives and professionals was overwhelmingly positive about the caring attitude of staff and the impact the service had on their lives. One person said, "They really are first class. They treated [name of another family member] for about two months and 80% of them are the same carers as we had back then. They are absolutely marvellous." Another said, "It's rare in this day and age to say it but you cannot fault them, they are the definition of a carer; they genuinely care about what they are doing; it's not just a job. I couldn't exist without them, I would be back in hospital. Them looking after me is freeing a bed up in hospital for someone else and I would much prefer to be in my own bed."

● A professional told us, "I hear excellent feedback from patients and families regarding the care and support they get from staff. Staff are caring, compassionate and always go the extra mile to ensure people feel safe and supported in their own homes." Another said, "Staff will drive miles to a community chemist that might stock the drugs, or a GP that might be willing to prescribe. For example, if a palliative patient is discharged without sufficient controlled drugs medicines to last a weekend."

● The service had received a high number of compliments. One stated, "All I can say is a big thank you to all of you from the bottom of my heart, and I am certain [name] would have felt the same. [Name] was discharged from hospital to hospice care with less than two weeks to live. They lived for another 10 months. None of this would have happened without the fantastic care your staff gave them. During their illness I came to know all the carers individually and they became part of the family. They were very gentle with [name] and continually tried to cheer him up. [Name] could not remember all of their names but remembered their faces. They took care of me as well and that gave me hope and strength to carry on this difficult task. I am extremely grateful for that."

● Equality and diversity were respected. The registered manager told us no one would be discriminated from accessing the service, and we saw examples of how the service had met people's diverse needs; often at extremely short notice due to people's rapid deterioration.

● Management attended VERVE (Valuing local diversity, Enhancing patient experience, Raising public

awareness and Visible Equality in end of life care) network meetings. This enabled the service, where necessary, to seek advice from other community groups that have links with VERVE'. This ensured people received person centred care that respected their privacy and dignity and met the needs of all protected characteristics.

● Staff were recruited based on values and did not necessarily need to have previous experience of working in health and social care. They received training to gain the skills and knowledge they needed to help care for people in their own homes, including how to provide care with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

● People were placed at the heart of the service and they were given every opportunity to express their views and be involved in making decisions about their care.

● Through the service's collaborative working with other services and professionals, people only had to tell 'their story' once. This meant individualised care, which was easily accessed and coordinated, and helped improve symptom management.

● Quarterly surveys were conducted to gain people's views on the service. We noted respondents had been extremely positive about the care they received. The latest survey covering the period April to June 2019 showed 100% of respondents considered the service to be excellent and their care plans reflected their individual needs.

Respecting and promoting people's privacy, dignity and independence

● Without exception, people told us they were treated with dignity and respect and their privacy was always upheld. A member of staff told us, "It's thinking if you were laying there, how would you feel? We did that in training. Sometimes when I am covering people over during personal care, they say they don't care anymore, but it's still important." Another said they always followed the lead from the person when delivering care to avoid offending them if they had specific cultural needs.

Outstanding ☆

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

End of life care and support

● People received exceptional end of life care and practical support, advice and emotional care was available to them and their loved ones. A professional told us, "The service is extremely caring and goes above and beyond to ensure care at home for those at end of life is prioritised and the needs of the individual and family are holistically met."

● People's needs and wishes at end of life were assessed and recorded. During the assessments, staff had discussions with people about their end of life needs and wishes and how this can be achieved. People's preferred place of care was recorded and most people using the service wished to die in their own homes. Staff demonstrated they did everything they could to ensure this happened.

● People, relatives, professionals and staff had access to one contact number to help them navigate the complicated field of palliative and end of life services, with the aim of ensuring people had a comfortable and dignified death.

● Staff were aware of the vital importance of acknowledging people's spiritual care and ensured care was delivered which was culturally sensitive and acceptable to people and their families.

● The majority of the qualified nurses had completed verification of death training. This enabled them to go out to people in their own homes to verify their death without the need to wait for a GP to attend. On the first day of our inspection, a call came through someone had passed and a nurse immediately went to the person's home. A member of staff told us, "It means relatives don't have to wait. The last offices can be done by staff. There is no time limit, we don't have to rush and take as long as we need. It's good for families as they know us." The last offices is the procedure performed to the body of a dead person shortly after their death has been confirmed.

● Staff had access to, and used, standardised guidelines on the management of symptom control. This included the Essex Palliative Care Formulary which follows the National Institute for Health and Care Excellence (NICE) guidance NG31 (care of dying adults in the last days of life).

● Staff demonstrated their passion and commitment to providing excellent end of life care. Staff feedback included, "I've worked in nursing homes and people weren't getting the right end of life care. Coming here, you can make sure they are getting it." And, "It's being able to help and do more and make a difference. Ultimately, helping people to die how they want to die, and they are not suffering."

● We saw many thank you letters and compliments the service had received. One stated, "I will never be able to thank you enough for how you helped myself, my family and more importantly [name], through the worst weeks of our lives. Words are not enough."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People received an exceptionally responsive service. To support this, the service had a rapid response

team in place to deal with crisis or rapid deterioration in people's health 24/7. A professional said, "The team are always very responsive to rapid changes or crises in patients and try to be as flexible as possible."

● An assessment of people's needs was carried out by a qualified nurse. At this assessment, people were able to express choice over their care needs; including any special needs after death. A member of staff stated it sometimes took several visits before people were able to have those difficult conversations about dying and their preferred place of care. This showed assessments were paced to meet and support people's needs in a timely manner.

● People's care plans were reviewed monthly by a qualified nurse, or daily if people's clinical needs changed. Information was also uploaded on system one which enabled other professionals involved in people's care to access it.

● We received excellent feedback from professionals about the person-centred care people received. Comments included, "They carry out very comprehensive assessments of patients and provide excellent individualised care." and, "They are the people I go to when I am concerned about a patient/family in the community as I know they will always try to support people in their own homes. They are the people I can rely on to work in a flexible way, with a 'yes' attitude to solving problems, that sometimes other teams in the community are not able or willing to do."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The registered manager assured us no one would be discriminated from accessing the service and information would be made available to ensure people's communication needs were met. We saw examples of how the service had extended this support to family members.

● Staff had access to resources to support effective communication, for example, hearing loops and pain assessment tools in a different format for people with learning disabilities which had been produced in partnership with learning disability services.

● Some members of staff were proficient in British Sign Language (BSL) and attended monthly deaf awareness groups to practice BSL and raise awareness.

Improving care quality in response to complaints or concerns

● The service had a 'Comments, compliments and complaints policy' in place.

● The service was committed to providing a high-quality care service where people were happy with the service they received. Complaints were seen as positive to help drive improvements to the service. A professional told us, "We have end of life partner meetings with [head of community services]. This includes representation from district nurses etc. There was one complaint involving lots of issues [across several services]. We took time to reflect and what we could have done differently."

● People were provided with information on how to raise any concerns when they first started using the service. Everyone we spoke with knew how to raise any concerns. One person said, "I would call the office, but I have nothing in this world to grumble about. I couldn't have been more looked after by anybody." Another person said, "If I did I would talk to my carer, I trust her. If you spoke to 1000 people, you would not find anything against them. They are amazing.

Outstanding ☆

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Leadership was exceptional and distinctive. Leaders and the service culture they created drove and improved high-quality, person-centred care.

Working in partnership with others; Continuous learning and improving care

- Working in collaboration with other services and professionals such as specialist palliative care teams, tissue viability nurses, GPs and the various services within the hospice was seen as pivotal to service provision.
- Excellent working relationships had been formed with external groups which demonstrated the desire to work collaboratively with others to ensure people's changing needs were managed and responded to by the professional with the most appropriate skills and knowledge. A professional told us, "The service lead is very experienced, very proactive and a great advocate for integrated working. Any incidents are used for learning and advancing future service provision." Another said, "I would say with [head of community services] and [Hospice at home and RADS manager] in charge it is an expertly not just well led service. They both have a wealth of experience and skills in managing such a busy and much needed service. As a locality we are so lucky to have such a great service in our community."
- Attendance at meetings with other external health and social care professionals supported the development of trusting relationships. One professional told us, "The management team are very focused on being part of the community and fostering collaborative working in innovative ways. They listen openly to other community colleagues with the aim of improving service delivery, avoiding duplication, and working effectively with limited resources etc. I hear positive feedback from GPs and community nursing teams." Another said, "They work well with other teams and integrate well. They have access to system one, so we can see what they are doing, that makes a big difference to everyone."
- The head of community services and Hospice at Home and RADS manager attended the Essex End of Life Care forum. They told us they were able to influence issues and developmental needs around end of life care. For example, they had identified how stressful it was for families to wait for verification of death. Now qualified nurses were able do this, and this has had an enormous positive impact on families. They had also raised concerns regarding obtaining medicines out of hours and action was now being taken to have a list of out of hour pharmacists who would be obligated to have the medicines the service may require.
- Management were committed to raising awareness of good palliative and end of life care, including the different services available to support this. This included holding and/or participating in events within the community.
- The head of community services and the Hospice at home and RADS manager worked alongside the local authority and four hospices based in Essex to deliver three-day training on end of life care for domiciliary care providers to enable them to develop 'champions' in end of life care. The aim of the training was to highlight that not all end of life care needs to be delivered by hospice staff and supported carers to recognise when people may be approaching end of life and having open conversations and knowing where to get support from.

● A professional told us, "I am always impressed by the professionalism of the managers and their wish to constantly strive to improve services. They are keen to know of anything that can be improved and foster a very open culture."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The service was consistently well managed and well-led. Management, and the culture they created, promoted an exceptional person-centred service which was open, inclusive and empowering. Senior management were visible and operated an 'open door' policy. Their leadership motivated and inspired staff to deliver positive outcomes for people.

● Staff fully embraced the visions and values of the service to deliver excellent care and support to people and their families. People, relatives and professionals were exceptionally complimentary about the service and the impact it had on people's lives. One relative told us, "They are so helpful and whatever you ask them to do, they help you with. I would struggle on my own. [Person] does not want to go back to hospital, so I don't know what I'd do without them. I'm so grateful for everything they do. I can't praise them enough." Another relative said, "We are very much supported and looked after. Knowing we can rely on somebody [makes a difference]. None of us know what to expect but if you ask they will tell you, they answer your questions." A professional said, "The service is outstanding, demonstrating commendable resilience, responsiveness and commitment to all service users (patients, carers, families, and bereaved people) but also to St Luke's as a partner organisation. The team, from managers to admin support to nurses and carers, are genuine and dedicated. They show high levels of empathy, courage and caring in the face of a difficult and often emotive job/service."

● Management recognised the emotional nature of the work staff carried out and had implemented weekly peer group meetings. These meetings were held 'off site', were open to all staff, and facilitated by qualified counsellors.

● Staff repeatedly told us they felt well supported and valued in their roles and said the service was a good place to work. One member of staff said, "You need to be supported because of the delicate nature of our work. We have support from the whole hospice team. You can be referred to a counsellor if needed. Hand on heart, you could ask for support at any point and they would be there." Another said, "I feel supported and valued that's why I've been here so long."

● The service is a member of NAHH which is the national representative body for hospice at home organisations. NAHH supports members to develop and improve the palliative and end of life care they provide to people in their own homes.

● Management understood their responsibilities under the duty of candour when things go wrong. A professional said, "I am impressed with the level of transparency and disclosure demonstrated by the team and particularly the managers. The service is incredibly committed to acknowledging when/if things go wrong or could have gone better. They demonstrate a level of empathy and humility around these situations that I find humbling and inspiring professionally and personally. The needs and real experience of the people they care for is truly at the heart of all they do."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Staff were clear on their roles and responsibilities and were provided with the resources they needed to enable them to effectively fulfil their roles.

● Effective quality assurance systems were in place to monitor the quality of the service. This included the review of people's care records to ensure information was up to date and reflective of their care and support needs. Management were constantly learning and reviewing quality assurance systems to help drive

continuous improvements and enhance quality of care.
● A risk register for the service had been developed. This recorded the measures put in place to mitigate identified risks and was regularly reviewed.
● Effective governance systems were in place to ensure regulatory requirements were met, and the registered manager had a good understanding of these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service regularly contacted people to ensure they were satisfied with the service. If anyone had any concerns, a senior member of staff would immediately go out and visit them.
● Surveys undertaken by the service showed people were extremely happy with the care and support they received.
● Staff told us they felt totally supported and management were approachable both for personal and work-related issues. Regular team meetings and away days were held, and newsletters were sent out to staff to keep them informed on the day to day running of the service.
● The service had forged strong links with other community services and providers. One professional said, "The commitment of [registered manager, head of community and Hospice at home and RADS manager] and the team to work collaboratively, with St Luke's, but also with our other providers is second-to-none. We have become 'seamless', prepared to support each other in training, commissioning, staff support and care delivery with trust, friendship and reciprocity. There is healthy professional discussion and challenge when necessary and an open willingness to share practice and learn from each other."