

St. Elizabeth Hospice (Suffolk)

St Elizabeth Hospice

Inspection report

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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?

Good 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

This unannounced inspection took place on 10 October 2016. We announced two further days of inspection that took place on 12 and 14 October 2016. We had last inspected this hospice on 22, 29 January and 5 February 2014. At that time we reported that care records were not consistently maintained. On this inspection we found that this had improved.

St Elizabeth Hospice is located on the outskirts of Ipswich and is owned and operated by a local charity. It provides palliative and end of life care for adults and young people aged 14 years and above. Based in Ipswich there are eighteen inpatient beds. The aim is for short stays to manage symptoms of illness, pain management, respite or to receive a specific treatment or end of life care. The hospice also runs and supports out-patient day services. The principle day service is run from the main site in Ipswich where there is a five day a week service. Another site is Ditchingham, ran on a Monday. A variety of therapies are available at these day centres as well as medical support from doctors and nurses. The hospice provides support to the majority of people through help at home. This is through the Clinical Nurse Specialist (CNS) Team and Community Healthcare Assistants. The CNS team work with people and those that support them in the community such as GP and District Nurses. They offer specialist advice on symptoms and end of life care as well as a link to all that the hospice offers. Community health care assistance at home provide personal care support to enable people to remain in their homes longer. The service as a whole was used by 844 people last year. The hospice also run a telephone advice line that gives access to expert advice and access to a CNS. 16700 calls were made last year.

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

The service was extremely caring and focused on providing a tailored service which people helped plan and develop. There were appropriate systems in place to ensure flexibility to people so their care needs could be met either at home, in the hospice or in the wider community. People were able to seamlessly transition through different parts of the hospice. Young people were effectively supported to transition from children's hospice services into this adult environment. In addition the service provided excellent support to relatives and carers. People spoke overwhelmingly of the positive support, guidance and healthcare interventions they had received. People were full of praise of the staff in terms of their kindness, compassion and knowledge about end of life matters.

Staff followed risk assessments and guidance in management plans when providing care and support for people in order to maintain people's safety. Medicines were safely and effectively managed within all the hospice departments.

Staff were able to describe what it meant to safeguard people and told us how they would report any suspected abuse. There were policies and procedures for staff to follow and there was an embedded culture of learning. Staff worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff. They told us they were involved in all decisions about their care.

Excellent leadership and management was demonstrated at the service. The culture was open and inclusive which meant that people received a tailored service which was flexible to their needs.

Staff were involved, listened to and empowered with training and support to offer excellent end of life healthcare and support.

Staff and volunteers shared similar values and worked closely with each other in a mutually respectful way. There were regular team meetings. Accidents and incidents were clearly recorded. Where any mistakes were made these were discussed and reflected upon in order to make improvements. The hospice presented annual quality accounts which looked at patient safety, clinical effectiveness and patient experience. Audits were completed across the organisation providing a thorough and comprehensive system of quality assurance. The quality of the service was enhanced by these measures and this was reflected in feedback received by the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

People felt safe using the service and trusted the staff who provided their care. Staff had been trained to recognise and respond to any actual or potential abuse. The service had developed systems for reporting and monitoring.

Potential risks to people were assessed and measures put in place to reduce risks. Accidents and incidents were analysed and learning was shared amongst staff to prevent reoccurrence.

There were the right numbers of staff with the appropriate skills and knowledge to meet people's needs at all times. Staff were able to support at the pace that people wanted and wished for.

Complex medicines were well managed. People received their medicines from staff who were trained and qualified in safe administration of medicines to ensure people received their medicines in time and safely.

Is the service effective?

Good 

The service was effective.

People received support and care from a staff team who were specifically trained to meet their needs. Training was well managed by a dedicated team within the service. Staff were keen to develop and share their knowledge and skills.

Staff understood and followed the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were genuinely informed and involved in making decisions about all aspects of their treatment and care.

People were supported to eat and drink and maintain a balanced diet. People were able to choose from a varied menu of fresh and appetising food. People with a reduced appetite were appropriately supported.

People had consistently good access to the healthcare support they needed. Health clinicians worked well together to ensure

the best outcomes for people.

Is the service caring?

The service was very caring. People's and their relative's feedback about the caring approach of the service and staff was overwhelmingly positive.

Staff showed kindness and knew how to show empathy when people faced challenging situations. People valued their relationship with the staff team who often performed beyond the scope of their duties to support people.

The service was very flexible and responded quickly to people's changing needs or wishes. Staff communicated effectively with people and treated them with kindness, compassion and respect.

People were consulted about and fully involved in their care and treatment. The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

Outstanding ☆

Is the service responsive?

The service was responsive.

People and their families were fully involved in assessing and reviewing their needs and planning how their care should be provided, which included their wishes and priorities regarding their end of life care and preferred place of death.

The service provided person-centred care based on best practice and focussed on continuous improvement. Staff understood and anticipated people's needs which enhanced the quality of the care people received.

The provider had positive approaches to seeking and responding to complaints and concerns to improve the quality of the service and this was closely monitored by the management team.

Good ●

Is the service well-led?

The service was exceptionally well-led.

The service promoted a positive and open culture and provided a range of opportunities for people who used the service, their relatives and people from the wider community to comment and influence the running of the hospice.

Outstanding ☆

Clear embedded values guided the service. The provider listened to all people involved about their experiences of different aspects of the service to drive the quality of the service on offer.

The service worked in partnership with other organisations to ensure they followed best practice and provided a high quality service. This service was highly regarded by everyone we spoke with.

The service delivered high quality health and social care as demonstrated through governance systems in place.

St Elizabeth Hospice

Detailed findings

Background to this inspection

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

This unannounced inspection visit took place on 10 October 2016. We announced two further days of inspection that took place on 12 and 14 October 2016. We had last inspected this hospice on 22, 29 January and 5 February 2014.

The membership of the inspection team consisted of an inspector, a pharmacist, a specialist adviser and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our specialist adviser had experience working in services provided to people affected by life limiting illness.

Information was gathered and reviewed before the inspection visit. This included notifications of significant events that affect the health and safety of people who used the service. 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.

We spoke with nine people who used the inpatient service and hospice at home service and nine relatives/visitors. We spoke with 18 staff members including nurses, a physiotherapist, and health care assistants. In addition we talked to volunteers, a pharmacist, a consultant, the chief executive and the registered manager for St Elizabeth's Hospice.

We reviewed seven people's care plans to see how their support was planned and delivered. We looked at a selection of medication records to check medicines were managed safely. We looked at a range of policies and procedures, quality assurance and clinical audits and meeting minutes for the different departments within the hospice.

Following the inspection visit we contacted other external health and social care professionals who work

with the hospice to seek their views. Seven healthcare professionals responded and shared their views about the care provided at St Elizabeth Hospice.

Is the service safe?

Our findings

People and their relatives told us they were safe at this service. One family member said, "[Name] feels safe here, so we can sleep at home knowing they won't be calling to say he has fallen out of bed or anything like that. At home we don't sleep- we just can't." Another person talked about how they felt safe because of the actions taken by the hospice to get to know them. They explained, "They came to the house which is a good idea so I knew I would be looked after properly and be safe here."

People had a comprehensive moving and handling assessment so staff knew how to move them safely, as well as assessments for the safe use of bed rails. We examined the electronic care records and found that people had appropriate risks assessments in place to identify and mitigate risks. Risk management plans took into account people's individual preferences. For example, one person had their individual preference documented that they wished to have their bed rails only raised at night.

All the single bedrooms had overhead tracking for hoisting people, if needed, from their bed into the en-suite bathroom facilities. The four bed bays also had tracking over the beds. The large communal bathroom had doors that slid back to allow bed access, and overhead tracking to lower someone into the adapted bath. These systems were safer for nurses and for people as it reduced the number of transfers requiring the use of a hoist. The hoist slings were appropriately assessed on admission for size and type and then remained by people's bedside for use. Any risks relating to moving and handling were well managed to keep people as safe and as comfortable as possible.

Any accidents or incidents that occurred were appropriately reported, investigated and fed back for others to learn from, with actions identified to prevent a reoccurrence if possible. All senior nurses on the inpatient unit received daily emails concerning all incidents that had occurred, together with the outcome of the completed investigations and the actions put in place to minimise risks to people. Incidents were audited and the senior nurses feedback to the team. This was an effective system as the nursing staff were responsible for the incidents and were better placed to discuss with staff what had happened and how to manage care safely and avoid future occurrence. For example, a change that had been successful in making people safer was the introduction of ultra-low beds. This had seen a reduction in falls and injury had decreased.

There was a comprehensive check list that covered all the clinical equipment and other aspects of the inpatient unit that ensured a clean and safe working environment. Daily checks were undertaken to ensure equipment such as oxygen cylinders, mask and tubing, Entonox and intravenous (IV) pumps were clean, charged and ready for use. Suction equipment was checked and clean, as was blood and blood pressure monitoring equipment and thermometers. The defibrillator and bed mattresses were also being added to this list. The systems in place were effective because our specialist adviser found the area was clean and equipment was safe and available for routine usage and in case of emergencies.

We spoke with the person responsible for maintenance and health and safety. They were able to show records that related to servicing and maintenance of all equipment within the hospice. The hospice also had

an emergency major incident plan in place should it be needed. This was important to ensure the service could continue safely with people's needs being met until a normal service could be resumed.

Staff had a comprehensive awareness and understanding of their responsibilities for protecting people against the risk of avoidable harm and abuse. Staff told us and we saw that they had safeguarding and child protection training and regular updates to ensure they were knowledgeable in safeguarding vulnerable people from abuse. They described how they would refer people to the appropriate organisation if they had concerns to ensure people were protected from potential abuse. Staff were aware of the provider's policies around safeguarding and expressed confidence in these. Staff felt able to approach their line manager or more senior staff if they had any issues or concerns. One nurse gave an example of how they had identified a person using the service was at risk from abuse from their family. The nurse took advice and acted in the best interests of the individual to protect them and achieved an outcome that involved the person and kept them safe. The example showed us that the systems and training in place for staff were effective and that the provider reported any concerns to the local authority who lead in safeguarding matters.

People told us that they felt supported and "watched over kindly," by the staff. They were very complimentary about the numbers of staff on hand and what they felt they could ask staff to assist them with. One family member said, "It's a bit slower at weekends but we don't mind, everyone needs so much care here." One person said, "They (staff) are always aware of what's going on, if I drop my stick someone always notices and comes to pick it up before I bend down and topple over." People were overwhelmingly positive about the staff who they confirmed were available to them and safely met their needs. One person who used the hospice at home service said, "They were brilliant. They came morning and night to my husband and washed him so carefully. They were always on time. They were so hygienic in how they worked and never rushed."

There were sufficient staff employed and deployed at every level to meet people's health and care needs. Everyone we spoke with said that there were sufficient staff. Nursing staff worked on a rotational basis, they were employed to work all shifts. Staff did not work long shifts in the inpatient unit; they worked either morning, afternoon or night shift. This meant they were always fresh and responsive to people.

There had been a successful recruitment drive to employ more nurses and only one nursing post was vacant at the time of our visit. If extra staff were needed, the hospice ran their own relief bank for nurses and care staff to ensure all shifts were covered. This showed that people received consistent care from staff who worked in accordance with the provider's policies and procedures. The staffing ratio for the 18 inpatient unit was four registered nurses and four care staff in a morning. There was also two volunteers. The afternoon shift had three registered nurses and three care staff. At night there were two registered nurses and two care staff on shift. During the day there are also occupational therapists, physiotherapists and doctors working in the unit to meet people's needs.

The hospice used volunteers in a variety of roles within the hospice setting. We found that both volunteers and employed staff were robustly recruited. We examined the recruitment records for four staff of different designations within the hospice. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff/volunteers had not started working at the hospice until it had been established that they were suitable to work with people. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and were obtained from their most recent employer. This showed that the hospice recruited and employed suitable staff to work and support people.

Medicines were safely managed and people were positive about their experiences with regards to receiving

their medicines. People receiving medicines, especially pain killers, said, "They come very quickly if you ask", and said that everything worked like "clockwork" with their medicines. One person told us they were, "very impressed" with the way medical staff were trying to manage their pain medication and how staff explained everything to them to try to balance pain versus sleepiness and sickness. The person was pleased that staff understood how important it was for them to get their pain medicine accurate. They told us that medical staff, "Get it right especially when my kids are here."

There was an effective system in place for obtaining medicines seven days a week from the local hospital trust pharmacy. Prescribing was done on dedicated treatment charts and records of administration were clearly documented on the charts including drugs administered through syringe pumps (medicines that are mixed together in a syringe and given through the skin). Pain relieving patches were monitored appropriately when people used them. All allergies were clearly recorded and explanations documented if a medicine was not given for any reason. Some medicines could be given without a prescription under a patient group direction (PGD). PGDs allow nurses to respond in a timely manner to certain situations and administer medicines appropriately with prior agreement. PGDs were regularly reviewed and documents updated.

Systems were in place should people wish to administer their own medicines. Individual lockable facilities were provided for people in the inpatient unit. When people using the day centre were not able to self-medicate, the hospice doctor had written up a medication chart which staff signed each time the person's medicine was given.

Medicines that were brought in by people when they were admitted to the hospice were checked promptly by a doctor (medicines reconciliation), however, we noted this could be more clearly recorded on prescription charts. Pharmacy staff from the local hospital trust visited the hospice once a week to monitor medicines that were prescribed at the hospice, check medicine stocks and provide hospice staff advice on medicines. We received feedback from them and they told us, "The Pharmacy Department has a very good working relationship with the hospice team, which includes the consultants and medical staff as well as nursing staff. We have a medicines management group (called QUAD-quality assurance of drugs) that meets periodically to look at guidelines, prescribing, incident reporting, financial aspects of medication, etc. We work with staff on the inpatient unit as well as day services. The hospice appears to provide a very good service to patients in a very caring environment, both for inpatients and patients at home."

Up to date references were available for staff which provided information about the safe and correct use of medicines. There was a system in place to deal with alerts and recalls of medicines.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room. In the day centre, medication was locked in a small drug cupboard in the nurses' office. There was a system in place to check that all medicines including those available for use in an emergency were within date and suitable for use, however, records of expiry checks were not maintained. Medicines requiring cold storage were kept within a refrigerator in the treatment room and the refrigerator temperature was monitored. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely and monitored appropriately. Higher dose controlled drugs were stored on a separate and clearly marked shelf for safety. There were appropriate procedures in place for ordering and disposing of controlled drugs.

Medicine policy documents were regularly updated and changes communicated to clinical staff. There was a programme of auditing, for example, prescribing at the hospice. Medicine incidents were reported by staff within an open non-blame culture, reviewed and actions taken and any learning was shared with staff. All

staff involved in medicines administration had a comprehensive induction, competency checks and on-going annual mandatory training in relation to medicine administration.

The hospice supplied information directly to people about their medicines. One person receiving treatment at the hospice told us that they received more information at the hospice about their medicines than at any time previously.

Is the service effective?

Our findings

Staff had the skill and knowledge to carry out their roles and responsibilities. Staff told us they had good opportunities for training. People felt the staff were well trained. One person said about staff, "They talk to each other which you don't get in most places." People told us staff knew them well and how to support them effectively.

We spoke with a member of staff in the education department. They were able to show us the systems in place to monitor the training and skill mix of staff employed at the hospice. We were shown evidence that everyone received a comprehensive induction, including volunteers. We spoke with a volunteer. They told us about having a daily briefing about people and being told, "What we need to know, but no more." The same volunteer was praised by a couple of the people we spoke with about how effective they were in their role. The volunteer told us they had learnt that "It's important people have dignity here whether they can remember things or not." We also saw a copy of a course that was run to develop volunteers and support them in their work with people who used the service. This included training courses in topics such as communication, bereavement conversations, dementia awareness, basic life support and supporting a person to eat. In addition courses that were available for staff such as the Dignity in Care course, were also open to volunteers.

We spoke with a nurse who told us, "New staff have a two week induction and then they have supernumerary shifts on the unit, the number of these shifts depends on their previous experience and skills, and is decided at interview, we have had several new staff in the last year and we are now really working together as a team." We saw evidence and staff told us of the on going training they accessed which provided them with updates on skills and ensured they continued to follow best practice. Nurses had been supported with their revalidation and appraisal. The hospice had invested in a computer system that allowed nurses to store their evidence and submit to the Nursing and Midwifery Council (NMC) to continue as a registered nurse. Registration with the NMC was regularly checked for practicing nurses at the hospice. We were told by managers about the development of lead roles within the staff group. This was also spoken about by a nurse who told us, "We have nurses who have a special interest and they are the link nurse for tissue viability, infection control, nutrition and diabetes. These staff are able to attend training days and then feedback to the team." Staff also consistently told us they were given appropriate support and regular supervision and had annual appraisals to enable them to reflect on their performance and set objectives for the coming year in line with the hospices aims.

We spoke with a student who told us they had chosen their placement at the hospice and praised the support and learning they had received. They explained that the ethos and way of the hospice, "Is showing me what care really means and not just end of life care."

There was good effective communication between departments and teams within the hospice. We attended handover meetings and daily meetings. This included a multi-disciplinary meeting with the Community Nurse Specialists with doctors present. This was to ensure good communication between the hospital and the hospice and that people received the most appropriate support at the hospice from either the medical

or therapy team or day care services. We observed handover on the Inpatient Unit where a senior nurse effectively communicated the events from the previous 24 hours to the clinical and therapy team and representatives from the 'Discharge Planning' and 'Emotional Well Being' teams. We also attended the daily admissions allocation meeting to the Inpatient Unit. The meeting was between the senior nurses on duty, the doctor, a member of the 'Emotional Wellbeing' team and a medical secretary. The purpose of the meeting was to check any referrals that had been made, to decide on priority of admissions and also if there had been any changes to inpatients condition overnight or other aspects of their care that need highlighting. On the day of our inspection all the referrals were for male beds. By re-organising some of the beds within the hospice to make a male only bay, the hospice was able to admit one person who was currently in an acute hospital bed. Later in the day following further bed moves and cleaning, another bed became available and a further admission was planned before 4pm so a doctor would be available to assess the person when they arrived at the hospice. This demonstrated that there was an effective system of communication, monitoring referrals and prioritising admissions that linked to competent staff availability.

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. We saw examples when people were supported and involved in making decisions. We sat in on a multi-disciplinary team meeting. [MDT] In these meetings matters of consent were routine within discussions to ensure people had information given to them to understand what they were consenting for. Capacity and consent were consistently discussed throughout the MDT and staff hand over, and documented within the electronic records for each person using the service. We found that decisions relating to treatment, disease progression or approaching death were made involving the person and their informal carers/family. Where people lacked capacity staff had evidenced the discussions with families which contributed to best interest decisions.

People were always asked to give their consent to their care, treatment and support. Staff always considered people's capacity to make particular decisions and knew what they needed to do to make sure decisions were made in people's best interests and involved the right professionals. On relative spoke about end of life wishes and how these were discussed and agreed upon with the person themselves. We observed whilst on home visits staff sought consent to share information and agree care and treatment plans.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection people using the service had capacity and did not require any DoLS. However staff understood the role of the MCA and the need to act in a person's best interests if the person they cared for had difficulty making a decision, for example about their treatment or their wishes as they approached the end of life. The registered manager knew the process to submit applications to the relevant authorities and had completed these in the past where relevant and we had been appropriately notified. We spoke with a representative of the local authority and they told us that St Elizabeth Hospice have shown a keen interest to understand both the MCA and DoLS and to know about how the Act and the Safeguards should be appropriately applied in practice. Staff had telephoned the local authority with specific questions to understand individual circumstances. The local authority team provided one 'Development Session' a year to update staff on the requirements and processes of the Act and the Safeguards. The local authority representative said, "In particular they have been keen as a staff team to understand about the DOLS, state detention and the role of the coroner. Working with them through an 'Exploration Session', we have been

able to explore the requirements expected of them as a provider and the roles of other professionals involved with the process."

People were encouraged and supported to have sufficient to eat and drink and maintain a balanced diet. A variety of tempting foods were offered which were based around individual preferences and choices made directly to the chef and their team. One person told us, "I reckon it's a bloody good hotel here." People particularly spoke of the choices of food on offer, with one person explaining, "If you are dozing or feel sick, they will keep it warm or make you something else later, it's not take it or leave it." One person we spoke with said, "I can't eat any more but it was so good I miss it." We saw that this person was supported to have regular small drinks of fresh water when they could manage them.

Risk assessments were completed and nutritional needs were identified. Records showed that these were managed and monitored well. Each person on the Inpatient Unit had a form for monitoring food and fluid intake. The records we looked at had been completed and accurately reflected how much food people had eaten. We spoke with the chef who gave us a copy of the five week changing menus. The one kitchen provided approximately 50 to 60 meals a day for people staying, using the day centre and staff and volunteers. All meals were homemade and used fresh ingredients. The chef had a good knowledge of specialised diets for people and had received appropriate training from dieticians at the local hospital. They told us, "We provide vegetarian food and food for people with diabetes. If we need to liquidise or puree the food we can sieve it to make it extra fine, but we always make it look attractive on the plate." The chef was booked on a new course in the coming months to develop their knowledge further. They went on to tell us they met with people who were staying in the Inpatient Unit to understand their likes and dislikes and regularly received feedback about the food. The main dining area was accessible to everyone and spacious. We ate at the hospice and found the food to be good quality and tasty.

There was a small kitchen on the Inpatient Unit where people and their visitors could make drinks and snacks at any time. One of the nurses told us how the availability of the kitchen was important to people and explained, "We had a family who always had a take away on Friday nights at home, so when the mum was in here they said this and we said to bring it in as normal. It smelt lovely and all the family enjoyed it."

People received access to on going healthcare support that was timely and specific to their needs. People spoke of being offered opportunities to see a range of clinical and non-clinical staff. One person explained to us, "There's no waiting here which is pretty good- you feel you are cheating the system in a way." A different person said, "I've already been referred to the physio and doctor; I'm very chuffed with what's happening here." One person spoke positively about how their health was monitored and said, "It's inspiring me what's happening here."

Our specialist adviser looked at records and treatment of various medical conditions and found that these were appropriately managed. One person had an indwelling catheter and they were able to manage this independently. This maintained their dignity and independence. The management of the catheter was well documented and routinely monitored by nursing staff. One person had a 'Complex Wound Care Plan'. The plan was comprehensive and gave information on the topical gel to use, the primary and secondary dressings and the frequency of daily dressing changes. Appropriate charcoal dressings were being used to minimise odour and the securing system of purple line tubifast ensured comfort as no adhesives were being put on the skin. This treatment also ensured the dignity of the person to prevent odour and protected the person's skin as much as possible.

We found good communication between health professionals at the hospice and hospital and the GP surgeries. This was additionally supported by monthly education sessions held in an evening to support

GP's and Nurse Practitioners.

Is the service caring?

Our findings

The standard and quality of care was exceptional. We received extremely positive feedback about the service and staff from everyone who spoke with us. From the moment people arrived at the hospice they were warmly greeted. The entrance to the hospice was open and well lit, and the volunteers on reception were friendly and knowledgeable about the services provided at the hospice. Everywhere was well signposted. People told us how unlike a hospital the atmosphere was and how that helped both people and family members feel welcomed. One relative said, "I've noticed every time I pass a nurse or a carer in the corridor they smile and say hello, not many people smile at me outside." People mentioned how they didn't know what to expect but how the atmosphere and whole approach was much more, "Upbeat and positive" than they had expected. One person said, "I never expected to be introduced to using a gym and weightlifting at my age."

We found a high level of care and visible compassionate caring was evident throughout the day across all areas. This made a big impression on our expert by experience and they were a regular user of hospice services at the time of our inspection visit. People when they spoke to us used words like "nurturing," and "lovely and kind," to describe the care and nursing staff. One person told us, "The doctor is tremendous. So supportive. In fact everybody we come in contact with is caring, helpful and kind. They are considerate and everything is excellently covered. I'm totally amazed at how they have responded to us as a family." One relative told us how their family member was very learned and an intellectual and how that was so important to his identity and position within the family. They said, "All staff treated him with absolute dignity. They were incredibly respectful. They used his first name and treated him as the intelligent man he was."

One person told us they had given a lot of thought to what they wanted to tell us. They started by saying they had been frightened when they first arrived at the hospice and how the staff, "Relax you, don't rush you but start with a cup of tea and a smile." The went on to say, "I'm surprised by how caring people are here, I didn't know what to expect. When I first came I sat woodenly but with hindsight they watched me, and worked out what they could do for me. They didn't rush me but I get a feeling they read up on things, know what they are talking about and then work out a solution to help people here."

The same person also talked about needing a sense of purpose and "function in life" and said, "The staff had seen that, respected that, and done things like introducing me to an old lady who I think is lonely." These two people now sat together and the person explained, "One feels useful and valued again." The other person was observed to enjoy the interaction hugely.

One person attending day care told us of an act of kindness that made a difference to them each time they visited the hospice. They said, "When I first came here I said I liked reading a newspaper but didn't get one any more as it's too much effort, but every day I come here there is a paper waiting for me with my first cup of tea. How kind is that and I never ever asked for it."

On the Inpatient Unit, a relative who had spent many weeks at the hospice said they felt they knew the place

very well, and told us, "When you are part of the furniture you see so much. They really care here because they come to [my relative] at least 20 to 30 times a day. When anyone is walking down the ward they don't just look straight ahead they are constantly looking left to right watching to see if anyone needs them, you only need raise your head and they come." Another relative said, "You can ask anything, nothing is too much for them, they are so lovely to us". We were able to observe this level of support for ourselves in the Inpatient Unit. A nurse was talking to us when they noticed a relative come out of a bed bay and they appeared upset. The nurse immediately excused themselves and went straight to the relative. The nurse gently led the relative to the conservatory area at the end of the unit and they went inside. A short time later the nurse returned and said the relative had been upset at the change in their relative and just needed to come away from the bedside. The relative had been offered a drink, a comfortable and quiet place to sit and a nurse to be with them. This showed us the high level sensitive responsive care that was routinely offered to people and their families.

We saw mutual respect and real fondness was quite evident between staff and people using the service. One person using the day unit said, "Have you met this nurse, she's a lovely girl. Well they all are." A nurse explained how important it was to take into account people's emotional needs and understand what was important to them. An example they gave was of a person who came accompanied by their dog. The dog was very important to them and gave meaning for them as well as an emotional attachment. Therefore a side room enabled the staff to accommodate them together. The nurse said, "The dog is a little overweight, so we all try and walk it a bit more and cut the treats whilst it's here, to keep them both healthy and be together."

The staff approach and delivery of care was extremely thoughtful, responsive and effective. We met and spoke with a person using the day unit who had a diagnosis of dementia. This person was cared for at home by a carer who was elderly. The carer was unable to visit the day unit regularly and the person could not always remember what information they needed to share when they went home. Therefore nurses had developed a creative way to support communication that included photographs. The nurse told us how they were concerned about managing this person's pain relief as the person was unable to describe their pain levels. They had devised an innovative way to monitor the person's pain levels. The nurse said, "With the guidance of a doctor, I drew up a grid for [the relative] to fill in at home, for a week, describing when they gave pain relief and its effects. With this information the doctor has reviewed medication and changed the tablets, [Name of person] now seems more comfortable." This was a good example of personalised care and innovative approaches to support communication involving relatives, even when direct contact was not possible.

People were supported and actively involved in making decisions about their care and treatment. On admission to the Inpatient unit a full assessment was carried out with the person and if the person consented to it, with their relatives as well. One relative told us, "The nurses had an intelligent awareness of what the relatives need." This information was put on the care plan and was seen as an important part of the care and understanding of the person. Records showed evidence of family meetings and the outcomes for one person was for their pain to be managed so they could still go to work for as long as possible. Confidentiality was protected because care plans were password protected for each member of staff. All areas in the inpatient unit or day care unit where people's records, medication or clinical equipment were kept were only accessible via a key fob system allocated to each member of staff. All access could be logged and traced. Therefore people's privacy and access to records was appropriately maintained.

One younger person and their relatives said how they were very much involved with care planning. The relatives of another person told us about the plan in place for end of life care. They said, "She really knows exactly what she wants, and they are helping her to achieve that the very best they can". One relative said

that staff knew their relative well and could tell if they were fed up and understood how important the fresh air was to them. They explained, "They (staff) were great and pushed the bed out into the garden so he could see the fish pond."

Staff were passionate about providing people with compassionate palliative and end of life care that reflected their preferences. At the hospice there were two rooms that were cooled which were for people to be moved to following their death. They provided a pleasant and comfortable environment if relatives wished to see their family members following their death. One room had a separate door at the side of the building for access by the funeral director to ensure people were transferred with dignity and discretion. One family told us how important and "marvellous" it had been for them that their relative had been clothed and buried in a specific outfit that mirrored their lifestyle. They told us, "They did treat him with dignity and respect right till the end even though he was not aware they acted right by him." A different relative told us, "We are so grateful that our parent had a good death. We were enabled and wanted to lay out our relative as our last act for them." This showed us that there was sensitivity in relation to individual needs that related to their cultural and individual circumstances.

People told us consistently how their privacy and dignity was respected no matter what part of the service they accessed. One relative who used the hospice at home service told us, "Staff were buoyant, but were able to match our mood each time. They respected that and altered their approach. They were good at respecting both mine and my relative's privacy in our own home and that takes skill." We observed that staff were able to alter their approach to match the different social standing of people and ensure that no one was discriminated based upon their circumstances.

We were told about the variety of bereavement services available to people when someone close to them had died. There was also literature freely available for people to pick up. This described a variety of therapies including counselling, art and music therapy which was open to all. 'Time to grieve in whatever way is right for you...available as long as you need it.' A nurse described the support available for relatives following a death. They said, "We give them a leaflet and brief details. We then ask them to come in the next day, if they are able, for a timed visit with a staff member. They will give them a bereavement pack and discuss any further needs. They will also refer them to the 'Well Being Team' or 'Spiritual Care Team', if they want this." They went on to say, "Relatives often call back onto the unit and staff will speak to them and offer meetings with the doctors or the nurses. All people are different and grieve in different ways, we don't mind how many times people come back or if they don't come back at all. There's no set pattern."

We met and spoke with a member of the emotional wellbeing team. They described all that was available to people in terms of the support available before a death, with the bereavement itself and the on going loss. They described the diverse ways in which people were supported (emotionally, spiritually and practically) as individuals as well as work that was completed with families. The team was made up of staff from a range of spiritual and faith backgrounds. As well as counselling talk based therapies alternative types of therapy were on offer. This included art and music to enable people to express feelings. One member of the team was developing their links with other health and social care professionals at the hospital and completing training to better support children aged four to eleven years. This was to ensure the support was available in an appropriate way to everyone bereaved.

On admission the person and the relatives were given a small leaflet entitled, 'Hospice Visitors Guide'. The first line of which said: 'Be comforted, some helpful information for you to get the most out of your visit.' The guide stated, 'To keep things flexible and make visiting easier, family, including children, friends and carers can visit any time throughout the day or night'. We spoke with a nurse on the unit and they told us, "Relatives are able to stay and sleep within the unit, either in the same room or in a separate room." A

relative told us, "My daughter wanted to stay close and they were brilliant and let her stay overnight." The guide gave clear information on meals and refreshments and stated, 'visitors are welcome to stay for meals, either at the bedside or in the dining room, which is open to everyone.' On the back of the guide there was information on laundry, the quiet room, chaplain services, where to go for help and advice concerning finance or advanced care planning and contact telephone numbers. This was a very informative guide and contained all the information that relatives may need.

Is the service responsive?

Our findings

People at St Elizabeth Hospice received a personalised service that was responsive to their needs. Whilst we were with the Hospice at Home part of the service, a call came in from a health professional in the community needing immediate support and advice. The health professional was distressed and inexperienced. They had been sent to a patient to renew a syringe driver, but could not find the house and were unsure of what to do when they got there. The Hospice at Home nurse said they knew the patient and had given the nurse directions and agreed to meet them there to support and educate the health professional. This level of immediate response allowed all professionals in the area covered by the hospice to use and benefit from the service on offer. A relative told us about their experiences and how their family member had been admitted to hospital and had been given a very short time to live. The acute hospital environment did not suit their family member but there was no hospice bed available. They explained, "The hospice at home team were amazing. It was a Saturday. The nurse said to me, 'We will get him home today'. She did just that. She organised everything including the bed and commode. By 3pm that day he was home with us. He went on to die on the Tuesday morning." This relative had nothing but praise for the hospice and how they had responded to their need and fast tracked processes so their relative could die in their place of choosing.

We spoke to a person on the inpatient unit and asked about their admission to the unit. They told us they had originally accessed the day unit but as their condition deteriorated, "I really couldn't wait to get here and the lovely doctor called me straight back and said I will get you in as soon as I can, and she did. She's lovely that doctor – a real treasure, you must hang on to her."

We saw good evidence of person centred care with staff proactively assessing people's needs and acting responsively to those needs. A person told us they were happy they had been allocated a side room when they were admitted to the hospice. They had not requested a side room but explained, "They know I have a young family and it's so hard for them. This room is huge and lovely and they can use this door and escape out into the garden without having to see the rest of what goes on here and that means they come more often. And my friend who works shifts comes at 10 pm for a cup of tea and a chat and they always make him feel so welcome". We reviewed this person's care records and found that they corroborated all the person told us. Good clear recordings were noted on reasons and goals for the admission. Pain management was recorded in detail and ensured this was in place when family visited to make the best use of that time. In the daily notes there were records of this treatment and the outcomes.

One of the side rooms had assisted technology in a 'Possum' unit. This is a system that uses either a hand pad, breath control or a pad controlled by head movements that can open a window, open or close curtains, switch on or off a television, alter the lights, or switch on a fan. This room was used by people with a neurological condition as the technology supported them in maintaining their independence. The control pad had different front plates so the items it controlled could be changed. This was very effective and personalised for a highly dependent person.

The environment had been well thought through to support individualised care and maintain independence

where possible. The large bathroom with access for a hospital bed and then tracking over the bath was an excellent resource for frail or ill people for whom the effort of using a bath was considerable. The bath itself had water jets with changing colours and music could be played. The back wall of the room was covered with an outdoor waterfall mural. This type of care was very therapeutic and beneficial to people, who because of their condition were often not able to access a normal bath. A nurse told us, "Often people will talk in here when they feel warm and safe and family can come in and support them too." There was an outside smoking area just for people using the hospice. A nurse said, "We encourage people not to smoke, but at this stage of their life it is not appropriate to not give people access to allow smoking safely." This showed understanding and respect for people's choices.

We went to the Hospice at Home office, from where the 24 hour telephone line was answered. A nurse told us there was always someone available to take people's calls, signpost them to all aspects of the hospice service or arrange a call back from the appropriate clinician. The nurse said, "All calls are answered, they come from GP's, District Nurses, relatives and the patients themselves." They told us, "Recently I worked a weekend and over the two days we had more than 180 calls, but they all got responded to, we do now have a secretary working on a Saturday and that really helps." This demonstrated a flexible and responsive approach to ensuring an increase in demand for the service was responded to.

The registered manager listened to people's experience of their service and responded positively to any feedback to develop and improve the service. We found that as well as having all the usual formal complaints policy, procedures and methodology the hospice regularly sought feedback about each aspect of service delivery by asking people to complete quality questionnaires. The vast majority of feedback was positive, but actions were implemented where needed. For example, following feedback from people who used the day centre, lunches in the day centre were now served from a hot trolley rather than the servery to ensure they were kept warm. There was also recognition that more people wanted access to chaplaincy support whilst using the day service.

The hospice at home service and community nurse specialist survey was concluded on 8 August 2016. This had positive feedback throughout with 98% of people rating 'respect' and 'dignity' highly and demonstrated that 91% of people died in their place of choice. In the survey there were good amounts of comments and free text relating to people's experiences for the provider to develop to further improve the service provided.

No one we spoke with had any concerns or indeed anything but praise. One person who was new to the service said, "I've no concerns whatsoever, it wouldn't bother me to say so if I had, as that's the only way management can put things right – it's that kind of place I think." We looked at two recent complaints and found they had been handled to the satisfaction of the people raising the concerns. One person had been invited in for a face to face meeting so the registered manager had a clear understanding of their concerns. The person had been given a clear apology and action had been taken to prevent any reoccurrence for them or others in a similar situation. The other person told us, "The staff were brilliant... They were lovely and even called us the next day. It hasn't put me off at all – far from it."

There were systems in place to monitor and audit compliments, comments, concerns and complaints to see how the hospice could learn and develop from feedback. This information was available in public areas for people to see the action taken on feedback received. In addition a copy of the audit was given to the Governance Committee so they too were aware of any complaints and action taken to resolve matters. This open and transparent approach to matters gives people confidence to raise suggestions to improve the service.

Is the service well-led?

Our findings

Exceptional management and leadership were demonstrated at St Elizabeth Hospice. Discussions throughout the inspection demonstrated that there was an open culture with staff empowering people to plan and be involved in the high quality care provided at this hospice. One person told us, "We were given the right amount of information. The hospice delivered what they promised." Another said, "I felt more able to cope." People continuously had a say in how they wanted their care to be delivered. The strong and positive management approach resulted in people receiving a tailored inclusive service, which focused on them receiving outstanding individual care. There was a clear understanding throughout the hospice that care needed to reach all sections of society with development and creative work for people living with dementia in evidence.

People could influence their individual care in a meaningful way through their own care planning systems. Groups of people influenced the care they received through the regular surveys completed in each department seeking people's views and developing actions to meet these. In addition there was the Partnership Group which was made up of people who used the hospice, relatives/carers and hospice staff supported them with clerical time allotted. The purpose of the group was to consistently feedback people's experience of using different aspects of the service. Group members were influential around the design and furnishings of the day centre extension from a service user perspective. They had been involved with feedback on meals and were represented at Ipswich hospital in the cancer service users group to promote links between services. The group had been advertised in various promotional materials and additional people had been invited to join as the provider was keen for more people's views to be represented by the group. The Partnership Group was consistently influential and part of the running of the service as they also spoke at certain events, which gave peoples perspective, and supported other patients to understand the hospice and lessen their concerns. Examples included being part of patient DVDs and playing a role in the induction of new staff and volunteers.

The values and behaviours expected by the hospice were clearly laid out in information for staff. The vision for St Elizabeth Hospice was to improve life for people living with a progressive illness. They followed the six C's principle in nursing led by the Department of Health that highlight key values and vision for delivering care to people. These included care, compassion, communication, competence, courage and commitment. We saw evidence that people received high quality care at the end of their lives which demonstrated that the values were embedded in the culture of the service. All levels of staff we spoke with told us that all the management team were known to them and "very visible. There truly is an open door if we need anything." One of the management team told us that from time to time they role model and coached staff. They explained, "We put on our nurses uniform and work with staff. We have a skilled staff team, we listen and answer any of their questions." This level of accessibility of management whilst working was warmly welcomed. Staff from a variety of departments confirmed that managers regularly attended their meetings and briefings. The hospice's strategy up to 2020 had objectives set to 'be caring, be innovative, be collaborative.' Staff spoke of time to reflect and understand the clear vision of the hospice. Regular away days were planned with the Heads of Department with staff invited to contribute to the development and way forward for the hospice.

We sent the registered provider a provider information return (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned within the given timescales. The information in the PIR enabled us to contact health and social care professionals about our inspection to gain their views about the service. Seven external professionals reported they enjoyed a close working relationship with the hospice and they provided an excellent service. One professional told us, "I have always found the Hospice to be extremely innovative and flexible in their approach. Their strategy is to improve end of life care, not just for those that directly access their services but also for those that do not have direct contact with their services, such as care home residents. Those that access their services consistently report exemplary services." A different external professional told us about a complex case they were jointly working on with staff at the hospice and how the multidisciplinary approach had enabled the person's needs to be met. They said, "This has demonstrated a very coordinated approach, which has ensured that there is good communication between the hospice and our staff, to ensure the best outcomes for the patient and family."

There was a clear management structure with a board of twelve trustees, a chief executive and senior management team contributing to the day to day running of the hospice. On day one of our inspection members of this team (including the registered manager) were away on a planned training day. There were systems in place that enabled the hospice to run smoothly in their absence. The registered manager had extensive experience of running the service having worked there for a number of years. The chief executive was registered with CQC as the nominated individual for the service. As well as a comprehensive reporting system fed up to the board of trustees to achieve their oversight of the hospice, there were frequent provider visits to the hospice. We saw the last visit looked at systems in place, for example around complaints, and staff understanding of policy and procedures. The visit also included looking around the whole environment and speaking to people using the service, staff and volunteers. Reports from visits contained recommendations that were reviewed each time a visit occurred to ensure any identified actions had been completed. To promote openness and sharing representative from the Partnership Group were on occasion invited to attend board meetings.

The service had an array of systems for auditing and reporting to ensure a high quality service delivery. This included, but was not limited to, patient safety and quality, medicines management, reports to the board of trustees, and quarterly reporting to the clinical commissioning groups (CCG) that covered Suffolk, Great Yarmouth and Waverney as well as the clinical committee within the hospice itself. A representative from a CCG told us, "They are always responsive to our requests for information and keen to work with the CCG in order to develop their services." We looked at the minutes and reports of the last meeting for all of these management groups. This demonstrated oversight and that safety was being monitored and reported effectively. This showed a transparent organisation that had clear links of accountability from the 'floor to the board'. Information on matters such as infection control, falls prevention, pressure ulcers, medicines incidents, staff recruitment/competencies, complaint management, safeguarding and finances were known about by those responsible and accountable within the organisation. An audit diary for the financial year 2016/17 set out each month what activity performed by the hospice would be audited. We saw that following the medicines incident audit, a learning paper was developed for staff. This was to optimise learning from reported incidents and reduce drug errors. The paper set out strategies to prevent errors and had topics set out for the next medical meeting. This showed that effective methods of communication were in place as well as systems to address any matters arising. Reports to the CCGs gave outcomes of work undertaken and ensured the CCGs were updated with events in the hospice and the effective management of those events.

The management of the hospice was keen to drive improvement and therefore had appointed staff into link practitioner roles. Staff appointed to these roles had appropriate support and training to develop their skills

within the roles and champion their individual areas of concern within the workforce. One nurse told us about how the wound care link practitioner had completed formal teaching sessions, but also coaching of staff on the job. A different nurse said, "I have attended the 'teachlette' sessions on pressure area care. It was very helpful."

Staff told us that they felt able to influence the running of the hospice and were consulted. There were regular meetings held by the staff and volunteer forum to ensure staff and volunteers were connected and had a voice. There had been a recent survey conducted of staff and volunteers. This had been completed by 86% of staff and 30% of the volunteers. The results showed that 93% of staff believed in the hospices aims and 91% were proud to work for the hospice. The hospice was in the process of developing an action plan to address areas such as concerns about workload, and realistic expectations. Staff we spoke with on the day said they felt supported in their roles with regular management support. One nurse told us, "I feel well supported, we have had a team building day and I enjoyed that." A recent initiative was to introduce a one page profile for all staff to aid communication for everyone. Each staff member had their photograph and then the staff member had written short notes on, 'What people appreciate about me, What is important to me, How to support me.' Staff were positive about this development as they said it encouraged team work. One said, "It's been really good and with our permission these photos have been added to the top of our emails, so now you can see who you are contacting and that's really good." There were plans to have these laminated so that people and relatives could identify the staff members and their role.

The hospice teams contributed to best practice in palliative and end of life care in the region through their support of people in care homes, education of staff and support of community doctors and other healthcare professionals. The impact of all their work was that they enabled people to have a more dignified death in their place of choosing. One care home told us about the support they received from the hospice and said, "The hospice team have opened up a number of places for training opportunities with the team at (named the care home) including Verification of Expected Death and Foundation in End of Life Care training for care assistants. There are many more courses we have booked with the hospice in the new year including Foundation in End of Life Care for registered nurses. (Named the care home) have felt supported by the nurses when needed for those individuals who require symptom management and to provide advice for family members and friends." This showed us how the hospice was effective and working in partnership with others also delivering end of life care.

St Elizabeth hospice was part of the Hospice Quality Forum in Essex and Suffolk. This was where nine hospices shared best practice. The impact this had on people receiving a service and other professionals was evidenced in the thank you cards and letters from professionals, families and relatives. These included feedback from a healthcare professional from another hospice. This healthcare professional told us, "I am currently working with St Elizabeth's in the area of transition for young adults with life limiting illnesses. I have found all staff to be enthusiastic and keen to consider the needs of young adults always putting the patient first. The service at St Elizabeth's is well run and they appear to be very caring and passionate about transition. They appear keen to work with other professionals skilled in this field and seem keen to learn. I have always found the staff to be polite and excellent in communication both with professionals and the patients." We spoke with the transitional lead at St Elizabeth hospice. We found them to have enthusiasm and a clear understanding of what was required to develop services for people aged over 14 who were transitioning into adult services. They along with some young people were attending and presenting in the coming weeks at a national hospice conference. Their presentation relied heavily on what they had learnt in terms of working together with families, reflection, and responding to individuals, some of whom were complex to support with their life limiting illness. There was also a strong understanding of the issues relating to capacity, consent and decision making as a child transitions into an adult where previously parents have been decision makers with treatment options. The lead was ensuring the staff at the hospice

had a good understanding of matters and was currently the chair of the East of England, 'Together for Short Lives Group'. This involvement and leadership with recognised external bodies was excellent and enabled the hospice to develop and go forward to meet upcoming challenges.

The hospice had also recognised and responded to the rural nature of this locality and lack of hospice services in north Suffolk and south Norfolk. Whilst the principle day service was run from the main site in Ipswich where there is a five day a week service. Another site was Ditchingham that ran on a Monday. This enabled people to access hospice services without having the long journey on rural roads. This enabled more people to have equitable access to services.