

Trinity Hospice

Trinity Hospice

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We undertook an inspection on 13 and 14 August 2014 to Trinity Hospice. The first day of the inspection was unannounced and we informed the registered manager that we would be returning on the second day to complete our inspection.

Trinity Hospice provides care and treatment for people with long term, chronic or terminal illness. The service supports people in their own homes, through an outpatient service and at an inpatient centre in Clapham, South London. At the time of our inspection the service was supporting 495 people. The inpatient service can accommodate up to 28 people. At the time of our inspection 15 people were using the inpatient service. At the time of our inspection many of the people using the service were too unwell to speak with us and were being supported with their end of life care.

At our last inspection on 20 January 2014 the service met the regulations inspected.

Summary of findings

The service's registered manager was their inpatient service manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Processes were in place to identify any risks to people who used the service and preventative measures were put in place to keep people safe and free from harm. One to one nursing was provided to further support people and maintain their safety when required. Staffing numbers were regularly reviewed and adjusted according to the needs of people using the service.

Assessments were undertaken to identify people's physical, social and psychological needs and these were reviewed regularly to ensure they were in line with people's current care, treatment and support needs. When required referrals were made to healthcare professionals to access specialist care that was not available at the service. People were transferred to hospital for further treatment in line with their wishes and preferences. People were able to have a dignified and pain free death.

People were involved in decisions about their care, and the service was responsive to their requests and individual requirements. People's religious, cultural and spiritual needs were met.

People's privacy and dignity was maintained and the staff ensured information was kept confidential and conversations could not be overheard.

Medicines were managed safely. The service was clean and there were processes to protect people from the risk of development and spread of infections.

Staff were aware of what to do if they suspected someone was at risk of abuse and followed safeguarding adults and children procedures. Staff were aware of their requirements under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had the skills and knowledge to support people using the service. Training needs were regularly reviewed and staff passed competency tests before being able to undertake any tasks unsupervised. Systems were in place to support staff and reflect on practice and service delivery.

The service regularly reviewed their performance and where further improvements were identified appropriate actions were taken. The service had systems for obtaining the views of people who used the service and there were processes in place to respond to and investigate complaints.

The service followed best practice guidance and were working with other health care providers to share and develop good practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. Staffing levels were regularly reviewed to ensure there was the number of staff required to meet people's needs and keep them safe. The staff were aware of what to do if they witnessed or suspected abuse was taking place. They were confident to challenge unsafe practice and report any concerns to their manager.

Staff were aware of their requirements under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Assessments were undertaken to identify any risks to people who used the service and these were regularly reviewed. People received assistance from staff as required to ensure their safety and welfare. Processes were in place to protect people against the risk of development and spread of infections and infectious diseases.

Medicines were administered and stored safely.

Good



Is the service effective?

The service was effective. Staff had the skills and knowledge to support people who used the service. Staff received regular training and there were processes in place to identify individual training needs to enable staff to further develop their knowledge and skills.

Staff liaised with other health care professionals to meet people's individual needs, and ensure consistency in care provided.

Meals were provided in line with people's preferences and choices. The catering manager communicated with nursing and medical colleagues if they had concerns that a person was not eating in order for the person to receive any support they required.

Good



Is the service caring?

The service was caring. People had developed positive relationships with the staff at the service. People were involved in decisions about their care and felt staff listened to them.

People's privacy and dignity was maintained. 'Do not disturb' signs were put on people's doors whilst nursing or medical care was being carried out, and blinds were closed whilst care was delivered. Staff closed people's doors whilst having sensitive conversations so that these could not be overheard.

People were provided with a dignified, comfortable and pain free death. End of life care was provided in line with people's wishes and preferences. Practical and emotional support was provided to people's families and those that mattered to them, and a bereavement service was available for relatives to access.

Outstanding



Summary of findings

Is the service responsive?

The service was responsive. Care, treatment and support was provided in line with people's needs, preferences and wishes. Assessments were undertaken to identify people's physical, social and psychological needs and these were reviewed regularly to reflect people's current needs.

People's religious, cultural and spiritual needs were met. The service had identified further work was required to engage with minority groups and work had begun to engage with the Lesbian, Gay, Bisexual and Transgender (LGBT) community.

There were processes in place to obtain the views of people who used the service. Complaints were fully investigated and resolved to the satisfaction of the complainant. Themes and lessons learnt from complaints were discussed during clinical risk meetings to ensure appropriate action was taken to improve practice.

Good



Is the service well-led?

The service was well-led. Staff were supported by their line manager, the service's senior managers and their colleagues. There were open and honest discussions amongst staff and staff felt able to express their opinions and that they would be listened to.

Systems were in place to review the service's performance and staff continued to look for ways the service could be further improved. Regular audits were undertaken and there was regular monitoring of all incidents. Lessons learnt were discussed as a team and there were processes in place to ensure any actions identified were completed.

The service had received recognition and awards for areas of service delivery. The team followed best practice guidelines and worked with other services to develop and share good practice.

Good



Trinity Hospice

Detailed findings

Background to this inspection

We undertook an inspection to Trinity Hospice on 13 and 14 August 2014. The first day of our inspection was unannounced.

The inspection team included an inspector, an expert by experience, a specialist professional advisor and a pharmacist inspector. The expert by experience was a person who had personal experience of caring for someone who used this type of care service. The specialist professional advisor was a palliative care nurse.

Before the inspection we reviewed the information we held about the service, this included a Provider Information Return (PIR). The PIR is completed by the provider informing us about areas of good practice and areas for future improvement under each of the five questions. We also sent 31 questionnaires out to staff who worked for the community service at the hospice. We received 16 completed questionnaires which included information about staff views on the service and the support they received. Questionnaires were also sent to 24 community professionals that worked with the service, three were completed and returned.

During the inspection we spoke with three people using the inpatient service and the relatives and friends of five people using the inpatient service. We looked at the care

records of five people who used the service and the medicine records for eight people. We spoke with 22 members of staff and two volunteers. The staff we spoke to included representatives from the inpatient service, the community service, the outpatient service, the patient and family support service including the bereavement support lead and the spiritual care lead, the pharmacist, the catering manager and domestic staff. We also spoke to staff from the executive team including the chief operating officer and the chief executive officer. We undertook general observations on both floors of the inpatient service.

We looked at records relating to the management of the service including reports to the board of trustees and the most recent reports to the service's commissioners.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

People who used the service told us they felt the staff kept them safe. One person told us, “I feel very safe and confident that the staff know how to use all the equipment, like my oxygen.” Another person told us, “It feels safe here ...The staff are around all the time and the reception areas are always manned.” All staff who completed the questionnaire prior to our inspection said people who used the service were free from abuse or harm from staff.

Staff were able to describe signs of potential abuse and had received training in safeguarding adults and children. They were aware of the procedures for reporting any safeguarding concerns. All staff who completed the questionnaire prior to our inspection said they knew what to do if they suspected one of the people they supported was being abused or was at risk of harm. Safeguarding concerns were communicated with the safeguarding lead for the service and recorded in a person’s care records. The safeguarding lead escalated any concerns to the local authority safeguarding team as necessary and supported them with their investigations as and when required. The service’s safeguarding lead liaised with one of the local authority’s safeguarding team to ensure they had up to date training and knowledge so they could support other colleagues at the hospice as required.

Staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The majority of staff who completed the questionnaire prior to our inspection said they had received training in and understood their responsibilities under the MCA. Through completing the Provider Information Return the service realised they did not have a policy in place to address MCA and DoLS. At the time of our inspection a staff member had been identified to lead on this area on behalf of the hospice and a draft policy had been written. At the time of our inspection people were able to come and go from the service.

People got the assistance they required when they needed it. Portable call bells were available for people who were using the garden so they could summon assistance. People told us staff had explained to them how the call bell system worked and how to escalate a call for help during certain circumstances. There were alternatives available to push

button call bells for people who were unable to use them so they could still obtain urgent assistance from staff. For example equipment was available that people could operate by moving their head.

Assessments were undertaken to identify any risks to the person. This included identifying those at risk of developing pressure ulcers, falling and becoming malnourished. Records showed this information was reviewed weekly, or more frequently if any changes occurred. Any risks identified were discussed during staff meetings, to ensure the information was shared amongst the staff team and the appropriate action was taken to minimise the risk occurring. If people were at risk of falls, preventative measures were put in place. For example, lowering the bed or using bed monitors. The service was also able to offer one to one nursing for people at high risk of falls if there were no alternatives available. One person’s relative told us, “They moved [the person] closer [to the nursing station] as they could see that he couldn’t walk very well. They did this without us having to ask which was really nice.” Pressure relieving mattresses were available and people were regularly turned to relieve pressure to particular areas of the body and reduce the risk of pressure sores developing.

Staffing numbers were calculated according to the needs of people using the service. The service reviewed the stability of the people using the inpatient service daily and ensured there were enough staff to meet their needs. The service had recently increased their staffing numbers so that on each shift the nurse in charge and the deputy nurse were supernumery to increase the number of experienced senior nurses on duty. A person who used the service told us, “As soon as the call bell rings they answer it.” Another said, “The staff respond immediately to the call bell including during the night.” During our inspection we observed staff responding promptly to call bells.

The nurse in charge had the authority to book bank staff to ensure short notice sick leave could be covered, and also to increase the staffing numbers if a person’s dependency level increased. An on call system was available for staff to contact senior nursing staff and doctors to provide further advice and support when required in order to meet people’s needs.

The outpatient and community services were staffed according to the needs of the people accessing the service. However, the community service noted that demand for

Is the service safe?

the service had increased and they were carrying larger caseloads. One community professional stated on their questionnaire, "Trinity Hospice is seen as a centre of good care in community and inpatient palliative care. We wish we had more services like this one. I do think the teams they have are stretched and this can affect the amount of service provision they can give." A staff member commented on their questionnaire, "Due to the nature and complexity of the work, it is not always possible to complete all the work you would like to within the 9-5 hours that you are employed." The service was in the process of recruiting additional staff to address these concerns.

The hospice had an onsite pharmacy. The pharmacy staff ensured they had an up to date list of all medicine people using the inpatient service were taking and ensured the appropriate stocks of medicines were available whilst they were at the service.

All medicines were stored safely and controlled drugs were managed appropriately. We looked at the medicine administration records (MAR) for eight people. These records were completed accurately. The records showed people were getting their medicines when they needed them, and any reasons for not giving people their medicines were recorded. A relative told us, "The nurses

deal very well with all his medicines." Staff completed a range of audits to ensure medicines were managed safely. These included checks to ensure national patient safety alert guidance was being followed.

When people were discharged from the hospice they received an information sheet about the medicines they had been prescribed and how they should be taken. Staff discussed this information with people to ensure they understood what it meant so they could take their medicines safely.

People using the service and their relatives commented on the cleanliness of the building. One person told us, "They are always cleaning everything." Cleaning staff were clear on their responsibilities and the importance of maintaining high levels of cleanliness. The lead nurse for infection control undertook daily checks on the cleanliness of the service and addressed any concerns with the domestic staff on duty so they could be rectified.

We observed staff washing their hands and using hand gel before entering and upon leaving people's rooms. Staff wore personal protective equipment (PPE) as required. Staff followed appropriate guidelines in relation to the safe management of clinical waste and soiled linen.

Audits were undertaken to review the cleanliness of the service and review staff's knowledge on infection control procedures. We saw that appropriate action was taken where areas for improvement were required.

Is the service effective?

Our findings

New staff were deployed in addition to the staff on duty for their first two weeks and were mentored by more experienced staff members. An induction programme was available and all staff that completed the questionnaire prior to the inspection said they completed an induction which prepared them for their role before working unsupervised. Competency tests were undertaken before staff were able to undertake tasks unsupervised, for example, administering medicine. A set of competencies were developed for each nursing level to review their clinical knowledge and skills, for example, their ability to undertake a blood transfusion. Staff were required to be assessed as competent before being able to progress to a more senior role. This ensured people received care and treatment from staff that had the skills and knowledge to meet their needs.

The majority of staff had completed their mandatory training in line with the service's policies and procedures. At the time of our inspection staff were knowledgeable about the Mental Capacity Act 2005.

The practice development nurse ensured a structured education programme was available for staff. Teaching sessions were held to deliver practical training sessions in house. An education needs analysis had been undertaken for each nurse and was in the process of being completed with healthcare assistants. This enabled the development of individually tailored training plans. All staff who completed the questionnaire prior to the inspection said they had the training they needed to meet people's needs, choices and preferences. Training was discussed during supervision and appraisals, and staff confirmed they received regular supervision and appraisal.

Bank staff were required to complete their mandatory training, and were also invited to a two day training session to complete additional training and develop their clinical skills, in order to provide a service that met people's needs.

Staff were in liaison with other hospices and health services to further improve their skills. The team were attending Quality End of Life Care for All (QUELCA) training at a local hospice and were working with local hospitals and residential homes educating them on the patient journey

through end of life care. The team were working with the local ambulance service to educate paramedics on end of life care and escalation of treatment to aid joint working and provision of care responsive to people's needs.

Inter-disciplinary team meetings were held at the service to ensure people's medical, nursing and therapeutic needs were identified. If people had specific needs that could not be met by the team at the hospice, referrals were made to the required professional. The community team developed working relationships with other professionals involved in the person's care to enable consistent and co-ordinated care, and regularly liaised with the person's GP. One person told us the occupational therapist had come to see them whilst they were using the inpatient service to talk about pain management on discharge. All of the community professionals who completed the questionnaire said the service co-operated with other services and shared relevant information when needed, and that staff acted upon any advice given to them.

When required, the service referred people to the hospital for specialist care and supported them to attend ongoing appointments. Discussions were held with people as to when they wished to be referred to hospital and for what illnesses and symptoms they wished to receive treatment. This information was included in their care records so staff were aware of the person's wishes and enabled the team to ensure people received medical treatment in line with their preferences. If people went to hospital in an emergency written information was provided to the ambulance staff including the person's medicine charts and recent medical observations. The hospice doctors also rang the receiving A&E department to provide a verbal handover. So staff at the hospital had up to date information on the person's needs and any treatment being provided.

The catering manager liaised with nursing and medical colleagues to ensure the food and drink provided met people's dietary needs. For example, if someone required a diabetic meal, a soft diet or if they had any allergies. A wide variety of meals were available offering people choice of what they wished to eat. People told us they enjoyed the meals. One person told us, "The food is excellent. I can't eat potatoes so they mashed carrot and swede instead. Nothing is fixed ... they can change it around to suit you." Another person told us, "No matter what you want, the chef can do it." One relative told us, "[The person] isn't really eating now, but the chef had come to see her to see if he

Is the service effective?

could make anything for her.” There was flexibility in the meals offered and people were able to request specific meals. People were able to choose when they wished to eat, and there was flexibility in the times of meals. For example, people were able to request a late lunch if they were tired or had a bad night’s sleep. Visitors were provided with the option to eat with people if they wished to have meals together.

The catering manager informed the nursing team if a person was not eating, especially if they had not eaten at all during the day, so that appropriate action could be taken to support the person in regards to their nutritional needs.

Nursing staff told us they were available to support a person with their meals if they were unable to feed themselves or were at risk of choking. We were unable to observe this during the day as people chose to eat in the privacy of their rooms.



Is the service caring?

Our findings

People using the service and those close to them told us they had developed positive relationships with the staff. One person told us, “All the nurses can’t do enough for you and they have a terrific sense of humour.” Another person said, “They [the staff] are so kind and supportive. They are incredible” and, “Everybody is amazing right from the volunteers, nurses and cleaners.” Another person told us, “The nurses are unbelievable ... couldn’t wish for a better hospital.”

People were able to have visitors throughout the day and, if people wished, additional beds could be accommodated in people’s rooms so they could have visitors stay overnight. One person told us, “My family are always welcomed when they visit and they can come whenever they want. They always offer them refreshments.” People were also able to have family pets come and visit. Staff offered support to family members as well as people who used the service. One person told us, “The staff have even contacted my partner at home to check that they are alright. They are in their 90s and it’s too much for them to come in.”

Support groups were held for carers and people who used the service to access. The content of these groups was determined by the needs of the people who attended. The groups enabled staff to provide information to people, gave people a space to discuss any concerns they had and also provided an opportunity for social and peer support.

People told us they had been involved in decisions about their care, and discharge planning.

One person’s relative told us, “They have told me everything that I need to know and always answer clearly anything that I ask.” Another person told us, “The doctors are so nice. I am involved in decisions. I asked to be told the truth and that happens.” We observed staff giving people the time they required to make decisions. One person found it more difficult to communicate and staff were patient and gave them time to respond. Staff had access to an interpreting service so they were able to communicate clearly with people who were unable to speak English. This ensured people had the information they required to make decisions about their care, and communicate their wishes and preferences. Family members were asked to write down basic phrases in the person’s preferred language to

aid communication and staff’s understanding of what the person was saying. Staff told us they got to know people’s preferred method of communication, including non-verbal communication.

Permission was sought from people to share information regarding their health and treatment with others. Staff respected a person’s decision if they did not want their family included in decisions or discussions about their care.

Staff were aware of their responsibilities under the Mental Capacity Act 2005 and it was assumed that people had the capacity to make decisions about their care and treatment, unless there was a reason to think otherwise. Capacity assessments were undertaken when required and staff worked with the multi-disciplinary team and the person’s family to make best interests decisions in line with the Mental Capacity Act 2005 for the person, for example in regards to stopping treatment. One person’s relative told us, “The doctors have given us plenty of time, they have kept us informed and discussed the care for the end of [the person’s] life.”

Staff were respectful of people’s privacy. ‘Do not disturb’ signs were put on people’s doors whilst nursing or medical care was being carried out, and blinds were closed whilst care was delivered. One person told us, “They always close the door for extra privacy and close the curtains when they are doing anything.” Staff closed people’s doors whilst having sensitive conversations so they could not be overheard. A separate room was available to have conversations with family members if people did not wish for this to take place in their room. All of the community professionals who completed the questionnaire felt people were treated with dignity and respect.

People were supported to have a pain free death in line with their wishes. One relative told us, “The pain management is good and she is sleeping and looks peaceful.” Another relative told us, “They have taken her off all her tablets and she is now pain free.” The service collected information on people’s preferred place of care (PPC) and preferred place of death (PPD). During April to June 2014 we saw that all people using the inpatient service had their PPC considered, and the majority achieved their PPD. In the community service the majority



Is the service caring?

of people had their PPC considered and the majority achieved their PPD. This showed that for the majority of people their wishes and preferences in regards to where they were cared for and where they died were respected.

Staff ensured people were comfortable and had the privacy they required when at the end of life. Staff were available to sit with the person if they wished. Staff ensured the environment was suitable and in line with people's preferences, for example, flowers were put in the person's room if they were known to like flowers.

Staff were respectful once a person had died and ensured the person's body was treated with dignity. Staff gave family members the space and time they required. Staff were conscious to use appropriate language and communicate clearly with family members during this time to reduce any confusion or misunderstanding. Staff offered families the opportunity to attend a bereavement meeting and gave them practical advice and support with funeral arrangements.

A bereavement service was available to support people whose family member had used the service and died. The service was offered according to the needs of the person. They were able to offer a programme of one to one support sessions, or signpost people to other services in line with their wishes. People were able to self-refer and were able to get back in contact with the team if they needed additional support and wished to re-engage. The team also made contact with the person at set milestones such as the anniversary of their relative's death in case people needed additional support at that time.

The service held remembrance services throughout the year and gave family, friends and staff the opportunity to remember the people who had died in the last year. This included a midsummer gathering and a 'Light up for Life' Christmas service. The 'Light up for Life' service also invited members of the local community to come to the service to celebrate the lives of people who had died and to provide people with the opportunity to discuss issues around death and dying.

Is the service responsive?

Our findings

Initial assessments were undertaken with people at their first point of contact with the service. Information was gathered about their symptoms and what was their biggest need at the time, for example, whether they required symptom control, pain management or end of life care. One person told us, “The doctor comes and explains everything. They ask what you feel about your care and nothing is imposed on you.”

People’s physical, social and psychological support needs were discussed during assessment, including any religious, cultural or spiritual needs they had, and information on how to support these needs were included in people’s care records. We saw advance care plans in people’s records which documented their wishes and preferences in regards to end of life care. At the inpatient service it was explained to people during the development of their advance care plan what life support could be delivered at the service. This enabled people to make informed choices as to when and if they wanted to be taken to hospital for further life support. Their choices were documented in their care records.

Consideration was given during assessment to the needs of people with dementia. When appropriate family members were invited to spend the first night with the person at the inpatient service to help reassure them and settle them at the service.

Plans were put in place to support people with any needs identified during the assessment process. For the inpatient service nursing assessments were reviewed daily and medical assessments were reviewed weekly, or more frequently if required, to ensure the care, treatment and support provided was in line with people’s current needs and took into account the frequency with which people’s needs changed. The care records we saw showed that people’s needs were regularly reviewed and plans were adjusted as required to meet people’s changing needs. These assessments and the plans in place were undertaken in discussion with people who used the service to ensure their preferences and wishes were respected.

There were designated admission and discharge nurses who ensured the required information was gathered and communicated during transitions to and from other health

and social care services to ensure continuity of a person’s care. Admissions meetings were held daily to identify people coming to the inpatient service and to start making plans for the person’s arrival.

The electronic recording system enabled staff to filter information, for example with regards to pain management, to look at the person’s history and identify the most appropriate treatment. One person told us, “I have had pain in the past, but they have soon got on top of it here.” The electronic system was used across all services at the hospice, so when people were transferred from the community service to the inpatient service, and vice versa, staff had access to people’s historic records and medical and treatment history.

The service had recently started using the Palliative Care Outcome Scale for new admissions to the service. The scale allowed people, with support from staff if needed, to express and formally record whether the service was meeting their needs, including physical and psychosocial needs, and whether they received a personalised service. The service planned to analyse their first set of data at the end of the year.

A spiritual care lead was available to support people with any spiritual or religious needs they had. The service arranged for religious leaders to come to the service if people wished them to. The spiritual care service was able to support people and their families with funeral arrangements and ensure any spiritual or religious needs were met during end of life care and after death.

People using the community and the inpatient service were able to access the outpatient service and attend the activities and groups on offer. There were a range of group and individual sessions available including complementary therapies, art therapy, music therapy as well as sessions by the physiotherapists and occupational therapists. The art and complementary therapists had started teaching sessions with the nurses so that the activities could be provided to people using the inpatient service.

The patient and family support team supported people with any social, employment or legal needs, including any help they required with benefits, welfare advice, and legal matters such as appointing a power of attorney. The service was able to arrange advocacy support for people, for example, around advanced care planning. The team also worked with relatives of people using the service. The

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team offered therapeutic counselling to the person and their family, and worked with colleagues in education to support younger family members. This provided them with emotional support around their parent's diagnosis and end of life care, and practical support for example around funeral arrangements or housing arrangements.

The service had recently changed their strapline to "always here, for everyone" to further strengthen their aim and intentions to support the local population. At the time of the inspection, people accessing the service did not reflect the demographics and diversity of the local population. The service was aware they did not have many of the Lesbian, Gay, Bisexual and Transgender (LGBT) community accessing their services and therefore were holding an event inviting people from the LGBT community to come to the service and attend a question and answer session around death and dying. Lessons learnt from this process would be used to further engage with minority groups.

Satisfaction questionnaires were sent to people who used the service and analysed for each service provided by the hospice. Findings from April to June 2014 showed 100% of people using the bereavement service were very satisfied, and 100% of people accessing therapies rated the service as either very good or excellent. The inpatient service had made some environmental changes in response to feedback from people, this included introducing reading lamps and repositioning the height of bed side televisions.

People we spoke with were not aware of the complaints procedure but, they told us they felt comfortable talking to the staff about any concerns they had. A new complaints

leaflet had been produced and was available throughout the service for people to access. We also saw that comments boxes were available for people to write comments, complaints or compliments. There was a central system for recording complaints and we saw that complaints received had been investigated and dealt with effectively. All complaints were reviewed at a monthly clinical risk meeting where lessons learnt were discussed as a team and any changes required were disseminated to the staff team. We saw that, where required, processes had been reviewed and changed to improve the service. For example, one complaint had been received about the quality of equipment issued. The service acknowledged that whilst the equipment was safe to use they needed to review their process in line with people's perception and their experience of using the equipment to ensure it met people's needs and expectations.

The complaints leaflet provided people with the contact details for advocacy services, if they required additional support to make a complaint, and who to contact if they were not satisfied with how their complaint was dealt with.

The service recorded compliments received and discussed themes from the compliments received during their clinical risk meetings. Recent compliments related to the warmth received from staff at the service and the time staff were able to dedicate to support people using the service. Compliments were used to discuss and share good practice amongst the team.

Is the service well-led?

Our findings

Staff told us they felt well supported by their line manager, the service's senior managers and their colleagues. The majority of staff that answered the questionnaire prior to our inspection told us their manager was accessible, approachable and dealt with any concerns raised effectively. There were a number of initiatives and groups in place to support staff, individually and as a group. Staff received individual supervision from their line manager and annual appraisals. Reflective practice sessions were held every two weeks for clinical staff and debriefing sessions were held after incidents. Sessions were held to discuss people with complex needs to provide further support to the staff team and give staff the opportunity to talk about any concerns they had or where they felt they would have done things differently. The service had recently started to resuscitate people and further support was provided to staff after the first cardiac arrest was experienced at the service. The service had introduced monthly 'Schwartz rounds'. These gave staff the opportunity to discuss as a group the emotional impact of working in palliative care. This group was open to all staff that worked at Trinity Hospice, not just the clinical staff. A volunteer told us that if someone they had been supporting had died the team came to tell them and offered support if they required it.

Staff were complimentary about the senior management team and told us the new systems and introduction of further management meetings enabled more staff to get involved at a strategic level and comment on service delivery. Staff told us the executive team were open, honest and transparent, and they felt able to approach them with any concerns or ideas they had.

A governance framework was in place to review the quality of care provided. This included a clinical risk management group and an audit and research group. These groups reviewed clinical incidents, complaints, policies and procedures, patient information, medicines management and audits to review the quality of service provision. The groups also tracked any actions required to improve the service to ensure they were implemented. One staff member commented on their questionnaire, "Our

managers are supportive of our desire to achieve excellence in the care that we provide as well as listen to the voices of our patients/families when a change in service is required."

A rolling programme of audits were undertaken, this included audits of high risk areas and audits that staff had particular interests in. Audits had recently been undertaken regarding infection control, safeguarding and medicines. Findings from the audits were presented to the audit group and shared with the necessary staff, together with any changes required and lessons learned. The audits included a combination of knowledge based questions and process questions, to ensure staff were aware of what procedures they were required to complete and ensure appropriate information was recorded. The audit group ensured that areas for improvement identified in audits due to a lack of staff knowledge or awareness were incorporated into the staff training programme.

Incidents were recorded centrally. They were reviewed monthly to identify any trends. Each month the risk management team reviewed incidents that had occurred over the last three months to identify any peaks, for example, if there was an increase in the number of falls in a month. The risk management team looked at the details of the incident and if there was any learning required to reduce the risk of the incident reoccurring. Root cause analyses based on the national patient safety initiative were undertaken for all people who acquired a pressure ulcer whilst at the service. This was to understand what led to the development of the ulcer and what could have been done to prevent the development of the ulcer for future learning.

A service risk register was available that identified all risks that impacted on service delivery, for example, lone working and out of hours arrangements. The register included details of the risk and discussions that were held within the management team as to whether the risk was to be managed or whether further action could be taken to reduce the risk.

Business continuity plans were in place and mock situations were role played to ensure staff knew what to do with regards to service level risks or if there was a major incident so that people still received the care they required.

Performance dashboards were produced and provided to the senior management team and the board of trustees to

Is the service well-led?

ensure they were aware of the current performance of the service and to highlight any areas of concern or requiring improvement so that appropriate action could be taken. This included reporting on the service's performance against their Commissioning for Quality and Innovation (CQUIN) targets. Quarterly performance reports were provided to the Clinical Commissioning Groups funding placements at the service.

The service kept up to date with good practice guidelines and attended groups to develop and share best practice, including representation on the London Opioid Safety Improvement Group and use of the Gold Standards Framework, a tool for ensuring a structured and evidence based approach for end of life care. The service had been accredited as a Stonewall's diversity champion, acknowledging the service as an inclusive workplace for lesbian, gay and bisexual staff. The service was working

towards the Investors in Volunteers scheme (a good practice scheme for volunteer management in the UK). Many of the volunteers at the service had received awards recognising the support they give to people at the end of their life. Service level, team and individual achievements were recognised in the monthly staff newsletter.

The service had reviewed their values, vision and mission in consultation with the staff team. Staff were clear about the services values and these were displayed and available to view around the hospice. The service's values reflected the service's mission to challenge barriers to equality and diversity, and to promote a culture of compassion, dignity, and respect. One staff member commented on their completed questionnaire, "I am confident under their [the Chief Executive Officer's] leadership they will continue to develop the hospice philosophy underpinned by equality and fairness."