

St. Helena Hospice Limited

St Helena Hospice

Inspection report

Myland Hall
Barncroft Close, Highwoods
Colchester
Essex
CO4 9JU

Tel: 01206845566
Website: www.sthelenahospice.org.uk

Date of inspection visit:
23 November 2016
24 November 2016

Date of publication:
21 June 2017

Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Good 

Summary of findings

Overall summary

This inspection visit took place on 23 and 24 November 2016. The first day of the inspection was unannounced. A further two days in February 2017 were used to speak to seven people using the service. The service was last inspected in April 2014 and was found to be meeting all the regulations we reviewed at that time.

St. Helena Hospice is a charity which provides a range of hospice services for anyone over the age of 16 with a life-limiting illness living in North East Essex and the Colne Valley area of mid Essex. St Helena Hospice provides a range of palliative care services to patients at home, through two day centres [Joan Tomkins in Colchester] and in an inpatient unit that has 15 beds. In addition the hospice offered a 24 hour telephone advice line, a range of complementary therapies, counselling, support for carers and bereavement support groups that was also available to children.

There was a registered manager in place at the time of the inspection. 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 had a strong person centred approach. People's dignity was supported and staff treated people with respect at all times. Staff were exceptional at helping people to express their views. People and their families who received care, treatment and support from St Helena could not speak highly enough about the staff who supported them. People who were challenged in coming to terms with a life limiting illness or a terminal diagnosis told us repeatedly that they were enabled to manage their condition and their emotional wellbeing because of the excellent care and support received from various departments within St Helena hospice. Staff were exceptionally kind, caring and compassionate. People we spoke with were only too pleased to share their stories of compassionate appropriate care, treatment and support.

The hospice was proactive in reaching out to communities who did not traditionally access their services. Innovative methods had been used to encourage people to access the support available to them. The model of care delivered was one of inclusion and acceptance and promotion of diversity. The 'Safe Harbour' project provided hospice services and supported people on the fringes of society, such as those affected by homelessness, alcohol and drugs misuse.

People received excellent care based on best practice from experienced staff with the knowledge, skills and competencies to support their complex health needs. Staff were supported and coached to deliver care and support following best practice guidance. People and families received care from staff and volunteers who developed positive, caring and compassionate relationships with them. Staff worked together as a multidisciplinary team and had excellent links to community based services to provide the care people needed.

Staff had permanent support and guidance from social care professionals employed by the hospice and were trained in how to protect people from abuse and harm. Staff were proactive and knew how to recognise signs of potential abuse and how to put measures in place to overcome safeguarding issues. Risks to people's well-being were assessed by staff daily and there were measures in place to mitigate risks and keep people safe as they could be. Risk assessments were reflective of people's changing abilities and needs and measures to ensure people were as safe as possible were implemented accordingly.

People told us they were fully involved in setting their priorities for care. Care plans in regard to all aspects of people's medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people respecting their wishes and preferences.

People who used the various services offered at the day hospice told us the help and support they received was invaluable for them and their family. They valued the support they received from the different activities, courses and clinics which helped them to live with and manage their symptoms to maximise their health and helped them prepare for the future.

People's consent to their care and treatment was regularly sought. People's aspirations, preferences and wishes were known by staff. People were asked what was important to them and supported on their journey to make decisions and choices about advanced care plans and desired places of death.

The SinglePoint service was a national award winning telephone advice line which offered support, assessment and advice to people with life limiting condition living in their own homes over 24 hour seven days a week. The support could be accessed via telephone where the calls were triaged and staff could arrange support for people if it was needed. People told us they received the care and support they needed when they wanted it –even in the middle of the night in their own home. People felt very assured by the range of support options.

There were sufficient staff employed in each department to ensure people's needs were not only met in a timely way, but so that staff could spend meaningful time with people when needed. People appreciated that staff had time for them when needed. Staff were safely recruited. The staff group are well trained and supported. Staff were consulted through surveys and listened to by management. People had opportunities to be involved with the running of the hospice. Volunteers were valued and involved. The management style was inclusive and open.

The registered manager and staff had a strong set of values that placed people at the heart of the service. All staff constantly strived to work towards these values throughout the organisation. There was a culture of openness and taking responsibility with complaints used to drive improvement and quality assurance systems looking at ways to develop practices and make matters better for the benefit of people using 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 exceptionally safe when they used the services provided by the hospice.

Robust recruitment checks were undertaken before staff and volunteers began to work at the hospice to ensure they were suitable to work with people with life limiting illnesses.

Sufficient numbers of staff were employed to ensure they could respond flexibly to people's complex needs.

People's safety was promoted because individual and environmental risks were assessed and reduced as much as possible. People received their medicines on time and in a safe way.

Is the service effective?

Good ●

The service was effective.

People, relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff.

People received excellent care which was founded on best practice guidance. Staff demonstrated a commitment to ensuring people were able to make choices about the care they received. Staff were aware of the action to take to uphold a person's rights should they be unable to consent to their care and treatment in the hospice.

The hospice provided a wide range of learning opportunities to staff employed in the service.

Staff developed good working relationships with other health and social care professionals and found ways of meeting people's complex health needs in order to achieve best outcomes.

Is the service caring?

Outstanding ☆

The service was very caring.

People told us they were supported by staff who were exceptionally kind, caring and compassionate. Staff were willing to go the extra mile to ensure people received the care and support they wanted.

The ethos of care was person-centred and valued each person as an individual. Due to the training they received, staff were exceptionally skilled at helping people to express their views and communicated with them in sensitive and caring manner.

People received care and treatment which enabled them to have a dignified and pain free death. Families and those that mattered to the person were supported to spend quality time with them. Relatives were also able to access bereavement support following their family member's death.

Is the service responsive?

The service was very responsive.

People received care that was exceptionally personalised to their individual needs. Staff worked in partnership with people to develop care plans which enabled them, as far as possible, to fulfil their wishes and goals.

The hospice was proactive in reaching out to communities who did not traditionally access their services. Innovative methods had been used to encourage people to access the support available to them.

The service encouraged people with life limiting conditions and their family's involvement in the hospice by offering a range of services and complementary therapies in the day service centre

People were encouraged to provide feedback about the care they received from the hospice. Records we looked at showed that complaints had been fully investigated. Robust systems were in place to share lessons learned from complaints with staff and ensure any required changes in practice took place.

Outstanding 

Is the service well-led?

The service was well-led.

People told us of the quality of leadership in the service. The leadership team promoted an open and positive culture that placed people and staff at the centre of the service.

Good 

The leadership team promoted strong values of person-centred care and worked in partnership with other organisations to provide high quality, evidence based end of life care for the local population.

The hospice had a range of robust monitoring systems in place in order to review the quality of people's care and the environment. There was a clear commitment to ongoing service improvement throughout the hospice.

St Helena 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 inspection visit took place on 23 and 24 November 2016. The first day of the inspection was unannounced. The inspection team comprised of two inspectors, a specialist nurse in palliative care and a member of the CQC medicines team.

Before the inspection we asked the provider to complete 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 what improvements they plan to make. We also looked at information we held about the service and provider, including notifications the provider had sent us. A notification is information about important events which the provider is required to send us by law.

The first two days of the inspection were spent visiting the hospice site including the inpatient unit, day centre and accompanying staff on two hospice at home visits. During these two days we spoke with seven people who used the hospice services, five relatives and two visitors. In addition we spoke with a total of 20 staff and two volunteers. These staff included the registered manager, the clinical nurse manager, the head of the Inpatient unit, a consultant who was also the medicines management lead and a chief technician. We interviewed five nurses and three support workers. A further two days in February 2017 were used to speak to seven people using the service.

During the inspection we looked at the care and medication records for five people using the inpatient unit. We also looked at the care records for four people using the inpatient unit and two people using the hospice at home service. In addition we reviewed a range of records relating to how the service was managed; these included staff recruitment and training records, quality assurance processes and policies and procedures.

Is the service safe?

Our findings

Every person we spoke with during the inspection told us they felt exceptionally safe when they received care and treatment from hospice staff. One person told us, "I trust them. They know what they are doing and they take good care of me." Another person said, "Oh yes I feel very safe here." A third person told us, "I've never heard or seen anything untoward. The feeling I have when I'm here is one of security and relief that I'm looked after safely."

Staff we spoke with confirmed they had received training in safeguarding adults and children. Safeguarding training was an important topic which had to be completed by all the staff working at the hospice. Two qualified social workers employed by the hospice attended training to equip them with the knowledge to deliver face to face training to staff and volunteers. The hospice also had a safeguarding lead who was a qualified social worker.

Through our discussions with staff it became evident that staff recognised the important role they played in preventing safeguarding issues from arising. For example when we reviewed minutes from a multidisciplinary meeting we saw that staff recognised a possible safeguarding concern in relation to a person who used the service. This person's main carer had become anxious and was struggling to cope with the physical and emotional demands placed upon them. Staff put actions in place by providing practical and emotional support to carers and family members during times of particular stress. This support was highly praised by all the relatives we spoke with during the inspection. Information relating to staff responsibilities and what to do in relation to safeguarding was available to staff within the hospice. This information was well referenced and had up to date information about contact details for local safeguarding authorities. We saw examples of the hospice reporting effectively and appropriately to the local authority and that they were involved with preventative work in place to protect vulnerable adults using their services. Three staff had attended the Essex Safeguarding Board Annual Conference to develop their knowledge and understanding further to help ensure they were following best practice in order to protect people who used the service. All hospice at home staff and a smaller number of staff in community services had completed training in understanding and dealing with domestic abuse. All these measures and training opportunities created for staff helped to ensure there was a high level of understanding in the service of the need to make sure people were protected from harm.

Staff we spoke with also said that their safety was considered and they felt that the systems and training in place ensured they were safe whilst working on their own. One staff member said, "Our safety is as important and that really comes across in all the training provided." A hospice at home staff member told us, "At night when we finish shift they make sure we are safe. If we do not notify them that we have concluded our last visit they will ring our mobile. If they need to they will ring our homes and others and escalate up to the police if needed. We know we are kept safe." Staff also confirmed that they had training and knew about whistleblowing processes if they became aware of any unsafe practice that placed people at risk. One said, "Yes we have training on whistleblowing and I have not needed to do this as I have brought matters to my managers attention and I'm confident they have dealt with the issue." We found that managers had appropriately dealt with the matters that had been raised by staff. This demonstrated to us

that actions were taken to keep people safe in line with the hospice's own policies and procedures.

We checked to see if there were sufficient numbers of staff available to meet people's needs across all the services provided by the hospice. People we spoke with in the inpatient unit told us they did not have to wait to receive assistance from staff and that call bells were always responded to in a prompt manner and this was also confirmed by our observations during the inspection. One person told us, "I was very wary of coming in here. I have been so surprised by the care and attention. There is enough staff. They are able to take time to listen and do as you ask." A person in the day centre told us, "There are enough staff. All the volunteers are lovely and they complement the numbers of staff. One day when I was ill they could tell and a doctor came over from the hospice to see me straight away." This demonstrated to us that staff were available in sufficient numbers to respond to people's changing needs.

Staff we spoke with told us they always had time to spend with people who used the service. This meant they were able to develop positive relationships which helped to encourage people to share any concerns or worries they might have had. One clinical staff member commented, "We will always step up to cover each other – there are never any shifts not covered."

People had individual risk assessments which were reviewed every time they received support from the service. An initial 'holistic assessment' was done for each person when they started using the service. This assessment looked at people's care needs and wishes, as well as the risks to the person's well-being. Comprehensive individual risk assessments were completed in relation to people's risk of falling, malnutrition and dehydration and about moving and handling risks. We saw care plans had been put into place to help reduce or eliminate the identified risks.

We found that the service was extremely responsive and focused to improve their practices and keep people safe. The registered manager told us about an initiative they had in response to monitoring and prevention of falls. They appointed a staff member to lead on falls prevention and analyse each fall to determine if strategies, changes or preventative options were needed to be put in place to keep people safer. The falls lead identified that good lighting helps with falls prevention. As a result the environment in the inpatient unit was improved by installing sensor touch lights that illuminated when someone moved past them. The falls lead also liaised with the occupational therapist and falls lead from the local hospital in order to share best practice and improve awareness on how to keep people safe.

Risks relating to pressure ulcers were appropriately managed. There was a lead nurse in place who oversaw all the processes in place in relation to prevention and treatment of pressure ulcers. They were able to confidently discuss with us current thinking related to the treatment and prevention of pressure ulcers for people receiving palliative care. They had recently been on a training course to update their knowledge associated with this role. Appropriate equipment was in place such as specialist mattresses and staff spoken with understood the importance of repositioning people who were in bed to prevent the development of pressure ulcers.

Infection control was well monitored and managed to keep people safe. There was a designated infection control link nurse. To keep their knowledge current and best practice they attended a patient safety conference and were a member of the North Essex Infection prevention committee.

There was an effective system used at the hospice that looked at reflective practice around incidents and accidents. Staff spoke of a 'fair blame' culture rather than one of 'no blame'. A fair blame culture looked at staff taking responsibility and action in developing systems further to protect people using the service.

We found that staff working at the hospice were open and keen to take responsibility to improve their practice in order to get matters right for people. The values of the service were evident in staff behaviour and in how they approached every situation they had to deal with. We looked in detail about one issue and could see that all the necessary actions had been taken, including making improvements in order to prevent further similar incidents. . This showed us that the management in the hospice and staff took appropriate steps to mitigate risks, learn from mistakes and improve their practices to keep people who used their services as safe as possible.

Management in the hospice had a staffing overview and monitored the staffing levels and people's needs for each department. They had drawn upon national guidance where appropriate, but had developed their own systems for the individualised services they offered. Therefore they could demonstrate how they took into account people`s changing needs and numbers of people supported when calculating staffing numbers for each department in the hospice. This information was available for senior management of the hospice to have oversight of staffing levels.

Staff told us that they had been appropriately recruited. One said, "I filled in an application. I had an informal interview then a formal interview with three people. They checked two references and did a criminal records check. I filled in a health form and things like vaccinations for tetanus and HIV and Hepatitis was covered." We examined recruitment records for permanent staff and volunteers. All records were stored electronically. All included a copy of the person's contract, offer letter and details from the interview. All the staff files we reviewed showed checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We saw that volunteers were required to complete an application form and provide the hospice with two references. DBS checks were also carried out in relation to volunteers who had contact with vulnerable adults in the course of their role within the hospice. These checks helped to prevent unsuitable staff from working with people who used care and support services at the hospice.

Checks had also been undertaken to ensure that all the nurses who worked at the hospice had a current registration with the Nursing and Midwifery Council (NMC). If any were due to expire a reminder was sent to ensure the nurses were aware and could apply to review their pin number.

People told us they had their medicines when they needed them. One person said, "They were good at ensuring I'm not in pain and manage any side effects well." The records we looked at showed that medicines were given as prescribed. People and their relatives were involved in developing medicine management plans. Information leaflets were available to help people make choices about their treatment including when medicines were used outside their licence (the use of medicines outside their license is widespread within pain and palliative care for example mixing medicines together in a syringe pump).

There was a medicines management group which involved doctors and pharmacists. This group met monthly and was responsible for the review of the provider`s medicine policy. We saw that the group was working to merge several policies which referred to medicines into one. Medicines management audits were carried out and following these audits improvements were made to the governance around medicine management. For example changes were made to the design of the prescription charts to reduce the risk of errors. Incidents involving medicine administration were recorded, reviewed by the clinical governance group, and learning was shared with staff to reduce the risk of recurrence.

There was a system in place to deal with medicines safety alerts and medicines recalls, and we saw an example of a medicines information newsletter which was distributed to staff to keep them updated about

changes and best practice guidance.

Staff involved in medicines administration had regular training and their competency was assessed. Hospice staff were involved, with other local providers, in a palliative medicines management group which supported consistent use of palliative medicines across the locality. Clinical staff kept up to date with current practice, for example they had worked in partnership with a pain consultant from a local hospital trust to review the effectiveness of prescribing medicines for chronic pain.

Medicines, including those which require extra checks and special storage arrangements because of their potential for misuse, were stored safely and records were appropriately maintained. There was a system in place to check that all medicines were within date. There were medicines available for use in an emergency and these were checked regularly.

A comprehensive medicines management service including stock top up, individual patient dispensing, clinical review of prescriptions and input to policy was provided by the pharmacy department from a local hospital. A senior pharmacy technician was at the hospice four days a week, and a pharmacist visited once a week to ensure there was professional input available when people had their medicine management plans developed. Staff could also contact the pharmacist by telephone for advice including out of hours.

There was a system in place for people to administer their own medicines if they wished to, and they were encouraged to do this in preparation for discharge. When people left the hospice they were given a list of their medicines which explained what they were for and how to use them. The hospice provided training for local GPs on symptom management, to support them to prescribe medicines for people when they returned home.

Is the service effective?

Our findings

People who used the service, relatives and healthcare professionals consistently praised the standards of care, treatment and support provided by hospice staff. One person told us, "My relative is a medic and they rate them here. This gives me confidence. I compare them to other healthcare services I've received and this is by far the best quality". Another person said, "They [staff] have the skill and the knowledge to meet the needs you have. They keep it safe and clean." A third person said, "The OT (occupational therapist) is unbelievable. They go above and beyond. Nothing is too much trouble. The staff so obviously, wholeheartedly enjoy what they do. They are dedicated and it shows in how they support me."

Newly employed staff for the inpatient unit in the hospice were supernumerary for their first month of employment and worked alongside more experienced members of staff whilst they were orientated to the service and developed specific skills to meet people's needs. A member of the hospice at home team told us, "I was shocked at the amount of training we had." Staff told us that their induction covered two weeks training as well as shadow shifts. The training included safety matters such as moving and handling, food hygiene and infection control. Staff told us that they had specific healthcare training to support people with catheter care, stoma and colostomy care. They also had planned training for medicines and first aid. They explained that they had completed shadow shifts with staff on the inpatient unit as well as hospice at home visits to develop their confidence and skills. This meant that the induction offered by the provider to newly employed staff was effective and people experienced constantly good quality care even when staff were new to the service.

The provider used an effective traffic light system to highlight when training was due for renewal and staff were emailed to inform them what training subjects they were required to refresh. Monthly updates were sent to the line managers to keep them informed of staff's training needs. This meant that staff were up to date with the latest best practice.

All registered nursing staff completed a safe management and administration of medicines competency. This ensured they had ongoing skills to practice, but also that they were up to date with any developments and changes in medicine management practices. There was a competency framework for all Registered Nurses and Assistant Nurses to support their professional development.

We found that the training staff received was related to the needs of people using the hospice and covered topics such as stoma management, terminal agitation, wound management and closure visits. Study days had been completed on verifying death and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) discussion. Planned training for 2017 included pain and symptom management, oxygen therapy, infection control and skin care. All relevant and appropriate training for the nursing staff.

Some clinical staff were called 'link nurses' with the view that they took the clinical lead in specialist areas such as nutrition, infection control and skin care. Their role extended to coach and train newly employed staff in these areas to ensure best possible outcomes for people.

Staff were supported to undertake additional courses that developed their careers, but also enhanced the overall skill set of the staffing team. For example the Clinical Director was undertaking a diploma in Palliative Medicine at the University of Cardiff and one of the clinical support workers was studying for a foundation degree in nursing. The inpatient unit had a monthly education meeting, which all clinical staff could attend, where current conditions and methods of treatment were discussed. Staff were able to access degree courses at Anglia Ruskin University. A number of modules were run at the Hospice in conjunction with the University. This meant that people received care and treatment from highly trained staff.

Staff told us that they felt well supported. One staff member said, "We have a once a month meeting. We are all emailed the minutes. I have regular meetings with my line manager, but we have a scheme whereby we can access counsellors for ourselves if needs be. There is always someone around to enable you to off load." We found that staff had regular one to one supervision or group supervisions if they wished.

There were approximately 1200 volunteers working at the hospice. All the volunteers completed training in health and safety and safeguarding people from abuse, after which the training was role specific depending on the areas they were working in. For example the volunteers working in the in-patient unit completed food hygiene and moving and handling training. Volunteers were highly thought of by the registered manager and staff. The registered manager told us, "I want them [volunteers] to feel valued and involved." Many of the volunteers had been at the service for several years. Long service awards were given to volunteers to mark their achievement. There was a volunteer forum which met bi-monthly to discuss any issues and to involve volunteers in sharing their ideas on how to move the service forward.

Observations of practice and speaking to staff showed us that they had a good understanding of consent and capacity issues. 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 observed a complex family dynamic being discussed whereby one family member had lasting power of attorney (LPA) in place and a new person had become part of the family. The health professionals at the hospice were aware of their responsibilities in relation to a person having capacity even though a LPA was in place, but they were keen to ensure that the person receiving treatment and support from them had given their consent to information being shared. Staff also demonstrated their awareness in relation to people`s different gender and ensured that consent was obtained to disclose such sensitive information and to whom. This meant people`s consent and capacity was routinely respected within staff practice and decision making. Information about the MCA was freely available to staff in the form of easy flow charts and set out the five principles to guide staff.

Staff understood their responsibilities relating to Deprivation of Liberty Safeguards. 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 care homes, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the local authority. Advice had been sought from the coroner in relation to people dying with a DoLS in place. A practical and pragmatic solution had been agreed upon to remove the DoLS in place to ensure the dignity of the person at the last moments of their lives. This meant that family members could stay with the person who died for as long as they wished and they were not immediately transferred to the coroner's jurisdiction upon death.

We observed a multi-disciplinary meeting between professionals working in palliative care services in the local area. We saw that the care and treatment needs of individuals were discussed in a sensitive manner

and arrangements made to offer people services to meet their needs. We observed that staff were proactive in considering what other support people might need in addition to the hospice services and were told that appropriate referrals would be made for the identified support with people's consent. This meant that staff built seamless working relationships with other organisations to ensure people received care, treatment and support in a timely and effective manner. We also observed that staff discussed whether people had advance care plans in place and how best they could accommodate any decisions which the person had made regarding their end of life care. The need for best interest decisions for people who lacked capacity was also reviewed by professionals at the meeting. A best interest meeting is where other professionals and family where relevant, decide on the course of action to take to ensure the best outcome for the person using the service. This demonstrated that staff understood the legal framework in which they were working.

People received appropriate on-going healthcare support and were involved in decisions regarding their care. People who were admitted to the inpatient unit had their care reviewed at least on a daily basis or more frequently in case their needs changed. People we spoke with told us they were always fully involved in any treatment decisions and matters were fully explained to them about treatment options. One person commented, "All the clinicians make me confident in their ability. The treatment I have been through at St Helena's – there has been accuracy for me." Another person told us of how the doctor at the hospice had correctly diagnosed them with a collapsed lung and ensured they received the treatment they needed in a timely way at a local hospital. They said, "They knew what needed to happen and I cannot thank them enough." We found that the day centre at the hospice offered complementary therapies and a variety of bereavement counselling courses, treatment and maintaining health and wellbeing courses for people. These included a breathlessness clinic, managing fatigue and a falls prevention group called 'head over heels'. This facilitated people to maintain better health and manage their conditions.

People told us that the food was of good quality and choices were always available. People who used the day centre said that they received a phone call before their visit to tell them the options on the menu and to seek their choice for the day. One person said, "You can even have a roast dinner, but I tend to go for the soup and sandwich options." Another person explained, "Lunchtime is a pleasant and social time. It is when we can learn from others about their situation. It is good proper cooking. I would say it is excellent because they cook for the individual. They are careful with people's eating limitations."

One person in the inpatient unit had a reduced appetite. They told us that the food was very good, but that they struggled to know what to eat at times. They said they could ask for whatever food they fancied and it appeared and this helped them to eat when they were able. A relative praised the food; they told us that their relative's appetite was poor but that the person could order food which was not on the menu on the day. They said, "They [person] had fancied egg on toast one morning and it was made for them." Another relative told us that they had been concerned about their relative's poor food intake, they discussed this with staff and a food record was kept so that they were able to see clearly what they had been eating. This gave them assurances that their loved one's needs were met. We heard one of the volunteers speaking to a person who had been newly admitted about what sort of food they liked and disliked. They clearly explained the menu, how to order food and that they could ask for something different if they fancied something in particular and they asked what sort or size portions they liked. People's descriptions of what happened and recalling their own experiences, along with our observations showed us that people's dietary needs were known and met.

Is the service caring?

Our findings

All the people we spoke with during the inspection told us they received outstanding care from staff at the hospice. Without exception people told us staff were always extremely kind and compassionate and were dedicated to providing high quality care and support. One person told us, "I can't fault anything. They are absolutely marvellous. Nothing is too much trouble and it's absolutely first class." One person explained that they had received treatment from several other services but that the hospice was by far the best. They told us, "They sit so far ahead of everything else I have received. The care and attention is outstanding. They have permitted me and my family a quality of life I would not have had." One person was able to tell us, "They are brilliant in how they treat you as an individual. You are never on your own. Having someone by your side means so much".

Staff working in the hospice provided specialist care and support for people with life limiting illnesses. This support was extended to families, friends and carers and included support and advice from other health and social care professionals working in partnership with the hospice team. People were fully involved in decisions about their treatment and care, enabling them to retain dignity and control of their life and death. All staff and volunteers aimed to foster a friendly, homely environment where there was a balance between specialist clinical expertise and comfort for people. For example one person told us of how they had been supported to understand and accept the terminal diagnosis they had received. "I was not a nice happy person. I was difficult. I was angry with the world. I had to learn to admit to myself that I was terminally ill. It was difficult for me to be cared for by others as that had been my role. People here have been fantastic. They are gentle with me, listen, talk with me and persuade me. But most of all, have given me confidence in my body." Discussions regarding people`s care and needs were held in private and in an empathic way. One person told us, "There is such amazing compassionate understanding of staff. They give me honest answers and that is what I want and need right now". One family we spoke with explained that if they had any questions they were able to speak to the staff at any time and that they explained things in a way which made it easy to understand what was happening or what the expectations were. They went onto say that before the doctors gave them any information about their relative's condition they always checked with the person first to make sure that they were happy for the information to be shared.

There was a continuous drive and dedication from staff at the hospice to enable people to gain control over their life and illness. Staff supported people to remain and re-gain independence and manage their symptoms effectively. For people diagnosed with life limiting illnesses staff promoted skills to self-manage and take back control, helping people to identify for themselves when to ask for help and how to set own achievable goals and stay independent for as long as possible. Two people we spoke with told us about how they had both been supported to walk again. One person said, "They supported me and gave me the confidence to leave my wheelchair." Another person told us how they had a conversation with hospice staff about not being resuscitated and the paperwork they completed. They said that the conversation had been honest and open and they were able to ask and understand what they were being told. This meant people were supported to have access and understand the information relevant to them to help them make decisions about their care.

People told us that the care and support they received met their needs and exceeded their expectations and as a result they were able to trust and be confident in the services they received. For example, several of the people we spoke with told us they had been very frightened when it had been suggested to them to use the hospice. They told us that it had been the reassurance, support and care from staff which had allayed their fears and allowed them to make use of what they now saw as an extremely valuable service. One person told us, "I was feeling sorry for myself and really did not want to come here. Why put myself through it? But they [staff] have been absolutely wonderful and I cannot praise them enough. My preconceived ideas were wrong. It is not a morbid place, but very comforting." Another person explained, "It gives you structure at a time in your life when you feel that your life is being deconstructed."

During the inspection we spent time in the inpatient unit, the day centre and in people`s own homes with the community nurse specialists and the hospice at home service. We observed staff to be very person centred in all their interactions with people. Staff were completely focussed on asking people what they wanted to do, how they were feeling, if they wanted anything and what support they required. One relative who was caring for a person at home told us, "I have hospice at home because I was having a meltdown. The girls come in and are strong for me and have taken over. They are bright and breezy in a good way. They have the wow factor in bucketful`s." The person themselves told us, "They are ever so helpful. They let you do what you want and that means a lot to me right now. They are nice and gentle".

Due to the training they received, hospice staff had exceptional interpersonal and communication skills. This enabled them to quickly establish a rapport with people and find out what mattered to them. One person explained to us that they lived alone and had called the hospice at 4am in the morning. "I was having an adverse reaction and they were calm and reassuring. I panicked in the middle of the night and was distraught. I was impressed by their explanations, but also their rapid communication. I got a follow up call at 9am to check I was alright. I'm reassured to remain independent." A different person explained to us that they had difficulty sleeping at night due to increased anxiety of the fear that they may not wake up. They told us that they were often awake until the early hours of the morning but whilst staying at the hospice that the night staff supported them with this. They usually slept with the TV on quietly. They spoke to staff about this, it had not been a problem and staff had made sure that it remained on.

There were no restrictions on visiting times. One person told us that sometimes their family visited in numbers and this was accommodated. They told us that they particularly liked the fact that small children were welcomed and catered for. The person said, "There is a room kitted out for younger children's play. It has a little slide and everything." There was a large family room available which was large enough to have a bed wheeled into it so that people who were not able to get up from bed could spend time with their family members. People spoke about the warm positive welcome they felt whilst being at the hospice. "It's the indefinable things that make it so special, like the atmosphere. Everyone that I have come across has had a quiet confidence, volunteer or otherwise."

Staff went above and beyond their professional duty to ensure people were supported to have a comfortable, dignified and pain free death. We spoke to two people who were staying at the hospice for pain management. One person said that since their admission, their pain had been well managed and that staff were always quick to respond to their buzzer and any complaints of pain. A different person told us that the staff had been trying several different ways to manage the pain. Initially medication had not been effective but now they were on a patch and that had helped to manage the pain.

Dignity and respect were maintained after a person's death as well as during all other interactions with people. Families were enabled to spend as much time as they wanted with the person. People were informed and given information sensitively. Specific clinical support workers were in post to support families

through the process of transfer to the undertakers. There was a specific room for families to spend time with their loved ones after death. Staff facilitated and created opportunities for people to continue with their cultural and religious beliefs in life and after death as well. For example staff facilitated for a person`s body to be blessed after death as required by the person`s religion.

The hospice staff provided counselling and bereavement support for people and their families. The bereavement and counselling services helped family members face the loss of their loved ones. This service was available for children as well and people using the service told us this support had a significant positive impact on them and their family members. For example, one person was concerned that their partner would not be able to cope after their death because they had been so close and spoke of the excellent support that has been offered to them both. Another person spoke of their teenage child being given appropriate support. They told us, "They are at a tender age, but the therapy has been great. There are now no qualms in talking - we are not frightened of it. This is lovely to know." This showed us the excellent impact felt by the counselling service.

There was an outstanding spiritual support service in the hospice, which was inclusive, and available to all in a person centred way. One person told us, "The chaplaincy support is particularly helpful for me personally." Another person said that they met regularly with the hospice chaplain. They told us that the support that these meetings provided them with had helped them enormously and helped them develop an 'inner peace.' A different person in the day centre said, "The Vicar is here if you need them." We saw that the hospice had a chapel available for anyone to use. There were a variety of ways of remembrance. We saw a tree with leaves that remembered the names of individuals. A book of remembrance was used on a daily basis for quiet reflection. People told us that the religious and faith support was in place for them. We also observed at a multidisciplinary meeting where different faiths were routinely acknowledged and facilitated where possible. Discussions included not only knowing a person's declared faith but also if they were currently practicing and if the appropriate religious leaders were involved in providing support for people.

Is the service responsive?

Our findings

All the people we spoke with during the inspection told us the hospice had been extremely responsive to their needs. People told us that the care and support they received was personalised and tailored to their needs and as a result, their symptoms improved. One person told us about how scared and intimidated they felt about going to the hospice for one week's respite. They went on to tell us, "I found a peaceful sanctuary and an amazing friendliness. I'm now confident in their ability. I could not walk before and they have supported me to get back on my feet." A different person told us that they felt that hospice staff understood what they were going through. They said, "They are always there to help you when you're sick. Nothing is too much trouble. They recognised I was ill and got me the treatment I needed."

People told us how they valued and appreciated the staff being calm, reassuring, and responsive to any needs they had. One person told us of their experience of using SinglePoint, "I have home visits from them [staff]. They are a huge support to me. They were there for advice in the middle of the night when I was having adverse reactions to my chemo. They were so calm and reassuring. Their rapid communication meant I got a follow up the next day." SinglePoint is a 24/7 advice and support helpline for the public, patients, relatives, carers, GPs and other medical and health and social care professionals. It works alongside other healthcare services such as GPs, Community Nurses or Specialists and helps coordinate a person's care with the hospice. The number of calls made to SinglePoint during the year 2015-16 was 45564. That meant that on average the hospice Singlepoint received and responded to 876 calls per week. One of the positive impacts this service had was more people were able to achieve their preferred place of death. This was because the care and support they needed was better coordinated via SinglePoint.

People spoke about the importance of the holistic care provided by the service; one person described this as being treated as an individual rather than a patient. They went on to tell us how they had experienced increased anxiety levels whilst they were receiving chemotherapy, however when they knew that they were coming to the day hospice they settled because they had confidence in the staff. They described the staff as supportive and easy to open up to and felt that there was, "A tremendous emphasis on empathy." People using the service were routinely shown compassionate, kind and caring treatment and support from every section of the hospice staff and this had a positive impact on people and improved their quality of life.

Professionals we spoke with consistently gave us positive feedback about the services provided by the hospice. A GP commented, "The service is exceptional. We have good communication systems and are always patient focussed." Relatives consistently said that they felt supported as part of their relatives journey. One said, "Everyone is brilliant. I think that this place is brilliant. I can't fault it."

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission to the inpatient unit, and when people received support from the hospice at home service, staff spent as much time as people needed, encouraging them to ask questions, discuss their options and reflect upon their choices. As people and staff worked as a team to ensure each support plan was unique and responded to specific needs, people felt valued and understood. People were admitted to the in-patient unit for a variety of reasons; for example pain relief, management of

a life limiting health condition and end of life care. Staff worked with people and those close to them to develop individualised care plans that reflected how each person wanted to receive their care, treatment and support. They supported each person, if they wanted to, to develop an advanced care plan, so people's wishes about their preferred place of end of life care were documented. This meant the person's wishes were known so staff could carry them out. One relative told us how before their loved one had been admitted to the hospice they had a key worker who visited them at home. They told us how staff went above and beyond their professional duty to ensure their loved one achieved their preferred place of death.

The effective communication between the staff from the entire department in the hospice and in various job roles meant that people received care responsive to their needs. The morning handover was recorded by the night staff onto a Dictaphone to ensure that day staff had the information at hand. The night staff stayed on attending to people's needs whilst the day staff listened to the handover. This ensured that people had their needs consistently met even when shift changes happened. There was also a typed handover sheet for each member of staff identifying people's name, diagnosis and a prompt of key issues which included medication, mobility, information regarding evacuation in case of fire, infection risks, pressure areas, nutrition, hygiene and emotional needs. This enabled staff who had been off shift to effectively catch up with any changes in people's health and care needs.

Every week day at 9am there was a 'Board Round'. This was a multi-disciplinary meeting attended by medical staff, the Clinical Nurse Manager, the Head of Inpatient services, the care coordinator (responsible for admissions and discharges), a representative from complementary therapies, physiotherapy, psychosocial services and the infection control nurse. We attended and observed this meeting. These meetings were effective in discussing people in the in-patient unit, any planned admissions and deaths. The staff were able to identify actions needed and established which department in the hospice was responsible for carrying out these. One of the doctors checked people's computerised records during the board round. The Integrated Palliative Care Outcome Scale was reviewed during this meeting. These outcomes are a multitude of tools to measure people's physical, psychological and emotional symptoms. They also look at people's spiritual and support needs and what information is still needed for staff to meet these needs. People's dependency score, and phase of their illness were also reviewed. We observed clear communication between the team members in this meeting as they discussed people and identified what needed to be done and by whom. This demonstrated that people using the service benefitted from regular reviews and good levels of communication between departments within the hospice to ensure they received the right service at the right time.

Staff were aware of the needs of the whole person which involved the family and the people important to them. Good planning and knowing people's wishes and needs from even before they joined the hospice were an important part of providing compassionate, holistic, personalised care. The admissions and discharges to the inpatient unit were well managed by three designated care coordinators. They received referrals, usually from the community team, but also had close working relationships with the local hospitals. They made sure that they got a detailed and accurate picture of people in need before they assessed which person was the priority for admission. After people were admitted to the hospice the team started discharge planning on day one. This level of forward planning showed us that people were getting the level of support and care when it was needed.

We went out on visits to people's homes with the hospice at home team. We could see that they worked well with other health professionals to support people in their own homes. An example of this was linking with a district nurse to ensure a wound dressing was changed more frequently. The daily notes written by all the staff involved in people's care were of good detail to ensure anyone following their care and support knew what had been completed. One staff member told us, "I always read the care plan before I support

someone. If there is anything I do not know I check first." We observed this in practice and found that the daily notes completed of the health and care interventions by the hospice at home team were detailed with observations made and interventions recorded. The people themselves and the families were aware of the care plans and daily notes in place and had access to these as they were kept in the private homes of the individuals. This showed us that people contributed and were aware of the plans in place with regards the care and support provided by the hospice at home service.

The staff from the hospice provided a range of rehabilitation, wellbeing, counselling and bereavement services through the hospice's day services. A wide range of therapies that were additional to medical and nursing care were available to respond to people's needs in regard to relaxation and general wellbeing. People were overwhelmingly positive about the day centre and the courses that they had attended. People spoke of attending yoga, gardening and art classes. One person spoke about how they had been admitted for rehabilitation at the hospice and the group sessions. They said that not only had they benefitted but also family members had been able to access counselling. The person told us, "My wife tells me that she would not have been able to cope without that." Another person told us that they had completed the 'Mindfulness course'. They told us that they were quite nervous about going. The volunteer driver had called them and arranged the times to go. They were worried and told us, "I thought – why put yourself through this? The driver noticed and said 'you will be ok'. And I was. It was fantastic. My preconceived ideas were wrong. The day centre involved me and got to know me." People liked that they were able to access transport to their weekly groups. This showed us that people's aspirations, preferences and wishes were identified and acted upon.

Services were developed to ensure there was a diversification of services offered by the hospice for people who lived with different life limiting illnesses and their families. For example, we were told about a support group entitled, 'Stars Residential Weekend' this was for the whole family to attend following the loss of a parent. Several family groups attended. The weekends were then followed up by three Friday evening meetings and a final Saturday meeting when balloons were released in memory of the parent who had died. We were also informed about support sessions that were also organised to support children at school and teenagers through art and drama therapy. The various support groups and sessions were wide ranging and developed over time given the needs expressed by people using the hospice or collated by other health professionals.

The model of care delivered was one of inclusion and acceptance and promotion of diversity. We spoke to a staff member about the 'Safe Harbour' project initiated at the hospice. They told us that they knew that the hospice services were fantastic for people, but these were not always accessible to people for several reasons. Either people were living outside the hospice's catchment area or the right type of support was not available at the hospice. Therefore, following a study of the need of the people living with a life limiting illness in the area it was established that hospice services needed to extend and support people on the fringes of society, such as those affected by homelessness, alcohol and drugs misuse. A support role had been developed whereby one consistent worker developed links and attended venues where the people coming from these backgrounds felt more comfortable. The hospice staff visited soup kitchens and voluntary organisations and developed links with accident and emergency departments so that those more vulnerable people in the society could access end of life care and support more equitably. This service was being actively evaluated to demonstrate the impact of how many people had benefitted to ensure ongoing funding for this project.

The hospice had a positive approach to using complaints and concerns to improve the quality of the services provided. The provider had a policy and procedure in place for managing complaints, which had very recently been reviewed, which outlined the arrangements for investigating and responding to

complaints. Information about the complaints procedure was on display throughout the hospice. The registered manager told us any complaints received were dealt with and people received a written response. We tracked one complaint that we had become aware of. We found that the registered manager was aware of the matter and had responded appropriately and lessons and practices had changed in a variety of departments within the hospice. The registered manager told us that they offer to meet with people and discuss concerns or they call people to talk matters through so they truly understand the concerns being raised. The registered manager was aware of the learning from The Francis Report and their Duty of Candour. They gave an example of a complaint where the hospice had admitted they were wrong and had unreservedly apologised to the people concerned. This open and transparent way of working fitted with the values and behaviour of the hospice. This demonstrated that the management and staff at the hospice wanted to develop and listen to people`s experience to drive improvements for the benefit of the people using their services.

People consistently said that they would be confident to complain if they needed to, but no one we spoke with had anything but praise. One person said. "They are genuine here. Without a doubt they would listen. They review everything."

Is the service well-led?

Our findings

People who used the service and staff told us they considered the leadership of all parts of the hospice exceptional. One person said, "They [managers] are professionally friendly like you would want them to be. They take their job seriously and manage to get the balance right in being pleasant." Another person said, "The service user group is well supported by the management team. They take our feedback seriously and act upon it. They have been consistently supportive of our work and feedback." It was obvious that staff working at the hospice were proud of the care that they delivered to people. One of the people at the hospice said, "The nurses here have told me that they work here because they can truly 'nurse' people and give the outstanding care they want to give."

People and staff were consulted and involved in the running and development of the hospice. We spoke to the chair of the service users group. They explained that there had been a service user group for ten years and that they were regularly consulted and their perspective was sought on many aspects regarding the management of the hospice. Group members were actively involved in the running of the hospice and were part of the various committees in the hospice like the clinical governance group. Recent work had been done in developing and reviewing the patient survey that had very recently gone out to people to seek their views. The chair of the group said, "This will be analysed and reported back on and the content will be taken seriously – I have no doubt. We have also been reviewing documents and leaflets used by the hospice to make sure they are accessible and correct to meet the target audience of people at the hospice."

In the summer of 2016 a staff survey was undertaken by an independent charity organisation. . The results were available with comments and showed that all staff were listened to. This has been used positively to develop matters within the hospice. A staff forum had been set up to look at the results alongside the human resources department. They looked at the five best areas and the five worst performing areas. This was then broken down into different staff groups and an action plan was developed to address the identified problem areas.

Concerns had been taken seriously, investigated, action taken and lessons learned. We saw that outcomes from complaints were linked to change of practice when necessary. A regular report was produced for the Board of Trustees detailing any complaints received; this enabled the Trustees to have oversight, were kept informed, to ensure lessons were learned from complaints in order to improve people's experience at the hospice.

The management team carried out work on the values of the hospice which were well known by staff. These included; Respect, Working Together, Passionate about Hospice Care, Appreciation for all and Valuing conversation. Our findings in this inspection showed that everyone working at St Helena hospice followed and adhered to these values. These were embedded in staff`s attitude, behaviour and evidenced by the feedback we received from people using the hospice services.

Both the Chief Executive Officer (CEO) and the registered manager were keen to engage and have conversations with staff. They had set a series of dates and invited staff to meet with them at sessions

entitled 'staff drop in sessions' and 'internal briefing sessions'. This showed us that management was available and approachable to all staff. A staff member said of the CEO; "I think that he is very forward thinking and that has to be a good thing for us as an organisation and for the people using it." The registered manager told us, "I think that there is a very good energy about the place. Staff have some very good ideas and we put them into practice."

The hospice was managed by a board of trustees, to whom the CEO and registered manager reported. Trustees had systems in place to work with committees including those relating to risk and incidents, quality assurances and audits. A report on clinical governance, clinical risks, and complaints was presented at the quarterly meeting of the Board of Trustees. The registered manager told us the trustees were robust in challenging them about the quality of the service but supportive of initiatives to improve the quality of people's experience at the hospice.

Staff we spoke with had a healthy view of quality assurance processes. We were told about several external audits that were welcomed and reports and action plans worked through. There was good joint working with other local hospices as 'critical friends' in several departments. One member of staff said, "Just because we are doing good, doesn't mean we can't do better." This belief of striving and developing was echoed by other staff in how they approached the inspection team and we found staff keen to listen and wanting to improve where they could for the benefit of the people using their services. We examined the last Quarterly Quality Report. Areas covered included but not confined to tissue viability, medicines, infection control, safeguarding, complaints, and clinical audits. This demonstrated that safety was being monitored and acted upon in several areas. The monitoring and evaluation of provision of service was being effectively quality assured. For example medicines management constantly monitored and improved where necessary, falls management was closely monitored, reported and actioned through the falls lead to look at individual circumstances, but also audits of environment and changes to lighting at night have been actioned. The quality report was comprehensive and was benchmarked through Hospice UK.

There was a clear management structure in the hospice with senior staff allocated in lead roles. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people with a safe, high quality and caring service and to continually improve, extend and develop the service to reach as many people as possible, including those on fringes of our society and those in care homes.

All staff were regularly supervised with appraisals in place. Following our visit a spread sheet was set up to record the training of clinical staff. This would then ensure that managers had oversight to clinical ability levels within the hospice and if there were any gaps emerging.

The registered manager told us and we saw evidence that they took action to ensure that staff were up to date with developing best practice. The hospice was a member of Hospice UK which is a national organisation, the aim of which is to help hospice care providers to deliver the highest quality of care to people with life-limiting or terminal illnesses. Staff had access to regular briefings provided by Hospice UK and were supported to attend annual conferences. We were told about how Assistant Nurses had presented a poster at a conference in Liverpool about their role as clinical support workers, how they support families as they move into the bereavement phase. The registered manager said, "I'm very proud of my team."

Part of the team had won nationally recognised awards in 2016. The SinglePoint service (24 hour telephone line offering advice and service coordination to patients, carers and professionals) had won The National Council for Palliative Care Effective Coordination of Care Awards 2016. They had also received highly

commended at the Quality in Care Oncology Awards in the 'End of life care and bereavement'. This level of recognition demonstrated that the hospice was committed to develop and maintain quality outcomes for people. People who used the service have left their reviews on an independent internet review site called iWantGreatCare.org. We found that this hospice was regularly rated as a five star service.

The registered manager sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. A newsletter kept people and supporters of the hospice up to date with developments. This included planned fundraising and stories about people's experience of care at the hospice.