

Darlington & District Hospice Movement

St Teresa's 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?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

St Teresa's Hospice provides in-patient care, a hospice at home service and a day hospice from one site. The day hospice services comprise disease-specific clinics and the hospice's bespoke "Choices" programme (a nursing assessment, rehabilitation and social model). The Hospice at Home (planned) service is part of the community provision, which also incorporates a Rapid Response (unplanned) service to respond to patient or carer crisis and prevent unnecessary hospital admissions.

The Family Support Team is comprised of social workers and person-centred counsellors, offering patient and family support. The complementary therapies offered to patients and carers include aromatherapy massage, acupuncture and reflexology. The hospice has an Education Department, focussed on workforce development and spreading the hospice ethos. The hospice's income generation team is based on site and all of the hospice's services are supported by a dedicated team of almost 400 volunteers.

There were six people using the inpatient service on the day of our visit and approximately 16 people attending the day hospice facility. The Rapid Response team had an active caseload of eight people on the day of our visit."

The care provided by the hospice is for people that live in the Darlington, South Durham and North Yorkshire areas. The service is a registered charity with a board of trustees. Day to day the service is run by a senior management team drawn from all departments within the hospice.

There was a registered manager employed for this service. 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 registered manager was very experienced after being employed by the hospice for several years.

People and their families told us that staff were extremely caring, compassionate and listened to them. People we spoke with who received personal care felt the staff were knowledgeable, skilled and their care and support package met their needs not just in terms of physical care but also in relation to their emotional support. Staff confirmed that they were not rushed and had time to provide the care people expected. People told us about the excellent care they received. People and professionals spoke very highly of the complementary therapies that were available to both people who used the service and relatives. The hospice provided excellent family support, counselling and bereavement support which people told us made a massive impact to their lives.

The staff undertook the management of medicines safely and in line with people's care plans. The service had health and safety related procedures, including systems for reporting and recording accidents and incidents. The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering the person's care and their environment. The hospice environment was

well maintained and there were regular checks on safety and equipment.

People were protected by the service's approach to safeguarding and whistle blowing. People who used the service told us that they were safe, could raise concerns if they needed to and were listened to by staff. Staff were aware of safeguarding procedures, could describe what they would do if they thought somebody was being mistreated and said that management listened and acted on staff feedback.

Staff recruitment processes were followed with the appropriate checks being carried out. There were sufficient staff on duty to meet people's needs and the service had a team of volunteers who provided additional support. The hospice had a bank of staff who they could contact if they needed additional staff.

The service had an electronic care planning system that we saw recorded people's admission assessment and on-going plan of care. Care plans were personalised to include people's wishes and views. Care plans were regularly reviewed in a multi-disciplinary framework. We observed staff caring for patients in a way that respected their individual choices and beliefs. There was evidence on electronic and paper records of advance care planning and specific Deciding Right (this is a North East initiative) which was used to capture people's choices and planning for future anticipated emergencies.

All staff received supervision individually or as a group and annual appraisals were undertaken. Staff and volunteers received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care.

Staff told us they were very supported by their management and could get help and support if they needed it at any time. Staff members told us they felt part of a team and were proud to work for the hospice.

Staff worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff.

People were supported to receive a nutritious diet at the service. Their appetite was assessed through talking to them which led to staff being able to give the person the type and amount of food they would be able to eat. There was a choice of menu on the days we inspected and drinks and snacks were available at any time. The service also provided a bistro for people, families and staff to enjoy a meal or snack and the chef provided support on cooking and nutrition for people and their families via the day hospice CHOICES programme.

People were confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.

There was a good quality assurance system in place to ensure the service and staff were delivering the desired level of quality and safety. There were regular reviews and feedback opportunities with people and families on the quality of their care to make sure they were happy with the service provided. Accidents and incidents were clearly recorded. There was an embedded culture of learning from mistakes and to share action plans for improvement work within 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.

Checks of the building and equipment were completed to make sure it was safe.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. This meant there were systems in place to protect people from the risk of harm and abuse.

On the day of our visit we saw staffing numbers and skills mix were sufficient to provide a good level of care to keep people safe. Robust recruitment procedures were in place to make sure staff were suitable to work with vulnerable adults.

Is the service effective?

Good ●

The service was effective.

People's healthcare needs were carefully monitored and discussed with people who used the service and their family members.

Staff told us they felt supported by the service and they received clinical supervision.

Staff of all levels had access to on-going training to meet the individual and diverse needs of the people they supported. Staff were trained to provide the specialist care people required.

People were assessed to identify risks associated with poor nutrition and hydration and spoke highly about the quality and choice of food.

Is the service caring?

Good ●

The service was caring.

People told us that staff were kind and compassionate at all times and treated everyone with dignity and respect.

The service provided emotional support to people, their family and friends via a team of dedicated social workers, counsellors, nurses and healthcare staff on an ongoing basis.

People were supported spiritually. People were encouraged and supported to make decisions about their care and given time to make their own choices; this included their end of life care.

Is the service responsive?

Good ●

The service was responsive.

People told us they felt confident to express any concerns or complaints about the service they received.

People and their families were fully involved in assessing their needs and planning how their care should be given.

Staff delivered people's care in a person-centred way, treating them as individuals and encouraging them to make choices about their daily lives.

Is the service well-led?

Good ●

The service was well led.

The management team gave strong and effective leadership and provided a clear strategy for the development of the service.

There were clear management structures and lines of accountability. Staff told us the service was well managed, that they were treated with respect and were actively involved in decision-making.

Systems were in place to monitor the quality of the service provided to ensure the service was run in the best interest of people.

St Teresa's 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.

The provider was given 48 hours' notice because we did not wish to impact on the day to day running of the service and wanted to enable nursing staff to be available to speak with us because they may be providing care in peoples own homes.

On the first day of the inspection there were three adult social care inspectors, a specialist advisor in end of life and palliative care and two pharmacist inspectors. On the second day of the inspection there was one adult social care inspector.

Before the inspection we reviewed all the information we held about the service, this included notifications of significant changes or events. The registered provider had completed a provider information return (PIR) prior to the inspection in April 2016 and we updated this information with them during the course of the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were six people who used the in-patient service and there were 16 people using the day hospice and the community Rapid Response service had an active caseload of eight people who may receive personal care in their own homes. We spoke with four people using the in-patient service, three visiting relatives and we spoke with three relatives of people who used the Rapid Response service.

During the visits we spoke with 15 staff, this included the registered manager, the nurse consultant, human resources manager, the clinical governance and quality assurance advisor, the operations manager, the catering and housekeeping manager, a family support social worker, nurses and health care assistants. Prior to the inspection we contacted external health care professionals by email to seek their views on the care and service received and commissioners of the service from the Clinical Commissioning Group (CCG).

Their views can be read in the main body of the report.

During the inspection we reviewed a range of records. This included five people's electronic care records who used the hospice, including care planning documentation and medication records in both the in-patient and day hospice facility. We also looked at staff files, including staff recruitment and training records, records relating to the management of the hospice and a variety of policies and procedures developed and implemented by the registered provider.

Is the service safe?

Our findings

People told us they felt safe in the hospice. We observed that people had their 'nurse call' to hand to call staff when required. One person said, "I have no worries in here at all." Another person commented, "Safe, oh yes. The service is lovely, no aggression, very relaxed." One relative whose family member received support at home told us; "I can go out and not have to worry. When they are there I can go out and it is all a bit different."

Staff we spoke with also felt the hospice was a safe place. One staff member said, "I think it is safe. We have lots of meetings about the care of patients, lots of discussions."

Staff displayed a good knowledge of safeguarding adults and children including how to report any concerns they had. Staff knew about various types of abuse and potential warning signs to look out for. For example, people becoming withdrawn, signs of injury, unexplained bruising and people reacting different to usual. Staff said if they had any concerns they would report them straightaway to the person in charge.

Staff were aware of the provider's whistle blowing procedure. None of the staff we spoke with had previously had cause to use the procedure. One staff member told us, "I can't honestly say I have seen anything of concern. You would be encouraged to raise concerns." All of the staff we spoke with said they would not hesitate to use the procedure if they had concerns about people's safety. One staff member told us, "We have an open door policy. I definitely have no doubt concerns would be taken seriously."

The two staff files we looked at showed us that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. The human resources manager who supported the recruitment process explained the additional measures the service took to check the identity of applicants, their right to practice and to process DBS checks promptly. The service also confirmed staff had the appropriate registration to practice checks on an annual basis such as Nursing and Midwifery Council registration. The human resources manager described the assessment centre approach used for some roles, including bank health care assistants to ensure prospective staff had an understanding of the function of the service.

Through our observations and discussions with people and staff members, we found there were enough staff with the right experience and skills to meet the needs of the people who used the service. We reviewed duty rotas and spoke with the care team about staffing levels and shift patterns. All of the staff we spoke with during the inspection told us they thought there was sufficient staff on duty to meet people's needs. Staff told us everyone worked well together as a team. The registered manager told us that during the day there was a minimum of two nurses and two health care assistants on duty and at night there was one nurse and a healthcare assistant.

The hospice was working with limited medical cover, due to the Foundation Trust not being able to recruit and appoint a Palliative Medicine Consultant; staff described occasions where delays in symptom management had happened due to the need to involve Out of Hours medical cover. This was a high priority for the service and we saw this issue was reviewed by the senior management team on a regular basis. The hospice therefore took the step of appointing a nurse consultant who was a non-medical prescriber and had completed clinical skills training, and additional sessions from a GP with Special Interest (GPSI), to ensure safe medical cover.

The Clinical Band 6 nurse had recently completed non-medical prescriber training and was awaiting sign off to be able to put this additional skill into practice. Non-medical prescribing is the prescribing of medicines, dressings and appliances by health professionals who are not doctors. One person said, "[Staffing levels] seem enough, I think they do very well." One staff member commented, "The majority of the time we can meet needs. There has been times when there was sickness but they try to get extra staff. They are always on the ball on getting cover."

Another staff member told us, "I think there is [enough staff], the majority of the time it is well-staffed."

Risks to people's safety were appropriately assessed, managed and reviewed. Care records we looked at during the inspection contained a number of risk assessments specific to the needs of each person. A nursing assessment was completed with the person using an admission checklist and an Activities of Daily Living form. The information retrieved was transferred onto an electronic care record system that included personal information, demographics and baseline risk assessments such as Waterlow (pressure care), a falls risk assessment, a moving and handling and oral assessment, MUST (a nutritional screening tool) score, and an assessment of mental capacity. The risk assessments were repeated after one week of admission or as required for individual people.

We looked at the way that medicines were managed within the hospice. We found that patients were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines.

During our inspection we spoke with three nurses on the ward and with one patient about their medication and looked at four patient medication records. We also spoke to the provider's Accountable Officer about the hospice's arrangements for handling controlled drugs (drugs liable to misuse). The Accountable Officer is a person designated under The Controlled Drugs (Supervision of Management and Use) Regulations 2013 by the provider to ensure that appropriate arrangements are in place for the secure and safe management of controlled drugs in the hospice.

We looked at how medicines were handled in the in-patient unit and day hospice and saw appropriate arrangements were in place for checking and confirming people's medicines on first admission to the hospice. When patients were discharged we saw that detailed information about their current medicines, including changes made during their stay in the hospice were given to the patient. This would ensure that up to date information about people's medication would be available to a person's GP if required.

There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management.

We saw that a lockable cabinet was located in each room for the secure storage of medicines. However we were told by staff that no one was managing their own medicines and that people were not routinely asked if they wanted to manage their own medicines on admission to the in-patient unit.

Appropriate arrangements were in place for the recording of medicines. The medication records we checked

showed that patients received their medicines as prescribed. For medicines which were administered via a transdermal patch, a system was in place. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream and a system was in place for recording the site of application; however this was not fully completed for two people we looked at which meant people may be at risk of not receiving their medicines safely.

Medicines were kept safely. Medicines were kept securely and only accessible to staff authorised to handle medicines. Medicines were stored at the correct temperature and therefore were suitable for use. There was a system in place for checking expiry dates of medicines. Controlled drugs were ordered, received, stored, checked and disposed of in accordance with the required legislation.

There was a day hospice on site. The medicines management arrangements in this service should be reviewed to ensure they are in line with pharmaceutical guidelines.

Nursing staff told us that they received training in medicines management and also specialist equipment such as syringe drivers. A syringe driver is a small, battery-powered pump that delivers a continuous dose of medicine through a soft plastic tube, into a syringe with a needle which is placed just under the skin. Their competency for administering medicines was assessed at regular intervals.

Arrangements were in place to ensure that medicines incidents were reported and fully investigated and we found there was an open culture around reporting medicine errors. All the staff members we spoke with were aware of how to report any medicines incidents. We saw that a recent medication error had been fully investigated and additional medication training had been undertaken and changes to procedures had been introduced promptly to reduce the risk of reoccurrence.

We asked about the arrangements for auditing medicines handling and storage in the hospice. We saw that controlled drugs were checked frequently. We were also told that the provider completed a full audit of all medicine charts. These checks helped to identify any issues in order to learn and prevent the errors happening.

There was also a system to receive and act upon national drug safety alerts.

We met with the operations manager who oversaw the health and safety checks undertaken at the service. They had a robust system in place for the regular checks of fire safety equipment such as fire doors and fire fighting equipment and also they reviewed procedures such as fire drills to show any learning requirements from such events. Tests of the fire alarm were completed on a regular basis to make sure it was in safe working order. All fire zones within the hospice were tested over a four week period and the service had an up to date fire risk assessment.

We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the nurse call system, emergency lighting and gas and electrical safety. We saw records that showed water temperatures were taken regularly. We saw that all water temperatures were within safe limits and Legionella checks were carried out by qualified contractors.

We saw that checks in relation to moving and handling equipment under Lifting Operations and Lifting Equipment Regulations [LOLER] regulations had been carried out and people and staff were also protected by a plan to monitor infection control risks. This plan to cover health care acquired infections covered staff training, cleanliness audits, clinical governance, downtime deep cleaning and waste disposal measures. We

saw any action points were recorded and addressed straight away. This showed the service had procedures to keep people safe.

Tests of the fire alarm were completed on a regular basis to make sure it was in safe working order. All fire zones within the hospice were tested over a four week period and the service had an up to date fire risk assessment.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. The registered manager said that accidents and incidents were not common occurrences; however they had appropriate documentation in which to record and review them should they occur.

Is the service effective?

Our findings

Staff we spoke with told us about the good support received to carry out their role. One staff member told us, "I am blown away by the support I have had from staff I work with up to management. I can talk to my manager anytime." Another staff member commented, "The support is absolutely fabulous." A third staff member said, "Very well supported, we work well as a team." One volunteer said, "I am very well looked after. I feel very safe. Your work is appreciated and very valued. It is the most wonderful place to be." We saw records of group discussions and clinical supervision. Annual appraisals were carried out between April and June and information regarding training was collated by the education manager for discussion and approval for the future.

Staff told us they received the training they required to care for people effectively. One staff member said, "We do essential training yearly. I am up to date on training." One relative whose family member received support at home told us; "They [staff] are trained to deal with situations. I would recommend it to anyone."

The hospice had its own education department that not only provided training to staff and volunteers working with the hospice but also provided training to other healthcare professionals. Themes for education for 2016 included communication, equality and diversity and development of self, teams and services. The family support and bereavement team had a programme of continuing professional development sessions for its counsellors, volunteers and social workers. Sessions included dementia awareness, facilitating group work in bereavement care, spirituality and supporting people with sleep difficulties. Development sessions for the in patient service had recently discussed preventing pressure ulcers, falls prevention and investigating incidents. Other specific induction events were also planned and delivered and we saw that all staff and volunteers received role specific induction that included an introduction into the hospice and service, moving and handling, food hygiene, fire and health and safety procedures as well as palliative care, listening skills and grief, loss and bereavement sessions. This showed staff and volunteers received training to understand the role they were to perform in a safe and effective way.

The staff spoken with demonstrated a sound knowledge base in specialist palliative care in keeping with roles and responsibilities and the service specification. Senior nurses were qualified to academic degree level in palliative care and all staff spoken to were well supported with personal and professional development via in-house or externally sourced education. The nurse consultant was a non-medical prescriber and has completed clinical skills training. The clinical band 6 nurse had recently completed non-medical prescriber training and was awaiting sign off to be able to put this additional skill into practice.

From April 2016 revalidation is the new process that all nurses and midwives in the UK will need to follow to maintain their registration with the Nursing and Midwifery Council [NMC]. Nurses were organised regarding revalidation and there was a system in place to support individual staff with a designated confirmer to sign off evidence within the process of revalidation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. When people were first admitted to the hospice they were asked if they were happy to be cared for at the hospice. If people were not happy then staff at the service were to consider the persons capacity and consider a DoLS. At the time of our visit, there had been no applications to place a restriction on a person's liberty. We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated a good awareness of the code of practice and confirmed they had received training in these areas. Procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

We saw evidence that mental capacity assessments were conducted and recorded and also evidenced in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. Mental Capacity Act assessment forms were available in paper format and were used to evidence assessment of capacity and decisions taken in people's best interests.

A general consent form was signed by the patient on admission and the five records we reviewed showed this form was in place and signed. On one occasion the signature was provided by the person's advocate, their spouse, however verbal consent was agreed by the person and documented on the form.

The five people's records reviewed included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. In all cases the decisions were dated and approved by a lead clinician or G.P [when DNACPR was initiated in the community] and on all five of these there was a clearly documented reason for the decision recorded on the form with clinical information included. All DNACPR forms included a review having taken place on admission to the hospice.

The clinical lead nurse consultant was equipped with the skills to initiate a DNACPR with people and the band 6 clinical nurse was equipped to review a DNACPR at the point of a necessary review, such as a change of care setting, and there was evidence to support this being carried out on the DNACPR documents reviewed. Discussions about DNACPR with people and relatives were recorded in sufficient detail within people's records.

Staff we spoke with understood the importance of seeking consent before providing any care or support. One staff member commented, "We always ask them first. I always explain what I am going to do, families are usually there." Staff confirmed they would respect people's right to refuse. One staff member told us, "We have to respect their wishes. If it is part of their treatment we would mention to the staff nurse."

People told us they were happy with their meals. One person said, "The food is wonderful, beautifully cooked." They went on to tell us they liked their food served a certain way. They said, "I only say that it is not right and it is changed immediately." Another person told us, "The food is alright, edible. They always say what do you want." We observed a staff member taking people's meal orders. People were given a choice of a starter, main course and dessert. Where people did not want the options on the menu a wide range of

alternatives were offered. The staff member made certain people had something to eat which they really wanted. One person told us, "They always say you can have something else to eat."

Food and nutritional needs were met with individualised care and evidence of care planning involving multi-disciplinary team members including a dietician was evident from care plans we reviewed. One person on the unit had a PEG [percutaneous endoscopic gastrostomy] in place and their feeding regime was personalised to meet their needs. A PEG is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines.

We met with the catering manager for the service. They told us how after receiving a nutritional assessment carried out by the nursing staff that they also went and spoke with people about what they would like to eat. They told us how they had a 12 week menu plan but people had choices at all mealtimes and freezers in the in-patient area were stocked with items such as scones and crumpets in case people fancied a snack at night time for example. We saw people's food and fluid intakes were recorded on the electronic record system. We saw that menus were available in a range of languages and the catering manager was knowledgeable about providing food to meet people's cultural needs.

The catering manager had also developed the services provided at the hospice to include a comfortable bistro dining area for people and families and staff and a three course meal for people attending the day hospice services. The catering manager also passed on their skills and knowledge in providing cookery lessons to groups such as the regular bereavement group as well as giving tips on shopping. This showed the service provided support to meet the nutritional needs of everyone using the hospice; people, visitors and carers and staff.

The registered manager told us they had improved communication across the hospice as part of their ongoing improvement work. A handover form had been developed and provided an updated summary of each person twice daily. This appeared to work well and the handover form was referred to when questioning interventions for individual people. The service had also put on weekly comms meeting where staff or volunteers could get updates on things happening across the hospice as well as a monthly bulletin that every staff member received via email.

The hospice had developed its services to provide a greater range of disease specific clinics at the day hospice. This included neurology, respiratory, heart failure and lymphoedema sessions. The CHOICES programme running three days a week at the day hospice gave people a care plan to enable them to participate in a variety of therapeutic activities with qualified staff such as a physiotherapist and other trained therapists. Sessions include complementary therapies such as acupuncture and massage as well as sessions such as craft, IT and exercise. We saw increased participation in day hospice sessions following a transformation programme in 2014. This transformation programme was carried out following a review of the service with people who used it which said that people wanted more specific activities and sessions.

Is the service caring?

Our findings

People gave us only exceptional feedback about the excellent care they received from the hospice. One person said, "I have lots of words to describe the care, superb rolls them up nicely. You can put in your report you met a satisfied customer." They went on to say, "As good as the hospitals are, they are not as good as here." Another person commented, "Excellent care, it is lovely in here. They can't do any more than what they are doing." Family members confirmed their relatives were well looked after in the hospice. One family member said, "Due to the care received from the hospice they got [my relative] eating again." Another family member told us, "There couldn't be anywhere better."

People and family members told us they were cared for by kind, considerate and caring staff. One person commented, "[Staff] couldn't be kinder, couldn't be more caring. They are lovely ladies. They are very kind." Another person told us, "The three days I have been in, it has been excellent. Staff are all kind, all different but kind and helpful." A third person said, "[Staff member] is a gem." One family member told us, "They seem very good. They are very kind. Kindness is what you need and they listen. [My relative] is always saying they are very kind."

We spoke with three relatives whose family member used the hospice at home service. One relative said; "[Staff are] excellent, very very nice, very compassionate, very helpful. Any questions, they answer them honestly. They have been such a big help to us." Another relative said; "[My relative] was very reluctant and did not want to use it at first. It was amazing, they had a lot of things to talk about. They had a right old chat."

We spoke with the catering manager who told us as well as providing food for people using the hospice and day hospice, they also provided teaching sessions for people about cooking and shopping to support better nutrition for people. They told us they were currently doing one to one sessions with a person who had recently been bereaved and whose partner had always done the cooking. This was an example of this staff member exceeding the remit of their role. They told us how they were supporting them over the last five weeks to cook a simple meal to enable the person to have a more varied diet in a manner that reduced their embarrassment and in which they could support them regarding their loss. This showed that all staff at the hospice were committed to supporting people in a caring way.

People were treated with dignity and respect by staff who listened to them. One person said, "Staff are respectful and professional, nothing is too much bother for them." They went on to say, "Staff come in and sit and talk to you. Somebody yesterday sat and talked for half an hour to help with cheering me up." One family member commented, "Very respectful, I wouldn't have it any other way." Staff gave us examples of how they provided care in a dignified and respectful way. This included telling people what they were doing, keeping people covered up as much as possible. One staff member said, "I always check it is okay. I always give people the option of doing things first and double check that I have their permission." We observed signs were placed on doors to inform visitors personal care was in progress and to give people their privacy. Staff all spoke about person centred care being a priority and individual care was centred around the patient's wishes and choices. Evidence of people being left undisturbed whilst sleeping and care managed

around the patients agenda was evident.

People said staff were attentive to their needs and supported their choices. One person told us, "I just open my mouth and my wishes are attended to practically immediately. Any request is attended to; if it cannot be done it is explained why." They also said, "They don't wait till they are called [staff], they pop in and ask 'can I do anything for you?' Lovely people." Another person commented, "I go to bed at 8 o'clock, that's what I like. There are no restrictions, [my relative] can come in and go as much as possible." They also said, "They come right away when I pull the nurse call." One family member commented, "We can visit anytime."

The service recognised the significance of family throughout people's involvement with the hospice services. One relative whose family member received support at home told us; "If I need anything explaining they see things from a different perspective. They can help in ways that I can't." People's family members and friends were able to visit at any time. In addition facilities were available for relatives to stay overnight. Support for family members was available for as long as needed. During our inspection we attended the carers group and bereavement group run by the family support service. Family members attending these groups told us about how much mutual support they had received. We heard people sharing information and ideas to help each other. Family members told us they had made some good friends who they also met outside of the group. The hospice also had an established 'Moving On' group which family members could attend when they were ready to move on from attending the bereavement group. One family member commented, "Brilliant, it has done wonders for me." Another family member told us, "They have really helped me a lot. If I have any problems they sort them out for me. They always have a smile and a warm welcome." A third family member said, "They listen which helps me." One family member told us attending the support groups was a "very successful way of meeting people". They also said, "It's marvellous, I wouldn't be where I am today without the group. There is always someone there to listen to you."

Is the service responsive?

Our findings

People and family members did not have raise any concerns about their care. One person said, "I haven't any concerns. They just say if you have any problems, just tell us. I don't know how you can have any problems in here." One family member told us they had; "No concerns". Staff told us people were given information about the complaints procedure when they first came into the hospice. Information about how to complain was also contained in the information file located in each person's room. We also saw each person using the hospice services received an information pack about the range of services and facilities available such as family support, complementary therapies, physiotherapy and bereavement support amongst others. People told us they could express their views and were involved in making decisions about all aspects of their care. They told us they felt listened to.

Core care plans were used throughout the hospice using an electronic care planning system to support care and management with additional text added or text removed to personalise care plans in line with individual needs.

We saw recognition of symptoms and management were evident in care plans however specific symptom management assessment tools [pain] were not seen. A body chart was included in the assessment documented identifying areas of pain however this wasn't supported by pain descriptors or visual analogue scales in the assessment. The Band 6 Clinical Nurse described their assessment technique which included methods to allow the person to score and describe their pain however this wasn't evidenced from electronic records. No evidence of using scoring methodology when intervention was provided, i.e. administration of analgesia, there was a record on people's notes however this was unsupported by a validated measurement scoring method to assess and monitor the effectiveness of the intervention provided. Therefore we did not see clearly documented evaluations of pain in relation to the effectiveness of medication given. The hospice management agreed with this feedback and told us they had recognised this lack of outcome recording and were looking at implementing a new outcome recording process.

Core care plans were in place to support individual plans of care for all people. The hospice were going to be implementing the Outcome Assessment and Complexity Collaborative (OACC) tool which will enhance the care planning process by ensuring that outcomes for people are clearly recorded. The hospice had recognised through their own clinical governance processes that they needed to improve the recording of outcomes for people in relation to managing palliative care and so were undertaking planning and training in relation to implementing OACC.

We did not see a specific care plan for caring for people in the last days of life other than the existing core care plans. We discussed this with the clinical lead and non clinical unit manager who told us that a tool was being reviewed with a plan to be uploaded to the electronic record. The need for transparency in practice was discussed with emphasis to address how this plan of care could be available at the person's bedside which fits with national recommendations. Currently the plan of care was communicated verbally to people and family members and this was documented on the electronic record. Staff told us discussions were supported by using the Regional Clinical Network information leaflet: "When someone is dying."

We saw people's cultural and religious needs were captured on the electronic record and the Clinical Band 6 nurse described the need to explore spirituality further with the person capturing what was most important to them. We found this evidence was difficult to locate electronically however written evidence was available from the initial admission discussion and the activity of daily living summary in the care plan.

We joined a handover staff meeting where people and their relatives' care and support was discussed. The staff team discussed discharge planning when it was time for the person to go home. This included a discussion on what support the family would need when the person returned home, equipment issues, and liaising with other agencies such as the local authority, the Rapid Response service and Macmillan nurse teams.

We attended a twice weekly multi-disciplinary team meeting where a full review of the person's care was undertaken. These involved medics, nurses, therapists, the Rapid Response service and community Macmillan nurse team. The meeting discussion included a short case history on each individual and explored issues such as treatment options and a discussion about meeting people's holistic needs such as checking all therapy options had been explored as well other individual issues such as spiritual needs. This meeting ensured anyone either receiving inpatient or community support was reviewed by a multi-disciplinary team in a responsive manner. These meetings helped ensure that people's care was individual and person centred.

The Community Hospice Team includes the Rapid Response Team of nurses and healthcare assistants, based at the hospice and working on a short term intervention approach of supporting people at home or to enable them to get home from another place such as a hospital. The team had a one hour target response time from referral from district nurses or other healthcare professionals and worked closely with district nurses and G.Ps to support people in their own homes.

The service had a Family Support Team, comprised of social workers and person-centred counsellors. Patients and/or carers were given practical support or advice or signposted to obtain information on housing issues, benefits, legal advice and wills; individual counselling and/or group work provided anticipatory grief and bereavement support. The Family Support Team manager was actively involved in the running of carers' groups. Their family support team remit was to offer support to anyone affected by a life limiting illness and the family support social worker told us this was a purposely broad remit to ensure as many people as possible could access its services. They told us about other services available which included bereavement support that provided support to families after death. They told us how counselling was available to people who used the service and their relatives. The service also worked with children and liaised with schools to ensure a child was supported with any loss by both the service and by their school and teachers.

We saw that the service provided transition services for people's families to offer them a carers group, a bereavement support service and then on-going counselling if this was needed for people. This meant that families were supported by the hospice and its service right through the journey of supporting someone with a life limiting illness and through the grieving process by trained and professional staff.

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

St Teresa's Hospice had a number of different ways in which it assessed and monitored the quality of service it delivered. We looked at performance reports, audits, the organisation's quality accounts, risk management/governance systems and questionnaires.

There was a clear management and governance structure at the hospice. The staff we spoke with were aware of the roles of the management team and told us they were approachable and we saw they had a regular presence within the hospice. All staff we spoke to demonstrated a positive culture and they were all enthusiastic to work at the hospice. They all demonstrated in their conversation that they felt the organisation was well managed and led. There was a sense in speaking with senior clinical staff that they had autonomy in practice with structure and support to allow that to happen in a safe way.

Staff told us they had opportunities to give their views about the care provided at the hospice. One staff member said, "We have communications meetings about the whole hospice, anyone can attend." Staff also said there were regular team meetings, staff development days and handover sessions twice daily.

Questionnaires were undertaken with people during and after their stays at the hospice and questionnaires were also sent to families. People's families were also reminded of the hospice bereavement services three months after a person's death to offer any support that families may need.

We met with the Clinical Governance and Quality Assurance advisor for the hospice. They explained the documents provided by the hospice showed how trends and themes of concern were monitored and acted upon by the clinical governance group. For example we discussed the issue of a lack of medical cover full-time at the hospice. We saw that this risk was reviewed regularly and actions the hospice had taken to mitigate any risks from this were recruitment, the development of the Lead Nurse Consultant role and additional clinical prescribing training for other senior nursing staff. The Clinical Governance and Quality Assurance Advisor told us; "This issue feels in a much better place than it did three years ago because we have implemented that key role." We saw minutes of these meetings where actions were clearly identified, delegated and given timescales for completion. There was also a quarterly review of the key performance indicators and electronic care plan targets, the aim of which was to review information relating to outliers, which would aid the hospice in focusing on improvements in quality and safety.

We saw that the hospice shared its lessons learnt with its staff and identified any improvements which could be made to enhance the outcomes for people using the service. We were given examples of improvements which included a recent review of an incident where a person was transferred into hospital and an issue occurred with their medicines which were not available. This led to the hospice implementing a named nurse system so any transfers from the in-patient unit had a clear discharge checklist and handover meetings were improved to record who was responsible for each patient and their transfer with medicines.

This showed the service learnt from events.

Staff members told us there was a good atmosphere in the hospice. One staff member said, "It is a very relaxed place to work. We all get on so well, very friendly. Sometimes it is quite light-hearted." Another staff member commented the atmosphere was; "Quite jolly sometimes".

Staff told us they felt consulted and included in planning and implementation of new services and the soon to be opened new build had generated excitement and enthusiasm from all staff we spoke with. Regular team meetings were held where staff were kept up to date with developments and could have discussions about the running of the service. We saw minutes of the meetings where staff had discussed their roles, training and health and safety. Staff also had an offsite development day every year where everyone involved with the hospice such as volunteers, shop workers, fundraisers and clinical staff came together to look at the service and its strategy and to put ideas forward.

We saw the service as part of their contractual arrangements supplied the Clinical Commissioning Group (CCG) with a quarterly Service Quality Performance report in which they gave information regarding their achievement against Performance Indicators and Local Quality Requirements set by the CCG. There were sections to report on incidents; safeguarding compliance and people's experience via feedback.

We spoke with commissioners of the service from the local Clinical Commissioning Group (CCG). They told us; "The hospice has a good working relationship with the CCG and works closely with them in order to help meet the needs of its patients." Another lead commissioner said; "I have no concerns about the quality and safety of care at St. Teresa's based on our monitoring. The leadership team are clearly committed to working in partnership with stakeholders and commissioners and demonstrate a commitment to quality improvement. They are also highly responsive to queries and issues raised with them."

We saw the service worked closely with other partners such as the NHS. We were given examples of how the service was working with the local NHS mental health trust to give staff at the hospice training in dealing with people who may exhibit mental health difficulties and also to share their palliative care knowledge with staff at the mental health site.