

St. Margaret's Somerset Hospice

St Margaret's Somerset Hospice - Taunton

Inspection report

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

Overall summary

St Margaret's Somerset Hospice is a charity which provides a range of hospice services for adult patients with life-limiting illnesses or advanced progressive conditions and support for their families and carers. This means they provide a service for people with a range of conditions including cancer. Services include an inpatient unit (IPU) with 16 beds. Twelve beds are used regularly with two further beds commissioned via 'winter pressure

funding'. This means the hospice are able to prioritise beds for those people with more complex symptom control or end of life care needs. The majority of people are supported by community services with over 600 people supported across the Somerset community at any given time.

Summary of findings

This inspection was carried out on 7, 9 and 10 December 2015 by one inspector, a pharmacist inspector and a specialist advisor. This was an unannounced inspection.

There is a registered manager who is responsible for the 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 and associated Regulations about how the service is run. There is a second St Margaret's Hospice in Yeovil and the two services work closely together. Services are free to people, with St Margaret's receiving some NHS funding and the remaining funds are achieved through fundraising and charitable donations. The hospices are largely dependent on donations and fund-raising and are assisted by over 1200 volunteers.

The service provided includes specialist advice and input, symptom control and liaison with healthcare professionals. The hospice has a 24 hour out of hours advice line and central referral centre (CRC). Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, physical, psychological and spiritual or complex end of life care needs or referral to other hospice services. The average length of stay was two weeks with some people being discharged home or to a local care home. The service was clear about their local demographic meaning that they had an understanding of the community they served and continuously monitored how best the service could meet their needs. They followed national guidelines such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice and this was the aim of St Margaret's as much as possible.

The registered manager was open and transparent in their approach. They provided excellent leadership ensuring all staff were engaged in providing an excellent service to individuals and striving to constantly improve. Staff told us they felt valued and inspired by the leadership team and the registered manager to provide a high quality service. Emphasis was placed on continuous improvement of the service. Comprehensive audits were carried out about every aspect of the service to identify how it could improve. Where the need for improvement was identified, remedial action was taken to improve the

quality of the service and care. The service worked in partnership with other organisations to drive improvements at national level, participating in research projects and end of life care awareness which positively benefitted people in their care.

An excellent on site academy training centre provides advice and support to St Margaret's staff as well as staff in care settings in the community. St Margaret's were committed to sharing good practice and enabling other health professionals to provide a high standard of specialist care. People could access counselling, family and bereavement support, a lymphoedema service (a chronic long term condition that causes swelling in body tissues. It can be a primary or secondary condition), occupational and creative therapy, physiotherapy, complementary therapy and spiritual support. There was also support from social workers and advice on practical matters such as finances. The day centre offered activities and support for people over a 12 week period and were able to signpost people to other local services. There were also a range of support groups and courses tailored for people with life limiting illnesses as well as their carers pre and post bereavement.

Staff received very comprehensive essential training based on best practice, national guidelines and research including end of life care and were scheduled for refresher courses. Staff had a wide range of opportunities for further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and an annual appraisal. This ensured they were supported to work to the expected standards and valued by the service. Staff were encouraged to always, "See what else we can do" to improve the service and to submit ideas for improvement.

There was excellent communication and delivery using a multidisciplinary and holistic approach. The service was responsive with people able to access a one stop referral centre and advice line for advice and support. The service continuously looked at the local community demographic to see how best they could provide the service. This included dementia champions and links with homeless communities. People were involved in the planning of activities that responded to their individual needs. A broad range of activities was available that included creative ways to keep people occupied,

Summary of findings

engaged and stimulated. Attention was paid to people's individual social and psychological needs in a holistic way that included support pre and post bereavement for carers. There was an excellent spiritual care service which was inclusive and their ethos was person centred. At St Margaret's "spiritual care honours the human spirit and cares for each individual as a spiritual person" however that may be.

People benefitted from a bespoke meal service that was tailored to their specific needs, likes and dislikes including when people felt like eating. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences, restrictions and reduced appetite. Staff communicated effectively with people, responded to their needs promptly, and treated them with genuine kindness and respect.

Staff were trained in how to protect people from the risk of abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place which included the checking of references.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. Staff knew each person well and

understood how people may feel when they were unwell or approaching the end of their life. They responded well to people's communication needs and worked in a holistic and multidisciplinary way. Plans in regard to all aspects of their medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people according to their individual plans and worked together to meet people's needs. This included overcoming barriers to enable people to have positive experiences near the end of their lives. There were some limitations with the use of the computer patient electronic recording system but this had been identified by the service and was being addressed and managed by a working group.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005 requirements.

People's feedback was actively sought, encouraged and acted on. People and relatives were overwhelmingly positive about the service they received. They told us they were extremely satisfied about the staff approach and about how their care and treatment was delivered. Staff approach was kind, compassionate and pro-active.

People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent before they supported them. Staff pre-empted and responded to people's individual needs and requirements and tailored support to suit them including sign posting to external services.

The environment was well designed, welcoming, well maintained and clean and suited people's needs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People were protected from the risk of abuse and harm by robust systems.

Risk assessments were centred around people's individual needs and there were always sufficient staff on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

The environment was secure and well maintained and fit for purpose.

People could be assured their medicines were managed safely.

Good



Is the service effective?

The service was effective.

People benefitted from knowledgeable and motivated staff who were valued and supported to "Be the best we can be" and worked with an ethos of "What else can we do for people?"

Staff were well trained and had an excellent knowledge of each person and how to meet their specific support needs. Staff training and sharing knowledge was important to the service and delivered via a pro-active and forward thinking on-site academy.

People benefitted from staff who understood how to provide care with people's best interests at the heart of their work. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

Outstanding



Is the service caring?

The service was caring.

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. People valued their relationship with the staff team who often performed beyond the scope of their duties and pre-empted people's emotional needs.

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

People were consulted and fully involved in their care and treatment and their wishes were respected.

The service provided good end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

Outstanding



Is the service responsive?

The service was responsive.

Outstanding



Summary of findings

People, families, friends and health professionals were able to gain support at any time and receive personalised, responsive care from staff with outstanding skills and knowledge.

People benefitted from person-centred care based on best practice and focussed on continuous improvement. People's care and support was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them.

The service had a wide range of ways to involve people and their families, stimulate their engagement and provide support.

People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life.

The service took a vital and key role in the local community. People, their families and friends were actively encouraged, enabled and supported to engage with events outside of the service.

Is the service well-led?

The service was exceptionally well led.

People described the leadership of the service as, "Fantastic" and "So focussed on helping people as much as possible".

The leadership team promoted an open and positive culture that placed people and staff at the heart of the service and ensured this was put into practice by all.

The leadership team promoted strong values based on holistic person-centred care and inspired staff to work in partnership with people.

Staff were supported, valued and inspired under the leadership of the registered manager and clinical director.

Strong emphasis was placed on continuous improvement of the service and best practice. Ideas from staff of all levels had been encouraged and implemented to drive service improvements.

The service worked in partnership with other organisations and professionals to ensure they followed best practice and provided a high quality service and supported other services to do the same.

Outstanding



St Margaret's Somerset Hospice - Taunton

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 carried out 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 was carried out on 7, 9 and 10 December 2015 and was unannounced. The inspection team consisted of one inspector, a pharmacist inspector and a specialist advisor in palliative care.

Before our inspection we looked at records that were sent to us by the registered manager to inform us of significant changes and events. We reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

At the last inspection carried out on 3 January 2014 we did not identify any concerns with the care provided to people.

We spoke with one person who was staying in the IPU and two relatives, two people receiving care in their own home, their relative and a friend and six people who used the day centre, community services and advice line. We spoke to five volunteers across the service, five health care assistants and senior health care assistants, seven nursing staff including community nurse specialists, two clinical co-ordinators in the CRC who managed calls to the 24 hour

advice/referral line, the spiritual care co-ordinator and volunteer, head chef and three medical staff, an occupational therapist and a social worker. We spoke with the registered manager, the clinical director, the lead IPU nurse, head of human resources and the human resources co-ordinator and the education co-ordinator. We contacted two GPs who worked with the service for their feedback about St Margaret's Hospice.

We looked at the premises. We looked at eight sets of records that related to people's care (five on the in patient unit, two in the community and one in the day centre) and examined four people's medicines charts. We looked at people's assessments of needs and care plans and observed care. We consulted documentation that related to staff management, training and three staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and the activities programme. We observed a 'ward round', spent time in the day centre and visited two people receiving a service in their own homes with their permission. We also spent time in the Centralised Referral Centre (CRC) and attended a multidisciplinary team meeting (MDT). We sampled the services' policies and procedures.

During our inspection we looked at the systems in place for managing medicines; spoke to six members of staff involved with prescribing and giving people their medicines, including the pharmacist lead nurse, looked at eight people's medicines charts and spoke to three people using the service and one person's relative in relation to medicines management.

Is the service safe?

Our findings

People told us they felt safe in the service. Comments included, "I feel so much more relaxed knowing that I am safe and there are people who know what they are doing. I don't have to worry anymore" and "If something is not right I know it will be dealt with. What a versatile lot they all are, if all hospices are like this then we are a lucky country." Relatives comments included, "I am staying here and I can just ring the bell if I want anything or just to talk, anytime. I feel so much better that I am involved in the care but I don't have all the responsibility that goes with it. I can totally trust them here." Relatives had also sent feedback to the hospice about the day centre including comments such as, "We truly can't express enough how much one day a week has lifted our spirits. We have a few hours to spend together knowing that [person's name] is being well cared for safely."

Effective systems were in place for obtaining medicines. Staff ordered medicines from a hospital pharmacy. There was a daily delivery service and medicines ordered before 10am were delivered later that day. Staff told us the system worked well.

Arrangements were in place to obtain medicines more quickly from a community pharmacy if necessary, for example if someone needed medicines to enable them to go home very quickly. Staff had information detailing which pharmacies stocked medicines for use in end of life care, so they could obtain these medicines quickly. People could be confident their medicines would be available for them.

A pharmacist from the supplying hospital visited the hospice once a week and checked the prescription and administration charts. The pharmacist was not part of the multidisciplinary team meetings but staff told us they were always able to contact them for advice. This helped to ensure that staff managed medicines safely.

There was good medicine management. Staff checked and recorded the medicines people were prescribed when they came to the hospice to make sure they would continue to receive the correct medicines. The pharmacist checked these records as part of their weekly visit. This helped to ensure people received their prescribed medicines.

Staff prescribed medicines on specifically designed prescription and administration charts. Staff recorded the medicines they had given or used a code to record the

reason if they had not given a medicine. There was a separate chart for medicines given via a syringe driver. Staff made regular checks of the syringe driver to make sure it was operating safely and documented these checks. Some people were prescribed pain-relieving patches that lasted for more than one day. Staff always changed the pain relieving patches at the same time of day and checked whether the patches were still in place. This was to ensure people received their pain relief effectively.

We saw staff give three people some of their lunchtime medicines. Staff used a safe method and talked to people about their medicines, asking if they needed those given 'when required'. People were complimentary about their care. Two people told us the staff were excellent in the way they looked after the medicines and said they were able to ask for pain relief when they needed it, without waiting for a specified medicine time. Staff told us they encouraged to people to ring their call bell and ask for pain relief rather than waiting for a designated time. People were able to self-administer their medicines if they wished to and staff had assessed they were able to do so safely. No-one was doing this at the time of our inspection.

Medicines were stored safely within a secure treatment room. We recommended that staff review the security of some medicines cupboards to ensure it follows current best practice. Controlled drugs, which need additional security because of their potential for abuse, were stored securely. A medicines refrigerator was available. Staff recorded the temperature twice daily and these were in the safe range for storing medicines, although we saw there had been some gaps in these records. Emergency drugs and equipment were available. Staff checked these weekly.

Up to date references were available with information for staff on the safe use of medicines. Comprehensive policies and procedures were in place. Staff reported any medicines errors; these were investigated and any action taken was documented. A drug and therapeutics committee met twice a year and discussed medicines issues. There was a review of any medicines incidents, the investigation and any further action needed.

Staff carried out audits to check the quality of their practice. Minutes of a clinical audit meeting held in October 2015 showed proposed audits and those undertaken recently. There was a summary of actions to be taken from this meeting which showed. The service was following national guidelines to ensure the safe use and disposal of

Is the service safe?

sharps. Sharps bins were all dated, semi closed and stored safely. Oral syringes were clearly available for the oral administration of medications separate to other types of syringes.

There was a housekeeping team and an infection control lead nurse. The infection control lead nurse kept up to date with national guidelines and research to ensure people were receiving safe care. They were involved in ensuring that clinical staff were up to date with their annual mandatory infection control training and they carried out regular audits. For example, they had identified that a recurring sharps spillage was a manufacturer, not a practice issue and that it required solving to ensure the sharps bin provided secure protection. The information had been shared with the infection control forum to ensure it would not happen again. They attended the national Hospice Infection Control Forum, chaired the South West Infection Control Forum and worked with the Lead Health Protection Practitioner for Public Health England South West to share best practice through a formal document agreement. For example, the policy for a particular infection screening process had recently been reviewed to reflect latest national guidance. The PIR stated there had been no episodes of hospice acquired infections in the last four years. The kitchen had received a five star rating from environmental health inspections.

The clinical areas and premises were very clean, organised and uncluttered. Waste bins were pedal operated, hand gel was easily available and sinks were wheelchair accessible. Systems were in place to make sure the staff were aware when a person had an infection. People's rooms were deep-cleaned using steam cleaning equipment before any admission. Systems in place for the segregation of laundry and the management of waste were implemented appropriately. Staff wore appropriate personal protective equipment (PPE) which was in ample supply. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe. These areas were regularly audited including hand washing.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks that included clear guidance for staff to follow. Staff understood how they should respond to a range of different emergencies including fire, and fire training was part of their induction. Staff took part in regular fire drills

which helped them to remember the procedures and there was appropriate signage about exits and fire equipment throughout the home. Fire safety equipment had been serviced and was regularly checked. Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. Maintenance issues were dealt with in a timely manner.

Staff knew how to identify abuse and how to respond and report internally and externally. Staff knew how to access the safeguarding of adults and whistle blowing policies. These policies were up to date and reflected the guidance provided by the local authority. Staff told us the whistle blowing policy was included in their staff handbook on employment and described an incident where the whistle blowing policy had been used effectively. This had resulted in their concerns being addressed, so they could be confident people were cared for safely.

Staff training records confirmed that training in the safeguarding of adults was part of the induction for all members of staff. We looked at one safeguarding example. There was clear documentation showing that the issues had been taken seriously and that appropriate actions were taken as a result. The person had been involved in the process and learning points and recommendations had been actioned. For example, to ensure that where appropriate important confidential information was shared with relevant practitioners to keep people and staff safe. The hospice also used a computer system which enabled alerts to be flagged up. For example, to clarify who people wanted information to be shared with, who was identified as the main advocate for people and issues relating to family dynamics.

There were sufficient care staff on duty, to support and care for people in the In Patient Unit and Central Referral Centre and community services. The service employed around 70 plus staff. The hospice used a dependency tool to ensure people's needs could be met by sufficient staffing levels on the IPU. The PIR stated that current staffing levels were above the required national NHS guidelines 'Safer Staffing'. Four of the IPU beds were funded by the local authority through 'continuing health care' (CHC). CHC could also be approached for further funding for additional staff for one to one care where necessary. There was an Assistant Practitioner scheme which was at foundation level. This

Is the service safe?

role was a level above a health care assistant and under a registered nurse. This enabled them to have a higher level of skills to assist the nurses. There was one practitioner in this Taunton hospice and three at the St Margaret's Yeovil site. These staff had input into health care assistant training and management and offered higher clinical skills and support for the nurses.

Staff worked in close collaboration with the consultant in palliative care medicine. A team of doctors worked across all services and visited people in all areas including the community. One of the doctors was always on call at weekends and overnight for advice with a consultant in palliative medicine consistently available for further advice if needed. Rotas indicated there were sufficient staff. The IPU lead nurse told us the usual staffing level was two registered nurses with five health care assistants supported by the ward clerk and a co-ordinated, trained team of volunteers. Staff told us there were enough staff to meet people's needs, including at times they preferred. Further clinical volunteers were being recruited as part of a new volunteer strategy to provide patients identified as being at risk of harm with one to one supervision to maintain their safety whilst freeing up other clinical staff. Staff were available to help people at various times on the IPU depending on their wishes and there was a sense of calm so that people did not feel rushed.

Community specialist nurses worked between the community and central referral centre. They said this gave them a good insight into problem solving issues that commonly came up in the community and how to manage them effectively. One staff member said, "We are always looking at ways to be better and smarter, for example the interchange between teams helps with staff learning and future opportunities and gives a good skill mix in the community as well as the more acute area." Staff felt there

were enough community staff to enable them to work out the frequency of visits due to patient need. A new MDT assistant role had been developed to prioritise community visits and assist the multidisciplinary community team.

Safe recruitment procedures were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established they were suitable to work with people. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and were obtained from their most recent employer. Where staff moved within the organisation a full recruitment process was done. If conditions of employment were imposed these were checked as completed prior to new staff starting work. Disciplinary procedures were in place to ensure staff respected their code of conduct. This ensured people and their advocates could be confident that staff were of good character and fit to carry out their duties safely.

People were protected and their freedom supported and respected because risk of possible harm was well managed. Risk assessments had been carried out to identify and manage people's individual risk but also with regard to their needs and wishes at the end of their life. The computer care planning system included risk assessments such as falls, dietary and mobility and tissue viability. For example, care plans showed how people were to be mobilised safely and how to minimise falls. Appropriate equipment and prevention methods were followed for people at risk of skin damage from pressure. Staff handover sheets documented clearly people's risks and staff were aware of the risks for each individual. Staff ensured that people had their call bells within easy reach so that staff could respond when they needed help. Measures were in place to keep people as safe as possible.



Is the service effective?

Our findings

People said the staff gave them the care they needed and had the knowledge and skills to carry out their roles effectively. People felt the service was outstanding. One relative said, "It's so reassuring to know that I don't have to worry anymore about how we are going to cope or what is happening. I am so thankful for the expertise the staff have. I only have to ring and they will come just for a chat."

People praised the clinical team, one person in the IPU said, "[The Drs name] is absolutely magnificent. Everything has been explained to me. Everyone has something to give, even the window cleaner does a soapy smiley face on my window. It's the detail." People in the community said they were so relieved when the community nurse specialists visited. One relative said, "It makes it all a little less terrible. They give you a sense of security that someone knows what is happening and what to do." A GP said, "Community services provide an effective and accessible support to people within their own homes, we have good working relationships with community nurses."

The hospice actively supported staff to ensure people experienced a good quality of life. For example, there was a dementia care lead nurse/champion and there were dementia friendly facilities within the hospice. For example, "This is Me" documentation which is a resource from the Alzheimers Society was used to enable staff to find out more about people and this was used to provide care and develop communication. The hospice had bought gardening equipment and fragrant plants, pictures for communication and media equipment to help staff engage with people living with dementia at the end of their lives.

The lead nurse role included implementing training, advise and develop a shadowing scheme for staff from a dementia care home and the hospice to share their experiences. The hospice had links with local dementia units and staff were receiving on-going training with completion of training to all clinicians scheduled for August 2016. Much had already been completed by a multidisciplinary group of staff and included a session from a dementia nurse who works at a specialist dementia unit. Their session covered symptoms, medication, practical ways to help and how best to communicate with dementia patients. It was particularly well evaluated by staff as they brought "so much first-hand experience to the session". In relation to people living with dementia, preventative measures, in the least restrictive

way, had been put in place to prevent further falls which may include one to one supervision with a member of staff. For example, one person was able to make decisions about eating and drinking and could feed themselves but required supervision to prevent them falling. The family were very reassured by this and were happy to help with the supervision when visiting. The volunteer strategy included training volunteers to sit with people living with dementia who are at risk of falling as well as supporting patients with dementia.

Another project had involved engaging with the local homeless community and staff to deliver training to carers from a homeless charity. The education co-ordinator said how amazing it had been to see the light bulb moment when these staff realised how they could give better care for end of life. They now met monthly and local homeless charity carers were now accessing the hospice advice line and improving end of life care for the local homeless community. Staff said that St Margaret's were always thinking, "What else can we do?" Everyone could feed in ideas. For example, there was a Skype Business project where meetings could be held on screen remotely for education induction advice, staff in the community or for private tutorials.

There was an excellent training programme run by the hospice academy led by the education team. This was described as a "regionally acclaimed and comprehensive academy programme to help staff increase confidence and competence in leading, co-ordinating and delivering high quality care". The hospice academy programme offered internal and external courses on a range of topics such as, what can I say and how do I say it, ethical and legal dilemmas in palliative care, dementia awareness, symptom control, syringe pumps and end of life champions which was aimed at nursing home staff in the community. Many people were cared for in care homes and the community staff encouraged them to work together, learn and take up training. This meant the hospice staff were sharing information to ensure people they provided a service for received the best care possible from others outside the hospice service.

Staff said they were always looking for opportunities to offer end of life training. The education co-ordinator said it was important to constantly evaluate and change practice through learning. The hospice also offered placement to nursing students from local universities, four at any one



Is the service effective?

time, and offered in-house mentorship and training. This scheme was subject to tri-annual reviews to make sure staff were competent to train effectively. They also facilitated return to nursing schemes and return to practice placements. A desk was also rented out to a research and study support role. They attended clinical skills induction days and enabled staff to access online journals, projects and literary searches. We heard of discussions facilitated with staff about the use of e-cigarettes for people within the hospice setting, for example and offers of proof reading work for staff academic projects. This meant staff were encouraged to gain further education and follow ideas they were passionate about to further improve people's care. St Margaret's Hospice, Taunton, have four nurses who are nurse prescribers in the community. This enabled people to have quicker access to medication which enabled more effective symptom control.

Staff told us how supportive the hospice was in developing their knowledge. For example, one staff member said, "They really do encourage people to work to their full potential. It has been a great experience for myself and I feel very valued." They were being supported to visit the unit in Yeovil to share expertise and implement any good practice. One staff member had been supported to train up from administrative work through to completing their health care assistant training and was now a training assessor themselves.

New care and nursing staff had a thorough induction before they started working at the service. This included the shadowing of more experienced staff until they could demonstrate they had attained the level of competency required for their role. Competency checks were carried out regarding personal care and the administration of medicines. Staff were provided with a booklet that contained comprehensive information about the code of conduct and standards the provider expected them to uphold. We looked at a new starter appraisal. This included a competency check about medication administration showing the staff member had been appraised and was competent following reflection. There was a separate induction for each team such as the catering team. This included the use of specialist equipment and future individual goals such as to gain further training in presenting puree meals. The catering staff member had

also given a talk about artisan bread in the day centre. Another staff member had completed Doppler (a particular ultrasound method) training as part of their training goal and booked wound care training.

Annual appraisals involved staff self appraisal and pre-meeting preparation. Objectives were then set for the coming year. All mandatory training was managed on a computer system which could monitor who was due or had done training. All staff were up to date. This was reported on at the clinical operations meeting. All staff reported having annual appraisals and having consequent objectives to fulfil, which they felt supported on. Staff were further supported through counselling opportunities, a staff wellbeing and stress management leaflet, health promotions and health surveys. They also received de-briefs where necessary to manage difficult working situations. Wellbeing and mindfulness training had recently been included in the hospice mandatory training. Staff said they loved to work at the hospice. Comments included, "They are all my guardian angels", "I feel privileged to work here. It is a great environment to be in. It is the best job I have ever had. It is amazing what a happy place it is to work in" and "I love it here, there is such a level of personal support and working as a team."

Bank staff (staff used on an ad hoc basis to cover vacant shifts) had the same induction, the hospice mainly used their own bank staff but did use agency staff for specifically funded patients, often motor neurone disease related. Not all staff were using the orientation checklist for agency staff meaning information giving was sometimes dependant upon each member of staff being thorough. We fed this back to the registered manager who would ensure this was done.

There was strong emphasis on the importance of good nutrition and hydration with focus on bespoke provision for people at the end of their lives. There was a flexible approach to meal times in that there were no set meal times and the hospice was able to meet people's special dietary requirements as well as likes and dislikes. There were also kitchen facilities for family and friends and opportunity for family to enjoy meals with people for a nominal charge. A snack trolley was always available on the IPU. People praised the food that was served; their comments included, "The soups are a dream. I'm having



Is the service effective?

build up drinks and they make sure there are no lumps for me". People felt there were plenty of options and they were able to request favourites that were not on the week's menu.

People were consulted when menus were planned and specific requests were taken into account. Menus were extensive and changed weekly. They stated whether particular dishes included possible allergens and offered a variety of alternative dishes. The catering staff were aware of each person's individual dietary needs and allergies and had access to people's nutritional details on the computer system. People had special diets such as pureed meals or soft diet when appropriate. The chef understood when people who may feel unwell may lose their appetite. The catering staff were also involved in monitoring how people were managing with their food and recorded what was eaten every meal. They could then offer different choices and suggestions for individuals. Produce was often local including grown on site.

One person told us how they were using artificial saliva spray and crushed ice and that their mouth felt more comfortable. People were supported by staff with eating and drinking when they needed encouragement. Handover sheets recorded who required assistance such as one person who had a soft, moist diet. A note also stated they liked fish and sausages and this was being looked at so it could be given appropriately. One person had difficulty swallowing and was having slightly thickened fluids and had been assessed by the speech and language therapist. Another person had sensory limitations so staff were using red crockery so they could be more independent. Hot and cold drinks were offered to people and each person in the IPU and day centre by volunteers. People who remained in bed had a jug of water or juice of their choice that was within reach and replenished throughout the day and night. People's individual wishes were taken into account such as how they liked to be positioned and what they liked or were able to eat. For example, every patient admitted met the chef on duty and information was collated on their likes, dislikes, specific requirements, allergies etc. The chefs delivered the food and subsequently recorded electronically everything eaten so intake could be monitored. Where people had risks associated with fluid intake there were charts showing how

much people were having. For example, one person was having their fluid restricted for clinical reasons. The relative was fully engaged with the process and was involved in monitoring the correct safe input.

All staff were able to discuss people's needs in great detail. They shared information using the new computer system. Staff on the IPU were able to tell us the correct, up to date information about people's care but were not always able to find the record on the computer system, depending where it had been inputted. Although the system had some identified limitations on the IPU it worked very well in enabling staff to instantly share information across the service. Staff on the IPU cared for named people divided into the blue and red team so they saw the same staff as much as possible for continuity. The unit was supported by two consultants. All clinical staff could input and access full information about people's journeys. For example, each clinical area had a specific page which showed them any tasks or communication between areas. One staff member in the day centre said, "[The system] is amazing. I can get people's full story so I know everything before the person arrives and they don't have to go through anything again which could be distressing." Another nurse said it helped them not to feel isolated in the community. This system ensured staff knew if people had had contact with the advice line, the day centre, community nurses and the IPU and other health professionals. The most recent contact and outcomes would be at the top of the screen and other details could be accessed. Staff could also access information on their lap tops and smart phones in the community. The staff used detailed handover sheets which highlighted diagnosis, active problems and daily updates. For example, one person's details stated they were unable to walk but could stand and a wound had been identified and was being followed up. This system ensured effective continuity of care and that staff were knowledgeable about people's individual care and treatment.

Staff knew how each person communicated and this was reflected in their records so all staff would know. During the ward round staff spoke at a slower pace waiting for one person to recover from breathlessness before continuing. Nursing staff returned to see the person to ensure they had understood the information. They knew how people liked to be referred to and what their family support and dynamics was. Alerts appeared on the computer to reflect people's wishes such as who to contact or not to give information to within families if there were disputes. Where



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people were particularly anxious staff knew what techniques people used, such as visual imagery, encouragement or sometimes additional medication. One person was hard of hearing and staff kept their conversations simple but informative. One person said, "If I can understand something I can hack it and I can always ask, they are all wonderful."

Each person in the IPU had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered. During the ward round the clinical team and the patient discussed how the person felt about medication changes and routes and what they would like to do. The person said, "As long as they understood what was going on they were happy with the changes." The person was fully involved in the decision and their wish was respected. They told us they felt confident they could discuss any issues again and change their mind. When people had physical examinations, the medical staff maintained eye contact with the person to assess whether they were in discomfort and responded to them accordingly. One conversation on the ward round was stopped as the team recognised the person was in pain. A visual pain assessment tool was outside each person's room. This was managed well and the staff returned to the person when they were more comfortable. They spent time reassuring them that they could call staff at any time. The PIR told us the hospice used a range of non pharmacological measures to relieve pain and distress including acupuncture, music therapy, guided imagery and psychological interventions.

There was a main weekly ward round on the IPU. Records were written directly into the computer system. There were also multidisciplinary meetings (MDT) held every week, one for the IPU and one for the community. The meeting included a full range of disciplines such as occupational therapists, clinicians, social workers and physiotherapists. For example, discussions included people's advanced care planning such as declining further investigations, funding, equipment and preparations for people who wanted to aim for being cared for at home. MDT agreed decisions were recorded on the handover sheet and updated each week. For example, "aiming to discharge to a nursing home", "continue with symptom management", "family support", "monitor response to steroids" and "await test results". Therefore staff were all aware of people's goals and wishes. During the community MDT meeting we saw how detailed

the care for people was. Care was considered in a holistic way and there were discussions about how other services could be approached for further support such as the Salvation Army, childrens' services for further support especially around Christmas and emotional support. For example, the consultant was arranging a further visit to a young family and to another person who was distressed to discuss their diagnosis again in their own home. This was to support them and give them informed knowledge in a sensitive way that would enable them to have realistic expectations that would help them cope more effectively.

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. The registered manager demonstrated a good understanding of the processes to follow. Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. When people had been unable to leave unaccompanied and needed continuous supervision to ensure they remained safe, their mental capacity had been assessed appropriately. This ensured people's rights to make their own decisions were respected and promoted when applicable.

When people had been assessed as being unable to make relevant and specific decisions, applications for the authorisation to restrict their freedom in their best interest had been submitted to the DoLS office. The multidisciplinary team had considered the least restrictive options for each individual. Comprehensive records were made of how appropriate meetings had been held to discuss people's best interest and make a decision on their



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behalf as per the requirements of the MCA. For example, there had been clear discussions including the person's family about when to cease further treatment and decline any transfers to hospital in people's best interests.

For example, one relative told us how although there was significant family distress at how to adjust to this change of focus in [the person's] care they reported [the person] was much more relaxed saying they now felt, "peaceful and everyone was so kind". Staff could explain what might constitute a 'best interest decision' and the criteria required to undertake MCA assessment. Staff sought and obtained people's consent before they supported them. One person said, "They always ask permission before they do anything and discuss any changes with me so I am happy with the decision." When people declined support, for example when they preferred their own company, their wishes were respected. During a meeting staff discussed one person in the community who was not following their care plan. They ensured the person had the knowledge they needed to make their choices and support contacts. They said they wanted to be sure the person was getting the care and support they wanted but also acknowledged that staff may need support when people made difficult decisions.

People were referred to healthcare professionals when necessary. For example, before a person had returned home, the service's occupational therapist had visited their home to assess what equipment and adaptations may be required and ensure this was provided. Staff in the IPU were following a mobility plan which reflected the care the person would receive at home for continuity. Staff worked in close partnership with people's GPs when they supported people in the community. During the multidisciplinary meeting we heard how a GP was supporting a person in difficult circumstances. The community specialist nurse had met privately with the GP to discuss how to provide care in the person's best interest taking into account their wishes and discussing alternative options for symptom control. The service's community nurse specialists were 'attached' to GP practices and attended regular 'Gold Standards Framework meetings' where they discussed care options for people known to the services and identified appropriate referrals.

All organisations providing end of life care are expected to adopt a co-ordinated process such as the Gold Standards Framework, which is a systematic, evidence based

approach, developed to improve quality of care for patients with a life-limiting illness. People were referred appropriately and without delay to consultants such as neurologists and oncologists, to hospital specialist teams such as chronic pain team and specialist nurses such as tissue viability nurses. This ensured that staff responded effectively when people's health needs changed. The computer system showed how these health professionals could also access the records. For example, a visit from a renal supportive care nurse had recorded discussions with the person and their family. They had requested that there were Christmas decorations in their side room when they arrived from the hospital and this had happened.

The premises had been designed and decorated taking people's physical and psychological needs in consideration. They were spacious, well-lit, and decorated in calming tones. Corridors were wide, with handrails to help people move around when necessary. All doors had been designed for easy access by people in wheelchairs.

The reception was welcoming with ample seating area, a shop and facilities for refreshments. People were welcomed by a ward volunteer. There was a sitting room with games to keep visiting children entertained. The attractive gardens that surrounded the premises were maintained to high standards and had been designed to promote an atmosphere of peace and comfort. All rooms had pleasing views of the gardens and included ample seating areas for people to relax in. A group of local marines arrived to decorate the outside Christmas tree for people to enjoy.

There was a dedicated, large room for the central referral centre (CRC) along from the IPU with multiple computer and telephone access. There were two four bedded bays and eight single en-suite rooms on the IPU. The nurses' office and nurses' station were situated in the IPU so staff were able to have immediate access to people when they needed help. There were rooms for complementary therapy and counselling, outpatient clinics, a physiotherapy gym and lymphoedema clinics. All bedrooms were spacious, had attractive views, were well equipped including a telephone and specifically designed to provide a calming environment. Colourful eiderdowns had been kindly made by a local quilting group to promote a homely environment. The IPU had a sanctuary, safe multi-faith space at the heart of the unit.



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There were private and quiet areas for family to reflect and have time together where they could stay overnight, including a “Sunflower Suite”. The Sunflower Suite was a one bedroomed, self contained flat to facilitate preparation for discharge for people and their families. People were able to prepare for discharge and work through any concerns to reduce anxiety with staff support when they needed it. For example, setting goals for their medication management and meal preparation. This enabled families to have the opportunity to be independent of the service but close enough to call in help and advice.

The day centre was accommodated in a vast well-lit area that included comfortable sofas, a kitchen, armchairs, tables and storage for art and crafts materials. All office space provided a pleasant environment for staff to work in and there were training rooms fully equipped in the hospice academy. There was a room for complementary therapy and another for the chronic lymphoedema clinic.



Is the service caring?

Our findings

People said the hospice provided outstanding care. Overwhelmingly, they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were overwhelmingly positive. People told us, “[The staff] are lovely, they treat you so well. They really care which makes you feel better”, “They are so patient, I wouldn’t change anything”, “[The staff] are all so welcoming, so happy to help. This is genuinely one of the nicest places I have been” and “[The staff] are always there reassuring you, even if you don’t want to talk, it’s ok.”

People’s testimonies included, “I personally will be forever indebted not only to the counsellors but to all the hospice staff who so lovingly cared for [relatives’ name] during their last two weeks of life”, “Excellent ambience, calming, relaxing and therapeutic. Nothing was too much trouble and [the staff] even made me a cup of tea when the treatment had finished, which helped me to relax and sleep.” Many people had written that they could not think of any ways to improve the service. Relatives told us, “You feel so peaceful here and everyone is so kind” and when describing the admission procedure one relative commented, “The nurse really listened, they were lovely”.

There was an outstanding spiritual support service which was inclusive and available to all in a person centred way. The hospice had a spiritual care co-ordinator whose focus was, “Not upon the creed but on the spiritual requirement for every patient and their families. This might be religious or something else, perhaps art or nature”. They were ordained within the Church of England and could provide all of the services related to this. Their model of care was to incorporate all models and beliefs of body, mind and spirit accessing the sanctuary space at the hospice if appropriate. They told us they let each person lead, facilitating what they referred to as ‘soul midwifery’ allowing the patient to give birth to what was on their mind. They were aware of every admission and ensured both people and their relatives and carers had access to them. They worked closely with the hospice team, providing support for people, relatives and staff every day of the year in both the Taunton and Yeovil hospices. They did not provide counselling but saw themselves as a “bolthole for all”.

The spiritual care co-ordinator was currently devising ‘spiritual care competencies’ which would be used by all the teams within the hospice, clinical and non-clinical. One relative spoke of the relief they felt having received support. This couple were due to celebrate their wedding anniversary. The hospice spiritual care co-ordinator had offered to provide them both with a blessing on that day. Staff had provided the couple with a ‘Christmas Day’ for the person and their family the day prior to our inspection.

The hospice had a “Sanctuary” space which was a neutral spiritual space open to all, offering a place to draw apart and be still. The spiritual co-ordinator said in the hospice leaflet, “It is important that everyone has time and space to ‘find sanctuary’, that is to nourish our emotional and spiritual selves in order that we may be strengthened and equipped to face the challenges of living with a life-limiting illness, whether directly or indirectly.” The Sanctuaries were open to all 24 hours a day. Each room had small multi-faith symbols discreetly available to those who wished to use them for prayer and worship and a wide range of religious services and funerals could be carried out by the hospice spiritual co-ordinator.

Staff knew how to respond to each person’s diverse cultural and spiritual needs in a caring and compassionate way. An interpreting and advocacy service was also available for independent support for people and the PIR stated there was access to Russian and Polish speakers. Staff were able to use a translator application on an iPad. There were examples of how the hospice had met the spiritual needs of people at the end of their lives with various beliefs. For example, enabling a Muslim family to care for their loved one according to the person’s wishes, facilitating a multi faith wedding and a Hindu wake. The hospice had representatives for a range of faiths within the volunteer team including a prison advocate, a counsellor working with alcohol and substance abuse, mental health and links with local churches.

Visitors were welcome at any time. Relatives were able to bring people’s pets to visit their owners in the service, to bring them comfort and lift their spirits. Staff told us, “There is a lovely atmosphere, all sorts of lovely things happen. We try and go that extra mile.” And “We have had dogs to visit their owners and we have had a parrot stay here.” Ginger Tom, the cat, was adopted by the hospice. A horse was brought to look through the window at his owner. Such measures ensured that people could retain and find



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comfort in routines that were familiar to them. Where people had requested assistance to fulfil an experience such as finishing art work, attending a wedding or national event, staff had worked to ensure they happened. For example, arranging travel with appropriate equipment, staff to accompany people and assist with pain control and organising pet care.

There was a homely feel to the service in the IPU and the day centre. A volunteer told us, "I love coming here. It is a privilege to meet the patients, it is so interesting. They have led such interesting lives." All our observation and listening identified a consistent, caring attitude demonstrated by all staff at all times.

There was a social atmosphere where people were encouraged to chat if they wished and were listened to. Staff were smiling and engaging. They stopped to listen to people and responded to them with genuine interest. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they spoke with them. For example, they recognised that attendance at the day centre for the first time could be an anxious time. Staff gently helped people to settle in, telling them what was available and introducing them to people. One staff member was sat having a cup of tea with a person who was new to the day centre. A staff member said, "Anxiety is our biggest issue. We help people settle in, sit with them and help them relax and chat. It's not all about the diagnosis." There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names.

Staff were attentive to people's needs including their emotional wellbeing. For example, the community nurse specialist tried to ensure continuity so that people met the same staff and built up a safe, open relationship. They knew in great detail where people were coming from and how they were managing their diagnosis and end of life management. For example, some people preferred to be more independent and others required more practical support. Staff skilfully managed conversations in ways that made people feel comfortable and discussed topics when people felt ready. Staff showed kindness and knew how to convey their empathy when people faced challenging situations. They allowed time for relatives to talk to them alone and comforted them appropriately and looked at

additional small ways in which they could be of help, such as picking up a prescription or following up on a question. For example, ensuring they visited at times which were convenient and parking in appropriate places.

Staff used appropriate touch when needed such as gently holding a person's hand and always checked to assess whether such gestures of empathy were welcomed by people. They offered companionship to people who stayed in their bedrooms on the IPU when they considered that people may not wish to be on their own and promoted the use of volunteer 'Sunflower friends'. The staff responded quickly to people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected and updated in their care plans. The multidisciplinary team discussed how to support people who were struggling to come to terms with situations.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. There was a range of comprehensive information leaflets that included in patient stay, last days of life, integrated palliative care, consent, bereavement support and managing leg swelling. The leaflets made it clear that the hospice was there for people stating, "We are here for you, our door is always open." There was a quarterly St Margaret's news publication which gave personal examples of people's experiences and additional information about specific events, fundraising and opportunities for people. For example, details about a new 'Men and Sheds' group organised by volunteers to provide support for male carers sharing new activities. The service had an updated website that contained clear, comprehensive information that was user-friendly.

Face to face information was provided to people tactfully in a way that ensured people were able to make fully informed decisions. The medical team interacted with transparency and sensitivity when a person enquired whether they would be able to finish a project or aim for a particular goal.

They had ensured the person's anxiety was alleviated and had promoted a climate of trust in which the person could be confident their concerns were listened to and responded to. During handovers, meetings and after 'ward



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rounds', staff spoke about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in 'advance care plans'. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline and who they wished to be their legal representative. These advance decisions were recorded, effectively communicated to staff and respected. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. Staff were also supported where people's wishes involved treatment withdrawal and able to reflect and explore experiences and procedures based on guidance, legislation and best practice. Training was being developed to ensure staff felt competent and prepared to meet similar requests.

As staff demonstrated great understanding and empathy, people could be confident that their individual needs were met and responded to in a way that may exceed their expectations. For example, there had been such a request recently and the whole family had been involved with the hospital to ensure that the person and their family were prepared and where they wanted to be. This person arrived on the ward to Christmas decorations as they had requested with their family close by.

All staff knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal needs. People were assisted with their personal care needs in a way that respected their dignity.

People followed their preferred routine, for example people chose meals and snacks whenever they wanted or felt like eating, stayed up late, or had a bath at any particular time of the day or night. The senior IPU nurse told us, "If a person wishes to die at home, we do everything possible to make sure this happens, as the person is the decision maker. We make plans for discharge as soon as possible so they are ready to go home for example, when their pain management has become stable."



Is the service responsive?

Our findings

People and their relatives told us that the way staff responded to their needs was, “Outstanding”, “Amazing”, “Easy” and “Without delay, we are so lucky”. They felt the 24 hour advice line and one stop referral centre were a lifeline and enabled people in the community especially to feel connected to support, advice and feel less anxious.

There was an extensive collection of testimonies and feedback from people, friends and relatives who expressed how responsive the staff had been to people’s needs. All were extremely positive and thanked the staff. Recent comments on the national review website included, “[The care] was tailored to me, all aspects (personality, childhood upbringing, health etc) all discussed before commencing treatment” and “I personally will be forever indebted not only to the counsellors but to all the hospice staff who so lovingly cared for [relatives’ name] during their last two weeks of life.”

The service was clear about their local demographic and what the needs of the local community were and followed national guidelines such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice. Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, physical, psychological and spiritual or complex end of life care needs. The average length of stay was two weeks with some people being discharged home or to a local care home.

This was recognised in the St Margaret’s ‘Hospice without Walls’ business plan. The hospice’s aim was to provide palliative care in partnership for all those in need and to play a role in enabling everyone in their community to have good end of life care. This recognised that there was a shift in focus from in patient beds to allocating resources to wherever the person chose where possible.

Phase one of the business plan resulted in a 24 hour advice line and central referral unit (CRC) being established. It also promoted a multi skilled approach to ensure people received the right care at the right time in the right place. Therefore we saw staff were encouraged to work in rotation throughout the service to support people throughout their journey. The staff working in CRC offered direct advice to carers at their time of need during working hours with an

advice line and night staff providing the service out of hours. It also allowed referral to all services with just one call. The responsiveness of the CRC had been effectively monitored. For example, administrative tasks were now carried out less by clinicians, referral times and waiting lists had been reviewed and all staff in the CRC had had specialised training. There were comprehensive guides for staff to use during their telephone shifts and these were added to for further learning.

We spent time in the CRC. There were three clinical co-ordinators and a community nurse specialist (CNS) on duty. Each member of the CNS team work around two or three shifts a month in CRC and therefore knew many of the people calling for advice and how the system worked in the community. Information available on the computer system was excellent. For example they were able to access medical team handovers of new patient so there was no chasing for information or asking people repeated questions. Medical records could be scanned in to the system also along with hospital discharge notes. Medical staff reported an extensive multidisciplinary approach to patient care, stating that initial admission was usually undertaken together by a clinician, to prevent repetition and ensure adequate information. Staff were able to accelerate referrals to NHS 111, district nurses, GPs and out of hours services. The computer system enabled staff to access planning ahead details, preferred place of death, other wishes and what decisions had already been made. One example of how the CRC was able to manage and co-ordinate care showed how they could support families in emergencies. The family were extremely grateful to the CRC staff for liaising and co-ordinating ambulance staff and an equipment company to enable someone to move downstairs safely. They were able to die at home as they chose rather than be admitted to hospital.

Staff were able to note which CNS staff member was involved with people for continuity. One person was spoken to with a lovely telephone manner and immediately the nurse they usually saw was called and a further visit booked. Another call was a relative worried about pain relief. The CNS talked them through the symptoms and gave detailed advice. They told us, “The most important thing is the person is where they want to be and happy with their decision. We explore the options and issues and then it’s about what they want.” Staff also



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added it was important to ask what people knew about St Margaret's before offering a service to understand their perception and avoid distress. We heard lots of conversations about best interests and consent.

We spent time with the community specialist nurse in the community. The community nurse specialist provided an excellent, responsive service. They managed their diaries depending on people's needs and support required. The community service provided a seven day service and consisted of a varied skill mix with nurses and health care assistants working alongside the CNS team. They provided hands on care, advice, support, signposting and symptom control to enable people to stay in their preferred place at home. The MDT meeting in the morning discussed a visit for one person and we visited them with a CNS later to discuss some issues in private with the relative as discussed in the meeting. A wide range of issues were discussed, some which the relative had not thought of such as transport in the future, the environment, benefits available and assistance with personal care. They told us how wonderful it was to be able to access the service and to know there was someone central to ring.

Specialist palliative care services worked together with primary care teams, care homes and hospital teams to ensure appropriate access to specialist palliative medical and nursing services when required. One GP sent us these comments, "We work closely with St Margaret's hospice in the palliative care of our patients. Referral pathways are easy to access over the phone. Advice lines for patients and professionals provide invaluable expert advice. This provides a very reactive and generally efficient part of their service." One nursing home were reported to be doing well with managing end of life care and the hospice team had been able to support the nursing home staff. They were now sitting with the person chatting about their time in London and confident they had all the support and equipment they needed. There was also a manager and consultant on call at all times. There was a bereavement enquiry line where people could access specialist support from the bereavement support team including signposting people to a range of external services. Support included telephone support, individual appointments, counselling, group therapy and family support.

The hospice day centre was open on a Monday, Tuesday and Wednesday by referral. Referrals could be for six or 12 weeks initially but were reviewed after three and six weeks

examining possible alternative approaches that might assist in helping the person achieve their specific goals. People first met with a member of the clinical team so their individual needs could be understood. Personalised goals, frequency and length of their attendance were discussed and agreed on. The day service also offered 'drop in' sessions for people and their carers to attend without prior booking. This ensured that staff could respond to people's needs when they arose.

The centre was person led, with suggestions from supportive staff. Activities were not prescriptive and might not actually involve practical tasks but could be discussions. The day centre provided a wide range of activities for people. This included activities people particularly liked or introduction to new experiences. For example, various hobby activities were run by a diversional therapist but there was support to also help people to make memory boxes or audio memories or talk about ways to include children in discussions. One person had put a dolls house together and enjoyed finishing the project. There was an owl visiting during our inspection. One-to-one activities were provided for people who remained in their bed on the PIU.

The senior health care assistant who managed the centre said that staff built an excellent rapport with both people and their carers and ultimately assisted any transition between the centre and in patient or community support. They had worked at the hospice for 18 years and understood how end of life care was changing with more support in the community. Staff were trying to encourage people to accept support and reduce any stigma people felt about receiving end of life care. She reported that day centre staff were able to facilitate people building their own consequent network of support. The day centre had a large turnover of people and they enjoyed seeing people become less nervous and feel more relaxed and safe over time. They told us how one particular person had really benefitted. The person had been experiencing significant difficulty accepting their terminal diagnosis. Their attendance at the day centre had resulted in them building a significant network of support, ultimately meaning they no longer required such a level of staff support. They were now sharing their experiences with a blog on the hospice website. They said how inspirational it was and hoped it would encourage and support other people and their carers. A volunteer said, "I absolutely love coming here, it is truly inspirational."



Is the service responsive?

There was excellent communication on a multidisciplinary level. The senior health care assistant said the computer system was amazing and they were able to have access to relevant information. They were able to identify any issues with people attending and had a “toolkit” of support to offer. An alert on the system for example stated that appointments were to be made through the person’s daughter which the staff did. They were able to note when some people preferred not to talk or where one person came to the centre to “offload” any worries which they felt they could not do with family and friends. One person had lost their own confidence in themselves and the staff were looking for alternative day centres following the end of the hospice programme that were suitable. People attending the day centre were clearly enjoying the day and told us it was, “Wonderful”, “Lovely and nothing is too much trouble”. They said, “I so look forward to coming here. I’m doing some flower arranging today and you can talk or not talk, whatever you like.” One person was visiting for physiotherapy support. People’s attendance was noted so that staff could follow up if people did not come. One person had not looked well. The staff member said they had looked on the system to see if the CNS team visited and was able to request a visit the next day.

The hospice offered a wide range of support for carers and their families. There were specific courses which provided practical information, explored the emotional impact, helped carers care for themselves and provided opportunities for carers to meet others. The hospice uses Quantock House which is a carer support centre whose current running costs are jointly supported by the cancer charity Macmillan cancer support.

People’s families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life. They were encouraged to attend support groups and socialise in the day centre in a comforting setting to ease their grief. This meant families could access emotional support from the service after the persons’ death.

There was a wide range of therapies that were additional to clinical available to respond to people’s relaxation and general wellbeing needs. Volunteer complementary therapists included aromatherapy, massage, reflexology, reiki, music therapy, occupational therapy and

physiotherapy. People were able to try a variety of options and choose the therapies they preferred and when they wished to have them. Sessions were recorded and people were able to request a chaperone if they wanted.

The hospice took a key role in the local community and was actively involved in building further links. There was a fundraising team who ensured the hospice maintained a high profile in the community and was regularly prominent in the local press. Links with the community were actively sought and encouraged and there were many organised events such as races, rock concerts and sales. Volunteers and staff contributed to the planning of events.

The hospice used many ways to ensure as many people as possible could be involved in giving their feedback about the service they received. A poster encouraged people to give feedback to help the hospice improve their service. This could be done by completing a suggestion card, emailing suggestions to a feedback email and submitting feedback via the St Margaret’s website. There was a new visual aid for feedback called “Your token counts” where people could put a token in the clear box which matched their general views. The caption on the box explained that the hospice were are continuously trying to improve the patient experience and asked how likely people were to recommend the service to friends and family if they needed similar care or treatment. There were four different colour tokens to represent the inpatient unit, sunflower centre, therapies and clinics and lymphoedema. Feedback cards were available nearby so that people could write explanations for their choice of slot. The feedback board in reception “You said, we did” ensured people that their comments were listened to and dealt with. For example, current comments stated, “We have to walk away from the ward to get a drink of water- the hospice now had iced water and glasses available”, “I was unhappy with the content of the lymphoedema letter- the hospice changed the wording of the letter to make it clearer for patients” and “It is difficult to find bereavement support for children- the hospice employed a family support worker to work with children and young people.” This showed they were outstanding in enabling feedback and communicating what actions had been taken.

The hospice was a member of the national website 'iWantGreatCare'. This is a tool for people to leave feedback about a service and to see other feedback about the service. St Margaret’s had a five star top rating. Comments



Is the service responsive?

recently added included, “The fact that I was able to talk openly and without any reservation about how I was feeling and what I had felt I had needed to do to help me get through the trauma of [relative’s name] passing, even though their death was expected with the outstanding support of the Hospice staff”. Another relative said, “It’s great to have people understand how dreadfully exhausted/tired I feel. I felt confident I would receive excellent care from the support team”.

Annual satisfaction surveys were carried out and responsive action was taken to address shortfalls that were identified as a result. All comments in the surveys were extremely positive about the quality of the service. Where people had raised issues such as cutlery not so clean, TV faulty, no handcream in the shop for example, these had all

been addressed. One person had suggested an ongoing “tab” for meals so relatives and friends did not have to pay individually but had an invoice later on and this had been adopted.

There was a clear complaints and concerns procedure. People were given a “Feedback, compliments and concerns” leaflet which showed them how to make a complaint through the three step process. Staff encouraged people to speak with them if they had a concern at the time or offered meetings with a senior member of clinical staff or the governance team. People were able to bring a friend or relative for support. Staff could record any concerns, however small, through the electronic system. Any concerns had been taken seriously and actions taken to address them.



Is the service well-led?

Our findings

There was an open and positive culture which focused on people. People's feedback about the way the service was led described it as, "A wonderful place where you can count on everyone you meet" and "We were all so distressed until we came here and we know we will all be ok." Staff all felt supported, lucky and privileged to work in St Margaret's.

Staff felt well supported, valued and positive about working at the hospice. Staff praised the registered manager, clinical director and leadership team for their approach and consistent, effective support based on a person centred and inclusive ethos. The leadership team was clearly linked in with the staff council to enable staff feedback to have a defined route to the trustee board. The staff council aimed to promote effective dialogue and consultation between the hospice and its employees, to enable contribution on hospice strategic objectives and provide a discussion framework for staff. For example, actions from a recent meeting included a Fit for Future project, actively seeking opinions from colleagues, updating notice boards, compiling a staff photo board and including new ideas and suggestions on the agenda. We saw that suggestions had been listened to and taken forward. For example, the use of patient alert bands indicating when a blood pressure reading on one arm was not appropriate.

Staff said they could come to the clinical team leads or any of the directors for advice or help and saw them as open and transparent. All the staff we spoke with told us they had confidence in the way the service was managed. Staff commented, "It's friendly and warm. Sad things happen here but so to do happy things" and "I feel privileged to work here, it is a great environment to be in."

All of the staff we spoke with told us they felt valued working in the service, and felt motivated to maintain high standards of care. One doctor told us how much they loved working there. Some staff loved their job so much they had worked at the hospice for 20 years, which they felt said something about the working environment. Another staff member said, "I have never heard anyone say anything negative about here" and another commented, "I enjoy working here because of the passion from everyone, the commitment, the patient focus. We are all working together."

People received care and support by staff who upheld strong values about person-centred care, and positive connections were promoted that enhanced their experience of the service. From what people told us and our observations, these principles were implemented by all staff throughout the service.

People were supported by a service where management and staff embraced new ideas about how to improve quality of care. Staff all felt listened to and involved in shaping improvement. The registered manager and clinical director involved the staff with the running of the service. Regular staff forum meetings were held where staff were invited to bring suggestions about the running of the service.

Staff told us the hospice philosophy was to continually strive for improvement and look at "What else can we do?" to improve the service for people. For example, we received information in the PIR which highlighted identified areas for improvement. A key task was to continue to look at how the computer patient electronic recording system could be improved. A working group was chaired by the Director of Governance and staff champions had been identified to monitor and work towards a re-launch of the system in April 2016. In the meantime there were paper systems in place to work around until the system was more user friendly and there had been further training for staff on input. There was a staff council with clear terms of reference. New ideas and suggestions were a regular agenda item and a recent meeting action was for council members to gain opinions for colleagues on work life balance, morale and workload. A sub group would then be set up to manage any ideas from staff.

A consultant was leading on a research study with another university on hydration in end of life care and other staff were involved with national Hospice UK projects. The aim of the research study is to evaluate the role of clinically assisted hydration in cancer patients in the last days of life. Staff told us about the hydration project. Already staff were able to give people informed choice and reduce anxiety about the level of optimum hydration and comfort based on research. One project about developing support courses for carers of community patients in a hospice setting had evolved from the government end of life strategy. St Margaret's community team had developed the project



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which supported carers emotionally and practically, for example through a cooking course aimed at male carers. These had continued for some carers post bereavement demonstrating the lasting impact of the support.

The hospice was a group member of the National Palliative Care Educators for the South West. Staff worked together with other local hospices and attended national conferences. A group of four non medical prescribers had presented a poster at the national Hospice UK conference on non medical prescribing (the prescribing of medicines by health-care professionals other than doctors). They had shown how this would have a better outcome for patients to reduce delays in accessing medication to manage symptoms. A case study was used to show what a difference this could make for people at St Margaret's and generally, such as reduced delay in receiving appropriate medication. They had also presented two other clinical innovations including family and carer support and the re-ablement approach taken with the use of the Sunflower Suites.

The hospice was working on a new volunteer strategy to enable staff to ensure people were as safe as they could be on the IPU. The HR department were leading the recruitment and training and the strategy would be closely monitored to ensure its effectiveness, for example in relation to falls. For example, increasing volunteers who would be able to provide further monitoring of people at a high risk of falls.

The PIR told us about where the hospice had received recognition of good practice. For example, St Margaret's had won the Return to Practice Employer Award 2015 and a return to practice student had been awarded a highly commended. A St Margaret's occupational therapist had received a highly commended in the "Can do attitude" award in the Somerset County Council awards 2014. The Sunflower Suite initiative received recognition at the national Hospice UK conference in 2015 with St Margaret's having input to the conference agenda relating to non medical prescribing, family and friends courses and support initiatives and their consultant partnership scheme. Many people had been able to care for their loved ones at home having used the Sunflower suite to practice supporting people and learning about how to provide practical care. This had allowed people to die in the place of their choice with loved ones who felt well supported themselves and less anxious.

There was an effective clinical governance structure that included a chief executive and the registered manager, who was the director of governance. There was a clinical quality and education committee which fed into a governance sub committee with links to the health and safety group, tissue viability group, clinical audit group and others. This meant ad hoc working parties were also set up to manage relevant topics such as a discharge working group and a group looking at the CRC.

The multidisciplinary team had looked at a "step down" process for discharge. For example, one person had been supported for discharge and preparing for a last family holiday. One week following admission, the multidisciplinary team discussed the "step down" process with the patient to identify what the patient needed to achieve in order for her to manage at home. The staff set clear goals with the patient which included the ability to self medicate, use the toilet independently, walk up a few stairs, prepare a few light meals and manage at home with a package of care. To prepare for discharge, the following day, the patient was transferred to the Sunflower Suite. This facility helped to prepare the patient and her family for discharge by enabling the patient to live independently to achieve her goals. The person was visited by a volunteer "Sunflower friend" who had been matched up with the patient to provide regular support once at home. Following two home visits with the multi-disciplinary team assistant and occupational therapist, the person was discharged home and achieved their aim of the family holiday. We were told the person said the discharge planning, step down process and time in the suite gave them the confidence that everything was in place for them to be able to manage. Another person had said, "This was a wonderful facility and made all the difference. I was able to gain complete confidence that I would be able to manage at home by spending the weekend in the suite with my husband, being independent but knowing that I could call on someone if I felt unsure about anything". The PIR was comprehensive and identified any issues we found during the inspection such as the limitations of the current electronic care planning system set up. This showed the provider had identified any issues and was making improvements.

There were robust systems to monitor the quality of the service. There was a comprehensive clinical audit programme covering a wide range of topics. For example, antimicrobial prescribing, use of steroids, prevention of



Is the service well-led?

skin pressure damage, spiritual care and pain management. The Director of Governance then completed spot checks to ensure that outcomes arising from the audit were embedded in practice. For example, there would be re-audits in drug omissions, assessment and documentation of spiritual care, management of pain and prevention of skin pressure damage and spot checks in areas such as management of constipation. Some audits were carried out regularly to ensure compliance with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care that defines clinical best practice. NICE provides specific quality statements and measures to provide service providers with definitions of high-quality care. Such audits to measure how the service performed were completed either monthly or quarterly, documented and used effectively to monitor the quality of the care provided. An annual audit report further monitored outcomes and gave updates on improvements. For example, a new constipation management leaflet was being produced.

The hospice used a benchmarking system which was a collation of information such as pressure sore occurrence and falls in comparison with other hospices in the south west. This showed the hospice had a low occurrence and higher bed occupancy in comparison. This further monitored how the service was doing and highlighted what other improvements could be made and helped to understand the demography.

Monthly management meetings took place to discuss every aspect of the service, including staff training and policy and guidelines reviews. The policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated on a continuous basis. A computerised system scheduled policies for regular reviews and these schedules were adhered to. Staff were made aware of the updates and knew where to locate the policies for guidance.

There were systems in place to manage lessons learnt. For example, there were regular significant event meetings. These discussed where care could have gone better, why an incident happened and what could be done differently. One event identified the need for improved processes when referring to specialist psychological input for example to minimise delay and another event was

discussed relating to recognising patterns of behaviour and how to deal with them effectively. The registered manager notified the Care Quality Commission of any significant events that affected people or the service.

There were systems to ensure that staff were receiving good quality, effective training that reflected people's needs and that staff were encouraged and supported to obtain further qualifications. For example, one senior health care assistant had been funded to undertake further education (an MSc in tissue viability). The registered manager said they had helped to "transform our pressure area care as a result of their learning." The hospice hosted a conference on the subject with five national speakers in 2015.

The Director of People and Organisational Learning would be responsible for undertaking a full training needs analysis and a competency programme was being developed. The competency programme was rolling out four core competencies from January 2016. A need for more trained supervisors for staff had been identified to further improve the level of staff support. There were plans to provide a two day teaching programme to meet the need. There were also systems in place to ensure management and staff were up to date with recent legislation and national guidance. For example, a leaflet was being produced on the duty of candour for staff, patients and families. The duty of candour imposes a duty on a service to provide all necessary support and relevant information to people in the event of a patient safety incident.

Staff were encouraged to make contact with external health professionals and share knowledge. For example, the head of education was leading on arranging for CRC staff to receive training on how to deal with difficult telephone conversations from the Samaritans. The HR department had also contacted Somerset County Council to take advantage of the Health Workplace programme and a local business had been to discuss staff support in areas such as physical activity, health eating and stress reduction.

There was a accidents, incidents/near miss procedure. This included a clear flow chart with severity rating and action instructions covering patient or staff events. This ensured relevant information was considered and analysed without delay. Action was taken to minimise risks of recurrence. These were audited to identify trends and patterns and were discussed at monthly clinical management team



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meetings. The falls group met every 6 months to review patient falls, discuss lessons learnt and action any recommendations to provide an environment that is as safe as possible whilst still encouraging the patients to be as independent as possible. Quarterly reports of accidents and incidents with audits were provided to a local governance committee for further examination.

Staff were encouraged to attend some fund-raising events in the community and made people aware of the services available. They were keen to emphasise that services for end of life care were not limited to people living with a cancer but for adult patients with life-limiting illnesses or advanced progressive conditions. The registered manager was later attending a local “Light up a Life” remembrance service. These services enabled people to remember loved ones in a book of remembrance and the registered manager gave a reading as part of the celebration of the ‘life of someone special’. St Margaret’s had also chosen to be a member of the Fundraising Standards Board. This is the regulator of charities and works to ensure charities are accountable for their fundraising and to improve fundraising standards.

The service worked in partnership with other organisations to ensure they provided a high quality service. They worked in collaboration with Continuing Health Care (CHC) with four in patient beds funded by CHC, local authority services, GPs, and hospital palliative care services for example. This enabled people who met the criteria for CHC funding to receive more long term care in the hospice if that was their preferred place of death. Specialist nurses visited care homes in the area to establish connections with the hospice services, to check that standards of end of life care were upheld, and to provide training and support when shortfalls were identified. Staff said there had been a rise in communication between the hospice and care homes and we saw that care homes felt able to contact the CRC for advice at any time.

The Chief Executive provided inspirational leadership and empowered the leadership team to be forward thinking and looked at how other projects and external initiatives could benefit people receiving the service. For example the

hospice had launched the “Fit for Future” review. This was designed to help the hospice understand and the address the needs of people living with end of life care across Somerset. The Fit for Future review involved a live website where people could share ideas and thoughts on how the hospice could improve, what they did well and be involved in shaping the future for those with a life limiting illness. The Fit for Future panel will meet monthly for a consultation period of 12 months until October 2016. Recommendations will then be made to the Board of Trustees with new pilot projects being rolled out in 2017. Information will also be shared with staff and volunteers at information and engagement sessions. This showed the service was committed to involving the community and staff and that they valued people’s opinions in a bid to continually improve.

There were regular Board of Trustees meetings every two months. These were organised and documents shared using iPads and a ‘Board Pack’ system. This was to facilitate decision making, communication and information sharing such as fortnightly chief executive reports. One of their roles is also to conduct a “Walk the Floor” visit. This is based on an NHS initiative. It enables a trustee and senior member of non clinical staff to have an opportunity to understand the challenges in the clinical setting. The hospice received feedback from the visits, for example the format was to be changed to become more meaningful and relate to CQC fundamental standards and a clinician from the community team would be included in future.

Satisfaction surveys and complaints were scrutinised to identify whether people’s experience of the service could be improved. People received feedback within the newsletter and also on a board showing “You said, we said” notice board and how the hospice had responded to make improvements.

All records relevant to the running of the service were well organised and reviewed regularly. All records were kept securely and confidentially. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.