Cornwall Hospice Care Limited

St Julia's Hospice

Inspection report

Cornwall Hospice Care - St. Julia's Hospice
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location went down. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
End of life care	Good 	Our rating of this location went down. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

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Summary of this inspection

Background to St Julia's Hospice

St Julia's Hospice is operated by Cornwall Hospice Care Limited. St Julia's Hospice is a purpose built hospice standing in its own grounds adjacent to St Michaels Hospital in Hayle, in Cornwall. St Julia's has an inpatient unit with 12 single rooms. The hospice primarily serves the communities of Cornwall and provides inpatient care for people needing help with complex symptom management, pain control and end of life care. It also accepts patient referrals from outside this area. The hospice also provides community services within neighbourhood hubs.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 30 June 2022.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The service was registered to provide: Treatment of disease, disorder and injury.

How we carried out this inspection

We carried out a comprehensive inspection of the service under our regulatory duties. The inspection team comprised of a lead CQC inspector, a pharmacy inspector and a specialist nurse in palliative care and was overseen by a CQC inspection manager.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This inspection took place on 30 June 2022 and was unannounced.

Outstanding practice

We found the following outstanding practice:

- The service had recently worked with the acute hospital trust to implement an electronic system to prescribe medicines and to record their administration. Staff worked alongside other agencies to provide palliative care to people who might be considered 'hard to reach', such as the homeless and people with drug and alcohol addictions.
- The provider had contributed to the development of the Cornwall and Isles of Scilly end of life strategy. The providers education group has expanded the training courses they provide for other services.
- The provider offered a range of community projects to support patients, families and professionals.

Summary of this inspection

Areas for improvement

SHOULDS

- The provider should improve the number of staff completing mandatory training.
- The provider should ensure 'I am clean' labels are used consistently when equipment is cleaned.
- The provider should ensure resuscitation equipment is thoroughly checked.
- The provider should continue to improve the culture of the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	Good	☆ Outstanding	Good	Good
Overall	Good	Good	Good	☆ Outstanding	Good	Good

Good

End of life care

Safe	Good
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Medical and nursing staff received training, and most staff kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. All staff completed a range of mandatory training which included fire safety, infection control, safeguarding, moving and handling, Mental Capacity Act, equality and diversity and spiritual care training. Records showed 54% of nursing staff and healthcare assistant staff had completed all or at least 85% training the provider required. However, 46% of staff were below the 85% compliance the provider deemed necessary. Some of these staff were on maternity leave or off sick, which affected the statistics. Other staff met the provider's requirements for training. Where training statistics were not meeting the provider's targets, the provider had training courses arranged and staff were made aware of the need to complete all training.

Staff also completed role specific mandatory training. For example, staff completed training for blood transfusions and syringe driver training. Staff training for Adult Basic Life Support level two was 100%

The education team worked closely with the registered manager to monitor compliance with mandatory training, and staff were alerted when they needed to update their training. Staff confirmed they were given enough time to do training.

The registered manager ensured staff could access online training appropriate for the service. Staff told us they were able to request additional training, and this would be provided for them.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Good

End of life care

At the inspection in July 2018, we found safeguarding children training was not provided and not all staff had completed safeguarding adults training. At this inspection, we found this was improved but not yet fully achieved. Staff training for safeguarding adults' level two was 77%, safeguarding adults' level three was 100%. Staff training for safeguarding children statistics were the same, 77% of staff who needed safeguarding children level two had completed this training, and 100% of staff who needed safeguarding children level three had completed.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Medical and nursing staff received training specific for their role on how to recognise and report abuse. The service had clear safeguarding processes and procedures.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to an up-to-date safeguarding policy. Staff we spoke with were able to clearly articulate signs of different types of abuse and the types of concerns they would report or escalate to the registered manager.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

Staff used infection control measures at all times when caring for patients.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve infection prevention and control practices if needed. The clinical governance board had effective oversight of audits.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. An audit programme was used to increase and maintain standards and help prevent the spread of infection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment. The service had appropriate handwashing facilities and sanitising hand gel was available. Staff were bare below their elbows and washed their hands before and after each patient contact. Personal protective equipment such as latex-free gloves, aprons and antiseptic wipes were readily available for staff to use at the service. Staff cleaned equipment after patient contact and most equipment was labelled to show when it was last cleaned, however 'I am clean' labels were not used consistently.

In the twelve months before the inspection there had been no incidences of healthcare acquired infections at the location.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Good

End of life care

At the previous inspection in July 2018 we found resuscitation equipment was not checked weekly in line with the provider's policy. At this inspection, we found this had been partly rectified. Although the resuscitation equipment was checked weekly, we were not assured the expiry dates of consumables were checked because signatures were missing from the check sheets. After the inspection the registered manager assured us the equipment was thoroughly checked by clinical teams and this included expiry dates.

People's individual needs were met by the environment at the hospice. The building was light and airy, with suitable adaptations for people with disabilities such as corridors suitable for wheelchair access, grab rails fitted and height adjustable Jacuzzi bath and wet room facilities. People had spacious ground floor rooms, so those confined to bed could access the outside space outside through wide patio doors. Patients could reach call bells and staff responded quickly when called.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. Service contracts were in place to ensure medical equipment such as beds and wheelchairs and equipment such as fire extinguishers and fire alarms were all serviced in line with manufacturers recommendations.

The service had suitable facilities to meet the needs of patients' families. A room was available for families to stay overnight.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

People were protected because most risks for each person were identified and managed. Patients did not have personal emergency evacuation plans in place, however, staff completed fire safety practical training as part of their mandatory training. Comprehensive individual risk assessments were completed in relation to people's risk of falling, malnutrition and dehydration, and about moving and handling risks. Detailed care plans identified measures taken to reduce risks as much as possible. For example, on how to reduce a person's risk of developing pressure sores, including details of pressure relieving equipment, the need for regular repositioning and skin care.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. Staff used Integrated Palliative Care Outcome Scales (IPOS), which measures the main symptoms and concerns which palliative care patients themselves report.

Staff told us they followed the hospice sepsis policy but did not need to use National Early Warning Score (NEWS 2). The NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis, in hospitals in England. However, when transferring patients between services, staff used the same language as the NEWS 2 tool.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Every patient was assessed for their risks of falls, nutrition and venous thromboembolism (VTE), also known as blood clots.

Good

End of life care

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared information and during daily meetings, so everyone understood the patients' dependency scores. Staff shared key information to keep patients safe when handing over their care to others.

Environmental risk assessments were completed in accordance with health and safety executive guidance. For example, detailed risk assessments about the fire risks related to the use of oxygen. Staff completed specific training about safe storage and how to change oxygen cylinders in accordance with the medical gases policy. Where people were using oxygen, hazard signs were on display outside their rooms warning about the flammable risks.

Where staff were visiting people's homes, a risk assessment was completed to identify any risks both outside and inside the home. This ensured the person's home was a safe place for the hospice staff to work. Staff had the benefit of a personal alarm system which was linked to a national centre.

Nurse staffing

At the inspection in July 2018 we found staffing levels were not assessed in relation to patient dependency. There was no tool for assessing how many staff were needed in relation to patient dependency levels. Filling shifts at short notice was challenging for the ward and impacted on the work being undertaken. At this inspection we found the service had designed a dependency tool and combined this with similar tools available nationally, to ensure patient safety was the priority.

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction. Staff roles included ward sisters, advanced nurse practitioner, senior staff nurses, staff nurses and healthcare assistants. Other staff roles included physiotherapists, occupational therapists and a lymphoedema specialist practitioner. Community engagement staff were also available.

The service had an escalation procedure where staff could bring in additional staff if there was a sudden absence or if a patient's needs or dependency increased. Twenty-four-hour advice and support was provided by a team of doctors. The duty rota showed recommended staffing levels were maintained.

Each healthcare assistant and registered nurses took responsibility to be a lead for a subject area, for example tissue viability.

Out of hours there was always an on-call executive team member to escalate staffing concerns if needed. A consultant was available for urgent patient review, a doctor and senior management were also available out of hours.

Patients told us staff checked on them regularly day and night and responded immediately to call bells. Staff were attentive and could spend as much time as people needed offering them assistance, comfort, support and reassurance.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service had access to a team of medical consultants who provided services to St Julia's Hospice. The service also employed a specialist for lymphoedema, which is a long-term (chronic) condition that causes swelling in the body's tissues.

Good

End of life care

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. GP's who were completing palliative care training also worked as locums.

The service always had a consultant on call during evenings and weekends

The provider had a recruitment policy which stated all staff had to have a Disclosure and Barring Service (DBS) check before starting their employment at the location. All staff had an up-to-date DBS check. We reviewed staff personnel files and all staff had proof of identification, full employment history and an up-to-date curriculum vitae on file. The service had obtained at least two references for all staff in line with their policy. We also saw employment offer letters, evidence of induction training, qualifications, and professional memberships were kept on file.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed patients' notes and found them mostly to be completed in full and were up to date. They included relevant risk and clinical assessments including escalation and ceiling of care plans, known allergies, nutritional and pain assessments, medical and nursing clinical management plans and pathways, and were linked to the Outcome Assessment and Complexity Collaborative (OACC) suite. Communication with patients and their families was clearly documented throughout the records. Records were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records.

The service had an up-to-date information governance policy, and a data retention policy. The registered manager was the information governance lead for the service. The service was registered with the Information Commissioner's Office (ICO).

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

At the previous inspection in July 2018, we found the management of prescription pads (FP 10) was not managed to ensure an audit trail of prescriptions used to minimise misuse. At this inspection, we found action had been taken to ensure safe processes for the management and storage of prescriptions pads.

The service had recently worked with the acute hospital trust to implement an electronic system to prescribe medicines and to record their administration. This system was used across all NHS hospital services and adult hospice services in Cornwall. This meant that information about people's medicines was more readily available when people transferred between services. These electronic records were complete and up to date with clear recording of allergies and reasons if medicines were not given.

Medicines for use in syringe pumps were prescribed on a standardised paper prescription chart, although the hospice was participating in a pilot to move these to the electronic system. People were appropriately monitored when having medicines administered via a syringe pump.

Good

End of life care

Staff followed national best practice to check patients had the correct medicines. Medical staff completed a reconciliation of patient's medicines when they were admitted. Staff checked patient's identity and allergies before giving medicines. Patients could self-administer their own medicines although no-one was at the time of inspection.

Staff reviewed patients' medicines regularly and provided patients and their carers with specific advice. When patients went home, they were provided with a discharge summary that explained their medicines and how to take them in an easily understandable manner. This was discussed with patients before they left the service to make sure they knew how and when to take their medicines.

Access to medicines was restricted to authorised staff only. Regular monitoring and checks meant that all medicines were in date and stored at the correct temperature. The service stored and monitored controlled drugs in line with national guidance. The service had a controlled drugs accountable officer who reported to the local intelligence network. Staff stored and managed prescribing documents, such as FP10 prescriptions, in line with the provider's policy. The use of emergency medicines had been risk assessed. Emergency medicines for anaphylaxis were stored in a tamper evident trolley. Other medicines that might be needed in an emergency were stored securely in the treatment room.

The service had access to pharmacy support. Ordered medicines were delivered frequently during the day and a process was in place to ensure deliveries were available if urgent medicines were needed outside of normal times. Clinical pharmacy support and advice was available and valued by nursing staff. The pharmacist attended the weekly multidisciplinary team meeting to ensure that patients medicines were safe and effective.

Staff completed audits to make sure medicines policies were followed. Staff reported incidents and near misses which fed into the monthly clinical incident forum to identify themes and any learning needs.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

At the inspection in July 2018 we found the findings from investigations into reported incidents was not widely shared across the organisation to improve practice. Incidents were not consistently managed. An incident policy was available, and the policy identified the level of investigation depending on the level of the incident. However, the severity level of the incident was not assessed or recorded so it was difficult to identify the appropriate response. This meant themes and trends could not be identified and used to improve the service. At this inspection, we found the provider had a clinical incidents forum where all incidents were reported, including patients having pressure ulcers, falls and blood clots. A step by step guide on investigating and completing a response to an incident had also been developed. The clinical governance team had oversight of incidents.

Staff knew what incidents to report and how to report them. Staff had access to an electronic system for reporting incidents. Accidents and incidents were reported with action taken to reduce risk of recurrence. There was evidence that changes had been made as a result of feedback. For example, the incidence of patients developing pressure ulcers was reduced because staff monitored the suitability of mattresses and changed them where necessary.

Managers debriefed and supported staff after any serious incident. Staff were able to take part in a team de-brief if necessary.

Good

End of life care

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. In line with their duty of candour, the service made the person involved and their family aware of the outcome of the investigation, lessons learned, and the improvements implemented.

Staff met to discuss the feedback and look at improvements to patient care. Staff received feedback from investigation of incidents, both internal and external to the service. Every incident was logged and monitored for trends. Accidents and incidents were discussed at clinical incident forums, and lessons learned identified.

Is the service effective?

Good

Our rating of effective went down. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

During our inspection in July 2018 we found staff were not aware of and guided by nationally recognised frameworks for the provision of care. Failings identified through audits did not result in actions to remedy deficiencies being identified. At this inspection, we found action had been taken to rectify these shortfalls. For example, a report in April 2022 from an audit of treatment escalation plans, identified areas of improvement from the standards in place from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, previously known as the 'Joint Statement'. The audit also identified how the improvements could be achieved. An action plan was in place and progress as being monitored.

The hospice undertook a comprehensive range of audits throughout the year to ensure healthcare was being provided in line with standards. The hospice used the audits as a quality improvement process to improve patient care and outcomes through systematic review of care against explicit criteria. For example, following a mini audit in October 2021 to identify if there were any missed opportunities for identifying the wishes of the patient, the education team were able to identify and provide the areas of training staff needed. The hospice promoted a culture of patient safety and wanted staff to see how the audit programme and specialist audits contributed to this.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A process was in place for policies to be updated with any new or amended guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory training. Patients had an individualised plan of care which reflected their personal needs. If the patient was at end of life, this was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with national standards and guidelines.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Good

End of life care

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. People were supported to eat and drink what they wanted for as long as they wished. They were asked about their food preferences, allergies and any specific dietary needs. If a person needed a special diet, the chef discussed their individual requirements with them. People could choose their meals from a menu, including their preferred portion size. The chef visited everyone every morning to discuss their choices. Where people had special requests, such as takeaway meals, these were provided. One patient told us how staff made marmite sandwiches for them in between mealtimes.

Mealtimes were protected, so no visitors or doctor's ward rounds were permitted, which meant people could enjoy their meal without interruptions. Food served was attractively presented to tempt people with poor appetites. If a person did not wish to eat the main course offered, they were offered an alternative and relatives could bring in favourite foods. Out of hours, staff had access to a ward kitchen and could prepare snacks such as cereals, toast, soup, yoghurts, rice pudding, jelly and ice cream.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Pain was a common symptom suffered by patients cared for by the hospice and its services. Staff used recognised tools for assessing patients' pain. Patient pain levels were regularly reviewed, and staff gave pain relief in line with individual needs and best practice. Staff assessed patients before and after any intervention such as moving them. Distraction techniques such as complimentary therapies and music were available. Nursing staff were taught how to assess pain and use appropriate medicines for effective pain relief. Anticipatory medicines were prescribed for patients who needed them.

Staff monitored patients for distress cues, for example patients who because of cognitive impairment or physical illness had limited communication. Staff told us how they used the nationally recognised tool Pain Assessment in Advanced Dementia (PAINAD) for people with with learning disabilities or cognitive impairment to help them describe pain. Staff also regularly assessed patients' ability to tolerate oral medicines with alternative administration routes prescribed if necessary, such as intravenous infusion.

Staff prescribed, administered and recorded pain relief accurately. Patients received pain relief soon after requesting it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Managers used the results to benchmark themselves with Hospice UK against other adult hospices. Audits included falls, medicines errors and pressure ulcers. Results showed the

service had fewer instances of patients with pressure ulcers and fewer medicines errors, but a higher rate of patients' suffering falls. Managers responded with an action plan to reduce the number of falls. Actions they took included setting up a group of staff with reducing the rate of falls as their priority. Changes made included renewing the falls policy and testing a new bed which alerts staff when people move.

Managers and staff used audits to improve patients' outcomes. Outcomes for patients were positive, consistent and met expectations, such as national standards. For example, 'a positive difference' may well be preventing deterioration, maintaining mobility, or lessening the impact of symptoms, rather than improvement. Staff had reduced the numbers of patients with pressure ulcers by monitoring the use of different kinds of mattresses. Managers monitored the numbers of patients engaging in developing advanced care plans and provided training for staff to improve this.

Hospice staff understood the importance of working together to provide seamless care for people. People's care was reviewed daily or more often by nursing and medical staff and treatment plans updated as their needs changed. Comprehensive discussions took place about the care of each person and those of close family members. Physiotherapists and occupational therapists helped people experiencing difficulties with mobilising, falling and breathing difficulties. This included arranging equipment to help them be as independent as possible, such as mobility equipment, moving and handling aids and electric beds. This meant people's care and treatment was actively managed.

People received effective end of life care based on best practice evidence. Staff had link roles to champion best practice. For example, in skin care and prevention of pressure sores, falls prevention, nutrition and hydration and infection control.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Hospice staff had a range of skills and experience, and received training, updating and opportunities for ongoing professional development. All new staff including bank, locum staff and volunteers underwent a thorough induction, which gave them the skills and confidence to carry out their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were champions within the service who actively supported staff to make sure people experienced good healthcare outcomes leading to good quality of life.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff said this was an opportunity for them to discuss their professional development. Staff also benefitted from weekly clinical supervisions with an external supervisor, either individually or in groups.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff were supported through an appraisal process where staff were able to review the past year, the year to come and agree competencies. The annual appraisal also had a mid-year review to monitor progress.

Managers identified poor staff performance promptly and supported staff to improve.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Good

End of life care

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Links with health, complementary and social care services were good. Where people had complex/continued health needs, staff always found ways to improve their care, treatment and support by identifying and implementing best practice.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Patients were reviewed daily by the medical team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds Mondays, Wednesdays and Fridays and were on call any other time, including overnight and weekends.

Patients were reviewed by consultants depending on the care pathway. Patients were reviewed daily by doctors. The provider employed two specialist doctors and a clinical fellow and had two GPs doing GP training. GPs in training spent six months with the service.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The provider had a 24-hour, 7-day a week palliative care advice line for patients and their carers and for health professionals such as GPs, district nurses and hospital staff.

Health promotion

Staff gave patients practical support to help them live well until they died. Staff made sure patients were comfortable and able to be as pain free and symptom free as possible. Staff provided practical support to help patients manage long-term conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

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Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Each person's mental capacity to make their own decisions and consent to their care was regularly assessed and reviewed, as their condition changed. Staff consulted relatives, staff and other professionals in 'best interest' decisions about the person's care and treatment.

Good

End of life care

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Patients were consulted and involved in all care and treatment decisions.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff respected people's wishes, set out in advanced care plans, even when the person was no longer well enough to communicate them.

Staff clearly recorded consent in the patients' records.

Clinical and nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

All staff, including volunteers, were aware of the importance of providing compassionate care and the impact their actions had on the patient and their families during this time of their lives. Support was always given by caring and empathetic staff who put patients and their loved ones at the heart of everything they did. All conversations and observations, without exception, with staff during our inspection demonstrated this. Big and small acts of kindness were embedded in how staff looked after their patients. For example, staff organised movie nights and live music for couples to dance together. Feedback from one family said how grateful they were that a patient's dog had been able to visit and get up on the bed with them.

People said staff and volunteers always treated them with the utmost dignity and respect. Curtains were fitted inside the door of each bedroom, which provided complete privacy for care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and their relatives and consistently took account of this when providing care and treatment.

One patient told us they "felt held and wrapped up in a warm blanket" and said she was very happy with the care and support staff provided.

Good

End of life care

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The hospice provided a comprehensive bereavement service for people and families, which also provided support for bereaved children in partnership with other support agencies..

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Friends and family could visit at any time, a family room with overnight accommodation was available, so relatives could take a break, make a drink or snack, and get some sleep.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff spoke with patients sensitively and appropriately dependent on their individual needs and wishes. Hospice staff knew what mattered to people and had excellent interpersonal and communication skills, and quickly established a rapport with them. We witnessed many kind and gentle interactions and staff spent time with people, chatting to them in an unhurried and relaxed way.

Staff had done multi-faith training and were knowledgeable about how to meet people's spiritual, religious and cultural needs. Where people had dietary restriction related to any religious or cultural beliefs, these were catered for. All were welcome to use the quiet room set aside which provided a quiet and tranquil space to spend time for quiet reflection.

Some ward staff had been trained to give soft-touch massage with pre-mixed oils. A qualified complimentary therapist prepared the oils. Staff had also been trained to use a diffuser to help people, for example manage symptoms such as nausea.

People were supported to have a comfortable, dignified and pain free death. Following death, a temperature-controlled room was available and relatives and friends could spend time with their loved one and staff could continue to support them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave overwhelmingly positive feedback about the service.

Staff supported patients to make advanced decisions about their care.

Is the service responsive?

Outstanding ☆

Our rating of responsive stayed the same. We rated it as outstanding.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Good

End of life care

People received personalised care tailored to their individual needs, wishes and preferences and responsive to any changes. People and relatives appreciated that staff involved them in regular reviews of their care. People told us that staff listened to them and involved them in the development of their care plans. People were supported, if they wanted to, to develop an advanced care plan, which captured their preferred place of end of life care, views about resuscitation and any withdrawal of treatment. This meant their wishes were known and could be carried out.

Managers planned and organised services, so they met the needs of the local population. The service provided a range of resources which had up-to-date end of life and palliative care information for patients, carers, family members and healthcare professionals. The provider had a community service which offered a wide range of services to support people with practical advice and information.

Neighbourhood hubs provided support, practical advice, information and treatment for people living with a palliative/terminal illness or a deteriorating progressive disease and their carers. This service was delivered by occupational therapists and physiotherapists.

A 'Listening Ear Service' was a telephone service for people who were isolated and vulnerable and had experienced the recent death of a loved one. 'Walk Talk Kernow' were adult walking bereavement support groups. Whilst walking in nature, each group provided a space for those who were bereaved and seeking social connections. The service provided a useful links directory which was an on-line resource providing contact details for local and national organisations, covering a range of topics including cancer, mental health, planning for end of life, bereavement and general health.

The service provided a virtual community friendship café, offering a virtual space for support and information, a place to share experiences, wellbeing activities and advice, bereavement support and virtual friendships. This was a social media group for those feeling socially isolated, carers and people coping with a long-term illness or bereaved. The provider's website offered virtual tours so people could see what was on offer.

The community team distributed 'What Matters?', an e-newsletter for those approaching or planning for end of life in Cornwall. This newsletter was distributed across the county to health professionals including GPs, social prescribers, nursing homes and funeral directors for them to print/pass on to their patients/clients.

The service had plans to open bereavement help points similar to Walk Talk Kernow, but in venues around the county in August 2022.

The service had systems to help care for patients in need of additional support or specialist intervention. St Julia's Hospice provided support to adults with a progressive, treatable but not curable life-limiting illness or with severe frailty, and their family (including children) and carers. Services provided included physical, psychological and/or spiritual support. The service also provided a Lymphoedema clinic, neighbourhood hub and therapists.

The hospice staff were doing outstanding work to improve equity of access to palliative care and end of life services for hard to reach groups such as homeless people and people with drug and alcohol addictions. A working group looked at the issues facing some marginalised groups and developed partnerships with relevant statutory and charitable organisations to enhance their end of life care.

The service worked closely with local commissioning groups, professionals working in care homes and national organisations to look at how people in deprived areas access care.

Good

End of life care

People received co-ordinated person-centred care when they used or moved between different services through partnership working. Hospice staff linked with several groups, organisations and networks, for example, child bereavement groups.

Facilities and premises were appropriate for the services being delivered.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

People received personalised care tailored to their individual needs, wishes and preferences and responsive to any changes. People and relatives appreciated that staff involved them in regular reviews of their care. People told us that staff listened to them and involved them in the development of their care plans. People were supported, if they wanted to, to develop an advanced care plan, which captured their preferred place of end of life care, views about resuscitation and any withdrawal of treatment. This meant their wishes were known and could be carried out. People's relatives told us that they had been encouraged by staff to voice their opinions, which made them feel their views mattered.

The provider worked closely with other healthcare providers to improve advanced care planning and make medicines for homeless people and people with drug and alcohol addiction at the end of their lives better available. This group set out to deliver a further conference which focussed on palliative & end of life care for the homeless and for those with drug and alcohol problems, bringing together professionals from both areas to deliver the conference.

The service was involved in a project to provide a palliative care nurse for 12 months working with homeless people which promoted equality, diversity and inclusion by recognising and acknowledging that homeless people often struggle to access palliative care due to their complex needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

The hospice had effective processes to manage admission to the service. Referrals came mostly from GPs, specialist palliative care nurses, community clinical nurse specialists and the local acute NHS hospital. Patients could refer themselves if they had been diagnosed with a life-limiting illness. The hospice was able to meet the needs of patients who would benefit from the service at the point they needed it.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Good

End of life care

Staff supported patients when they were referred or transferred between services. There were discharge processes to ensure patients could be safely discharged home to their preferred place of death, wherever possible. These included liaising with other hospice services such as occupational therapy team and pharmacy to ensure an appropriate care package was in place.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. The service had an up to date complaints policy, which outlined procedures for accepting, investigating, recording and responding to local, informal, and formal complaints about the service. The provider's policy outlined the process to learn from complaints and learning was shared across the provider.

It was easy for people to give feedback and raise concerns about care received.

If any patient or family provided any negative feedback and wished to discuss this, a member of staff contacted the family. Feedback was discussed at the clinical governance committee.

The service received 130 written compliments during 2021/22. Patients and families overwhelmingly gave positive feedback about the quality of the care and the kindness and support from staff. Comments included, "Every single member of the team at St Julia's Hospice were outstanding at all times, not just to my partner….but also to myself and all who were able to spend precious time with him" and, "I can't express how much your kindness meant and how comforting it was to know that he spent his last day with you."

Is the service well-led?

Good

Our rating of well-led went down. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

At the previous inspection in July 2018 staff commented they did not often see members of the board at the hospice. At this inspection, staff acknowledged the pandemic prevented trustees from visiting more. However, staff said they felt the 'open door' forum could be better used.

Leaders had the experience, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

We saw the leadership was visible, approachable and well respected by the staff within the service. The registered manager told us that the service had an open-door policy and staff confirmed this was the case.

Good

End of life care

The hospice leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the services. Senior members of staff we spoke with had been in post for several years and had good knowledge of the service and its systems and processes.

Two members of staff were being supported to complete a two-year foundation degree to become nursing associates.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a vision for all people living with a terminal illness in Cornwall to be able to access the care and support they may need at a time and in the place this was right for them and their families.

The work the provider did leading the Cornwall and Isles of Scilly End of Life Education Group ensured the group developed their 'End of Life Care Education Strategy'. It was developed to inform programmes of education and to help support the needs of health and social care staff to achieve the end-of-life care learning outcomes. This strategy was paramount in providing guidance for organisations across Cornwall and Isles of Scilly. The provider had received positive feedback about the training the education team had provided to care homes and the community.

The provider worked with other providers to deliver its strategy and improve outcomes for patients considered hard to reach such as homeless people and people with drug and alcohol addiction.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an improving culture where patients, their families and staff could raise concerns without fear.

At our last inspection in July 2018 we found there was a culture of low morale and concerns about bullying in the hospice. Before our previous inspection in July 2018 we received concerns regarding the leadership, low staff morale and bullying of staff. During the inspection in July 2018 we found evidence which partly supported these issues. For example, staff spoke of low morale and said they had concerns in approaching senior leaders with these issues and had fears about reprisal. Documentation also supported this, for example staff appraisal forms. At this inspection we found much had been improved. Staff told us they felt they could raise concerns and were able to share ideas during meetings. However, the provider had recently been rated inadequate for GP training after receiving critical comments such as, "a toxic environment for learning in."

The board of trustees and senior managers were actively working to improve the culture, and said they felt things were much improved. Staff had been provided with 'Active Bystander' training to give staff the tools and confidence to speak up. This training was mandatory for everyone. These sessions were held regularly to ensure new staff were included. Senior staff hoped to regain their previous high rating feedback score from GP trainees.

Additional ways the board was working to improve the culture included becoming a living wage employer for staff who had previously been employed on a minimum wage. The board had introduced a benefit called 'early pay', where staff could access some of their salary early. The date staff received their salary was changed so they were paid earlier in the

month, this was in recognition that staff paying rent needed their salary in time for these payments. Staff were also provided with access to counselling and had access to life assurance cover. The board were also trialling giving staff free complimentary therapy sessions twice monthly. 'Freedom to speak up' guardians had been appointed and the executive team were available for staff to talk with during open door sessions."

Independent Health providers

Staff were able to discuss anything that had been difficult during a weekly team talk and had access to monthly Schwarz rounds. Schwartz Rounds were conversations with staff about the emotional impact of their work. Staff could also access counselling.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We found a clear line of governance to communicate information throughout the service, and to escalate and cascade information up and down lines of management and staff. Staff were clear about their roles and understood what they were accountable for and to whom. Staff could describe the governance processes for incidents and complaints and how they were investigated.

The service had a governance framework in place through which the hospice was accountable for continuously improving their clinical, corporate, staff, and financial performance. The board of trustees and the executive management team through the governance management framework oversaw governance within the hospice. The framework and supporting policies provided the structure for managing and reporting on a range of auditable metrics.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At our last inspection in July 2018 we found there was a local risk register for the ward, but this did not include risks regarding equipment or environment risk. Incidents were not assessed and graded to ensure a consistent response. At this inspection, we found the recording of risks had improved.

The board of trustees had oversight of risks. Each executive team member prepared a report for the board. For example, these included governance, clinical governance, health and safety and risk registers. This enabled the board to identify risks that were increasing or decreasing and take action as necessary.

The board of trustees had effective oversight of the quality and safety of care which enabled them to make sure decisions were in keeping with the strategy and values of the hospice and progress was delivered. Safety of the workforce was also paramount. For example, the provider used a phone application for staff who were lone working which meant staff could instantly access help when needed.

The service had a contingency plan with identified actions to be taken in the event of an incident that would impact the service. For example, extended power loss, severe weather events, short notice staff sickness and equipment failure. The contingency plan included contact details of relevant individuals or services for staff to contact.

Good

End of life care

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had policies and procedures to promote the confidential and secure processing of information held about patients. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant, having been scrutinised quarterly.

We saw appropriate and accurate information was effectively processed, challenged and acted upon. Key performance, audit, and patient feedback data was frequently collated and reviewed to improve service delivery.

The service was up-to-date with information governance and had data retention policies. These stipulated the requirements for managing patients' personal information in line with current data protection laws. The service was registered with the Information Commissioner's Office (ICO), which is in line with 'The Data Protection (Charges and Information) Regulations' (2018). The ICO is the UK's independent authority set up to uphold information rights.

The service was committed to continuous learning from accidents, incidents, complaints and from training. At monthly meetings staff received feedback about any issues that had arisen in their own and other areas. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly.

The provider had provided staff with a lone-worker application on their phones to give them additional security. This application meant staff could be tracked if they went missing and the service could speak with the member of staff's family.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. The board was working at improving engagement with staff.

The board were working to improve engagement with staff. Staff we spoke with said they did not have regular contact with the executive board or the trustees. The executive board had been made aware of this through the staff survey and conversations with senior clinicians. Several changes had been made to improve engagement, such as new board members and empowering staff to enable change and improve communications, for example with the Active Bystander training. The executive board gave staff time out from the ward to attend workshops. Staff forums had ended during COVID-19, but these were restarting. All staff and volunteers had been given the opportunity to contribute to the five-year strategy. Staff received a clinical newsletter. Senior managers told us they had an open-door policy and had open-door events.

The provider produced a monthly newsletter called 'All Together' which was widely distributed. This was used to celebrate the many achievements and successes and shared the news from activities such as the provider's stand at the Royal Cornwall Show. Staff had taken part in fund-raising activities including a sky-dive.

The community team worked to signpost hard to reach groups of people with advice such as claiming benefits, bereavement teams, a helpline and putting people in touch with advocacy services.

Good

End of life care

The provider was a registered regional training provider for the Gold Standards Framework (GSF) in care home programme.

The provider offered a palliative care advice line available to professionals 24 hours a day, seven days a week. This service provided access to specialist nursing and medical advice. For example on symptom control, use of syringe drivers and drugs and management of palliative care emergencies.

The provider's website was proactive in identifying the topics people would need to ask questions about. There were links to podcasts and websites to support people managing grief and topics such as action for happiness. The service was had have been shortlisted for an excellence award for their podcast.

The provider engaged with patients, families and carers and used the feedback to develop and improve the service they provided. Between April 2021 and March 2022, 92% of respondents were very satisfied with the service, 6% were satisfied.

The provider used technology to ensure staff felt safe working on their own.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service demonstrated a strong commitment to professional development. Managers were proud of the work done by the education department. The service had systems to monitor staff training and development. Staff had taken advantage of the opportunities available to learn, develop and improve their skills.

The service worked collaboratively with universities and colleges providing placements for nursing and other students. The registered manager told us plans were being investigated around how to use digital technology to improve sharing of patient information and the development of patient e-notes. This would enable a 'virtual ward', recognising patients would rather be at home and using technology to keep safe.