

Douglas Macmillan Hospice







Douglas Macmillan Hospice

Inspection report

Barlaston Road
Blurton
Stoke on Trent
Staffordshire
ST3 3NZ
Tel: 01782 344300
Website: www.dmhospice.org.uk

Date of inspection visit: 5 - 6 August 2014
Date of publication: 03/02/2015

Ratings

Overall rating for this service	Good	
Is the service safe?	Good	
Is the service effective?	Good	
Is the service caring?	Good	
Is the service responsive?	Outstanding	
Is the service well-led?	Good	

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Our inspection was unannounced which meant the service and staff did not know we were visiting.

The Douglas Macmillan Hospice provides care and treatment to people using the 28 bedded inpatient unit, three community led beds, the hospice at home service, the domiciliary care service and outpatient clinics. People may also receive support from the hospice's ambulance transport service and a telephone advice line. All these services provide specialist palliative and end of life care to people with progressive, advanced disease

Summary of findings

and a limited life expectancy. The hospice also runs a day therapy unit that provides a service for up to 25 people per day. This service falls outside of our regulatory role, therefore we did not include this in our inspection.

At the beginning of our inspection there were 26 people using the inpatient unit, three people were using the community beds, 708 people were using community and outpatient services and 37 people were using the domiciliary care services. There were 75 people using the hospice's transport service to access the day therapy unit, and in the two weeks prior to our inspection 175 calls had been made to the telephone advice line.

Care and support was provided within the hospice environment and within people's own homes dependent upon their care preferences and needs.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People and their relatives told us they were very happy with the care. We saw that people were treated with dignity, respect and compassion. People were involved in the planning of their care which meant their care preferences and choices were identified so they could be met by the staff.

People were safe because there were effective systems in place to help manage the risks posed to people. For example procedures were in place to protect people from the risks associated with medicines and the risk of falling.

There were sufficient numbers of staff to meet people's individual needs and keep people safe. Volunteers were innovatively used to help manage the risks posed to people and to improve the effectiveness of the care.

The staff and volunteers were trained to provide the specialist care people required. A holistic approach to care was used which meant the staff treated the whole person and their family rather than only treating the person's medical condition. People's health and wellbeing were closely monitored so they could receive the right care at the right time.

The staff worked closely with other professionals and services so that people received consistent care. The staff responded positively and inclusively to people's changing needs and the diverse needs of the local population.

The staff worked with people on an individual basis to plan their end of life care. When people required end of life care, it was provided with the aim of achieving a private, dignified and pain free death.

The legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were being followed. The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

Managers regularly assessed and monitored the quality of care by completing audits and seeking feedback from people who used the service and the local community. The service actively engaged in project work and research to identify best practice and make improvements in care.

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. Staff knew how to keep people safe and how to report any safety concerns. The staff had a positive approach to risk and people who used the service were involved in risk assessment and management in conjunction with the multidisciplinary team.

When people did not have the ability to make decisions about their own care the staff followed the legal requirements that ensured decisions were made in people's best interests.

There were sufficient numbers of staff to keep people safe and the innovative use of volunteers complemented the work of the staff.

Medicines were managed safely and the premises and equipment were monitored and maintained to keep people safe. Effective systems were in place to prevent and manage potential infections.

Good



Is the service effective?

The service was effective. Staff and volunteers received specialist training that enabled them to provide effective care and support. The service had worked innovatively to develop and integrate the various roles of the volunteer to maximise the quality of care.

A holistic approach was used to provide effective care that met people's needs. Staff worked closely with other professionals and services in a manner that ensured people received the right care at the right time.

The staff encouraged and supported people to eat and drink a balanced diet that met their individual needs and professional advice was sought if people's eating and drinking deteriorated. The hospice environment met the specialist needs of the people who used the service.

Good



Is the service caring?

The service was caring. People were treated with care and compassion. The staff respected people and their choices and they promoted people's privacy and dignity.

People were involved in making decisions about their care which meant care and support was individualised.

The staff were suitably skilled to identify when people required end of life care. People were supported to receive individualised, comfortable and pain free end of life care and support. Support was also offered to the families of people who used the service both during and after end of life care.

Good



Summary of findings

Is the service responsive?

The service was responsive. People were assisted to devise advanced care plans that recorded their end of life care preferences and choices. These care plans provided the staff with the information that enabled them to provide care in a manner that was responsive to people's individual needs.

People and professionals acting on their behalf could access advice and support from the service's twenty four hours a day.

Effective communication systems were in place that enabled information about people's needs to be shared with the staff and other professionals that provided care and support.

The service sought feedback from the people who used the service, their families and the community to monitor and improve the quality of care.

Outstanding



Is the service well-led?

The service was well led. Effective induction and training ensured staff were suitably skilled to provide care and support in accordance with the service's positive and inclusive values.

The staff understood their roles and responsibilities and the roles of the management team. The staff and people who used the service were empowered to share concerns about the care.

An effective management team regularly assessed and monitored quality and drove improvements. Staff worked with other agencies and used national and best practice guidance to implement improvements in care and innovative practice.

Good



Douglas Macmillan Hospice

Detailed findings

Background to this inspection

Our inspection team consisted of two inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses services. The expert by experience on this inspection had experience in elderly care.

Prior to our inspection we checked the information we held about the service and the provider. We also asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements that they plan to make.

We spoke with 17 people who used the service and five relatives. We also spoke with eight nurses, a physiotherapist, eleven members of care staff, three managers, two volunteers and two health professionals who accessed the service on behalf of their patients.

We observed the care people received in communal areas and we visited three people who used the community services in their own homes whilst staff reviewed their needs.

We looked at 11 people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, health and safety checks and minutes of meetings. We also looked at the results of the most recent satisfaction surveys that had been completed by 1078 people who used the service or their relatives.

Is the service safe?

Our findings

Without exception all the people we spoke with told us they felt safe accessing care and support from the service. One person said, “I feel perfectly safe and reassured here”. Another person said, “I feel safe especially at night because the staff lock the doors at night”. We saw that people’s views about safety were sought through a regular ‘patients forum’. Records of the forums showed that people who used the service were encouraged and supported to raise safety concerns and we saw that where concerns were raised they were listened to and acted upon. For example concerns about the safety of one of the hospice’s transport vehicles had led to discussions about the purchase of a new vehicle.

Procedures were in place that ensured concerns about people’s safety were appropriately reported. All of the staff we spoke with explained how they would recognise and report abuse and training records confirmed that staff received regular training that enabled them to do this. We saw that suspected abuse was reported in accordance with the local reporting procedures. This included the reporting of abuse that related to the children or families of people who used the service. This showed that the staff safeguarded all people who came into contact with the service.

The rights of people who were unable to make important decisions about their health or wellbeing were protected. Staff understood the legal requirements they had to work within. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out these requirements. The staff demonstrated they understood the principles of the Act and the DoLS and they gave us examples of when they had applied these principles to protect people’s rights. Managers monitored and evaluated the mental capacity assessment process which ensured they were completed appropriately.

Systems were in place that enabled people to be involved in writing advanced care plans that outlined their end of life preferences and choices. This meant the risk of people receiving end of life care that did not meet their needs was reduced.

Risks to people’s safety were assessed, managed and reviewed and people who used the service were involved in this process. We saw that the staff had a positive approach

to risk. A staff member told us, “We are rehab focussed so we allow patients ‘to do’. We never say no, but we always make sure patients do things in the safest possible way”. Staff gave us examples of how they worked with people who used the service in conjunction with the multidisciplinary team to assess and manage risk. One staff member said, “We have open discussions with people about their risks”. People who used the service confirmed this. One person said, “We agreed what I needed help with to keep me safe”.

Recruitment checks were in place that ensured staff and volunteers were suitable to work at the service. There were sufficient numbers of staff available to provide care and support. People who used the service confirmed this by telling us they received their care in a timely manner. One person said, “When I press my buzzer the staff are here within a few minutes or even seconds”. Managers demonstrated they reviewed the dependency levels of the people who used the service so that staffing numbers were appropriate to people’s needs.

The service used volunteers to complement the care and support the staff provided. Staff told us that suitably trained volunteers were used in many ways to free them up to provide direct care. One staff member told us how volunteers could be used to help manage people’s risk of falling. They said, “If someone was confused and at risk of falling we would move them to a more visible area, use a sensor mat and get a volunteer to sit with them to be our eyes and ears. The volunteers know to raise the alarm if support is required”. We saw that some volunteers were utilised specifically to sit with people who used the service to maintain and promote their safety and welfare.

Medicines were consistently managed by staff in a way that was safe. Accurate records were kept of medicines prescribed for and given to people. These demonstrated that people who used the service received their medicines at the times that they needed them. People we spoke with confirmed they received their medicines when they needed them. One person said, “The nurses come round regularly with our tablets, they have helped me get on top of my pain”. Medicines, including controlled drugs, were correctly stored to protect people using the service and to ensure that the medicines would be effective when used. When people wished to administer their own medicines independently they were supported to do this and the risks

Is the service safe?

of them doing so were assessed. To protect people with limited capacity, the correct procedures were followed when medicines need to be administered covertly (hidden in food or drink).

People were cared for in a safe environment. The hospice environment and the equipment it contained was regularly monitored and serviced to ensure its safety. Safety checks were completed to ensure staff were safe when working in people's home environments when people received their care and support in their own homes.

People were protected from the risk of infection. The premises and equipment were clean and the staff told us

the procedures they followed to prevent and manage potential outbreaks of infection. We saw that protective equipment such as, aprons and gloves were readily available and utilised by the staff and volunteers. One staff member said, "We always have access to gloves and aprons".

We saw that when safety incidents occurred they were reported and investigated appropriately. Staff told us they were made aware of actions taken to reduce further incidents through staff handover meetings and changes to people's care records.

Is the service effective?

Our findings

The staff and volunteers were trained to provide the specialist care and support that people required. All the staff and volunteers completed a structured induction which included training and shadowing colleagues. Examples of subjects covered during induction training included; communication, infection control, end of life care, moving and handling and safeguarding. One staff member described their induction as, “Really helpful as it helped me to get to know the role”. Another staff member said, “All volunteers receive an induction and we use volunteers themselves to deliver their role specific training”.

Without exception people who used the service told us they had confidence in the abilities of the staff and volunteers. One person talked about the volunteers who transported them to and from the hospice. They said, “Unlike ordinary taxis, the volunteers are properly trained in how to provide physical support when and where it’s needed”.

The staff told us about the additional formal training opportunities that were available to them. These included certificates, diplomas and degrees in palliative care, nurse prescribing and masters in hospice leadership. One staff member told us, “I completed a two year course in palliative care and learned so much. I’m really passionate about training and I now have a coordinator role where I support the volunteers to provide care that’s based on best practice”. Another staff member said, “The training is excellent and is often at degree level. I’ve done a diploma in relaxation which has been really beneficial to the patients”. This staff member told us that the relaxation training had enabled them to teach relaxation techniques to the people who used the service, which helped them to manage their symptoms of anxiety and pain. This showed the provider supported staff to attend a wide range of advanced training that enabled them to improve the quality of care.

Volunteers were utilised at the service in various roles. These roles included; companions, housekeeping, sitters and transport escorts. The service had innovatively provided opportunities for suitable volunteers who wanted to develop their skills to work in a clinical role. These volunteers received the same training opportunities and support as the staff but they also completed a competency framework. Once assessed as competent they could

provide direct clinical care and support to people who used the service. A volunteer told us, “I’ve been working as a volunteer here for 18 months now and it’s helping me to reach my dream of becoming a nurse. Before I started here I had three taster sessions to see if I liked it. I shadowed the staff and gradually completed my competencies. I’ve got my diploma in care now and I love volunteering here”. Volunteer records we viewed confirmed that volunteers were supported to gain the knowledge and skills required to enable them to provide effective clinical care and support.

People’s health and wellbeing were monitored regularly. This included the monitoring of people’s baseline observations, pain and mood. This enabled the staff to identify when people were ready for discharge or when additional support was required such as when a person’s condition had deteriorated and they required end of life care. This monitoring and review of people’s needs meant the right care could be provided at the right time. An assessment tool was also used to prioritise care provision in the community. One manager said, “We use the tool to make sure our resources are prioritised so the right care is given at the right time”.

The service used a holistic approach to care which meant they considered people’s physical, mental, emotional and spiritual health. One person told us, “They are very thorough”. Complementary therapies were readily available and people and their families could access psychological therapies if this was required. This meant that staff addressed the psychological wellbeing of people and their families in addition to their physical health needs.

People were supported to eat, drink and maintain a balanced diet. All the people we spoke with told us they enjoyed the food at the hospice and they appreciated the varied and flexible menu. One person said, “The food and drink is excellent and always available. It’s like a five star hotel, I don’t want to go home”. Another person said, “There is always a choice of meals, but you can ask for food that’s not on the menu. I fancied a banana this morning. There wasn’t one on the trolley but the staff found me one anyway”. Records showed that the food people ate was recorded and people’s weights were monitored so that staff could identify concerns with people’s nutrition.

Some people who used the service had a reduced appetite or difficulty eating and drinking. The staff told us they encouraged and supported these people to eat ‘little and

Is the service effective?

often? A relative told us, “My mum hasn’t been eating, but she said she wanted some ice cream and the staff gave her this straight away”. We saw that the staff had the skills to request specialist support from a dietician or speech and language therapist if a person’s eating and drinking deteriorated.

We saw that staff from the different services within the hospice worked closely with each other and other professionals and services to ensure people received seamless and consistent care. Staff who worked in the hospice at home team told us, “We monitor people’s conditions on a daily or hourly basis and then we see what support they need. We work with other services like Marie Curie and Katherine House to make sure patient’s care needs are covered”. One person who used the service told

us, “My palliative care specialist nurse has visited me while I have been staying here (at the hospice). All the staff have worked together to organise me going home. I’m going home today, but I wouldn’t be upset if I had to stay longer as I like it here”.

The hospice was spacious and accommodated the equipment required to provide effective care. Overnight facilities were available to people’s relatives if this was required. This enabled relatives to stay with people and be involved in their end of life care. People could access areas of the hospice freely, this included the hospice grounds. One person told us, “I go and sit in the conservatory and go outside. The staff are more than willing to help me get out of this room”.

Is the service caring?

Our findings

Without exception all the people and the relatives we spoke with told us they were happy with the care and support provided. One person said, “The staff give us all the love and care they can”. Another person told us, “The staff really care, I just can’t put how much into words”. A relative said, “The staff have gone above and beyond”. Other people we spoke with described their care as, ‘tremendous’, ‘absolutely marvellous’ and ‘wonderful’.

People told us they were supported with care and compassion. One person said, “It doesn’t matter what you want, they say don’t worry we’re here for you”. The relative of a person who used the community services said, “The staff don’t even turn on the TV at night when mum is asleep. They tell me they want to be able to listen out for her. Mum is their number one priority”. During our inspection we observed that staff talked with people about their end of life needs in a sensitive and caring manner.

People told us they were treated with dignity. One person said, “They draw the curtains and close the door when they come to help me”. We saw that bedroom doors were closed in the hospice when care was delivered and engaged signs were used on the doors to show when people were receiving care. We also observed staff knock on bedroom doors before they entered.

People and their families told us the staff treated them with respect. One person said, “The staff ask if you want help before they do it”. Another person said, “They respect all my wishes”. During our inspection we observed that staff addressed people with respect and we saw that staff sought people’s consent for care before they provided care and support.

The service sought people’s feedback about the quality of care provided. This included asking people if they were treated with dignity and respect via satisfaction questionnaires and patient forum meetings. People’s feedback showed no concerns with dignity and respect, but the managers monitored this feedback in readiness to make improvements if required.

People told us they were involved in making decisions about their care and support. One person said, “I have regular consultations with the doctors and nursing staff. They let me know their recommended plan and I give them

my thoughts about it”. Another person said, “The staff tell me everything that’s going on and I can ask questions. They involve my wife too”. Care records also confirmed that people were involved in making decisions about their care and support. Do not attempt resuscitation orders and advanced care plans (records of people’s end of life care preferences and choices) also showed that people and their families had been involved in making important care decisions.

The staff were suitably experienced and skilled to identify when people required end of life care. We saw that people received their end of life care in private whether this was at the hospice or in their own homes. People’s families could stay with them during this time and the staff offered family support. One staff member said, “Looking after families is very important. We keep communication channels open so they understand what’s happening”. A relative of a person who was receiving end of life care told us, “The staff are supporting me and my family as well as my mum”.

People received their end of life care in accordance with their care preferences. One staff member told us, “We offer holistic, individualised end of life care”. This was reflected in the different care and support people told us they received. Advanced care plans were followed that recorded people’s personal preferences and choices. One staff member said, “These care plans empower people to get the end of life care they want”.

Systems were in place that aimed for people to experience comfortable and pain free end of life care. If people received their end of life care at home the medicines required to achieve this were put into place in advance so they could be utilised when the person required them. People we spoke with told us the staff worked with them to control their pain. One person said, “They’ve done a brilliant job controlling my pain”. A relative told us, “They have made mum comfortable, the staff have been superb”.

Family members could access bereavement support services after the death of a loved one. The service had ensured these services were available to people on or away from the hospice site, dependent upon the needs and preferences of the families. A manager told us, “Not everyone wants to come back to the hospice for support because they associate it with the death of their loved one. It’s important that families can access this support away from the hospice too”.



Is the service responsive?

Our findings

People and their relatives told us the staff were responsive to their individual needs. One person told us, “I woke up last night in pain, I pressed my buzzer and the staff immediately reassured me and gave me pain relief”. A relative said, “I’m still able to work full time and function because of the help they are giving me to care for [Their relative]. They fit in around our needs and routines”.

Because people were involved in the planning and regular review of their care, care was personalised to meet their individual needs. We saw that one person who received inpatient care had listed the times and specific tasks that they wanted the staff to provide assistance with. We saw that the person’s requests were incorporated into their care plan and the staff respected and responded to the person’s requests. We saw that a person who received support in their own home had requested that their care should be delivered by female staff only. A staff member told us, “We’ve put a marker on the computer system that says female carers only. This means the system doesn’t allow us to send male carers out to that person”. This meant effective systems were in place that ensure care was delivered in accordance with people’s preferences. This showed people’s specific needs and instructions were met.

There was a dedicated member of staff who assisted people to make advanced care plans. A manager told us, “This staff member was originally employed as part of a project to promote advanced care plans in care homes. We then retained the post after the project because of the value it offered to our patients”. As a result of this, the services offered to people were tailored to meet their specific needs and preferences. People told us they were supported to receive their end of life care in their preferred environment which could be within their own homes or within the hospice or community beds.

People who had chosen to receive their end of life care at home and who were approaching this phase of their care, had specialist medicines in their home that could be administered by community staff when required. One staff member told us, “We use anticipatory drugs packs. These can be administered if anything arises out of hours by district nurses and hopefully they will help to stop an unnecessary hospital admission”. Anticipatory drugs are medicines that are used to manage people’s symptoms during their end of life. These medicines help people to

experience a pain free and dignified death. The provision of anticipatory drugs ensured that medicines and pain relief were available to people at the right time to enable them to receive their end of life care in their preferred place.

Support and advice was consistently available to health professionals and people who used the community services via a 24 hour telephone advice line. A manager told us, “This service is manned by a dedicated palliative care nurse specialist 24 hours a day”. People and professionals told us this service was, “a really good idea and source of support” and, “a very good service”. A person who had used this service told us, “I had a good response from the phone service. They called me back straight away and gave me advice. It was very reassuring”. A health professional who used the phone line told us, “I phoned to get urgent care for someone in crisis on a Friday afternoon. As a result they got out to the patient very quickly”. This showed there was always a member of staff available to support and advise people and professionals when this was needed.

Effective communication systems were in place that promoted coordinated and seamless care. All the staff within the service used the same computerised care records system which meant information about people’s care needs was available to the staff as people accessed and moved across the various hospice services. This innovative data sharing agreement between the service and some of the local GP’s meant important clinical information could be shared quickly. This ensured health professionals had up to date and correct information about the people’s health and care needs. One staff member told us, “This has really improved communication between us and GPs”. Healthcare professionals who accessed the service on behalf of their patients spoke positively about communication between them and the service. One health professional said, “Communication is very good. The staff frequently ring and fax requests or updates and we do the same”.

People were given verbal and written information in a suitable format to help them understand the services offered. One person told us, “I’ve read all the information that’s been given to me. It’s helped me to understand what is available”. Another person said, “I can’t always read the information I’m given so the nurse explained it all to me”. We also saw that staff had worked with a learning disability



Is the service responsive?

charity to devise an easy read information guide for the hospice. This meant people had access to all the information about their care to ensure they could make informed decisions.

The staff were aware of the potential impact that people's conditions posed to their mental health and wellbeing. Services were offered to people to help reduce the risk of depression, anxiety and social isolation. These included access to the hospice's day hospital, psychological support services, complementary therapies and community support groups. One person told us, "I've been an inpatient and a day patient. I don't know what I would do without this place". Another person told us they were supported by the staff to adopt a voluntary role at the hospice. They told us their voluntary work had become very important to them and had improved their self-esteem. This showed that people could choose to have consistent care from staff within all sectors of the organisation to provide a complete care service.

Community groups were tailored to meet the unmet needs of the local people. For example, a body image group had recently been developed to meet the needs of people who had difficulties adjusting to their body image as a result of their condition or treatment. This innovative project was developed because the psychological needs of people with body image problems was not available from any other local health or social care providers. One person who used a community support group said, "It's the best service I've ever received, it's fantastic". This meant the provider had identified where the service could be improved and developed this service to ensure people's health and psychological needs could be met to enhance their wellbeing.

Care and support was inclusive and responsive to the diverse needs of the people who used the service. Spiritual support was available to all people and their relatives and there was a spiritual space in the hospice that people of all beliefs could access. The environment could be adapted to display only literature and religious objects of people's individual faith. This meant where people could not access their own place of worship a suitable environment was available for them to practise their faith. We saw that

adjustments were made to make the service accessible to people of all abilities. A manager told us, "We recently had concerns that the main carer of one of our community patients would not be able to access our telephone advice line because they are hard of hearing. We purchased a mobile phone at the weekend and gave them the number so they could text for advice".

The staff regularly sought feedback from people who used the service. This was via patient forum meetings and satisfaction questionnaires. Some of the people and the relatives we spoke with confirmed they had attended forums and received questionnaires. People described the patient forum as, "letting us know what's in the pipeline" and "to consult". One person who attended the forum told us that concerns raised by people about the condition of the hospital transport vehicle had led to a discussion about the possible purchase of a vehicle. Minutes of the patient forums showed that people's opinions about the quality of care were sought, listened to and acted upon to improve quality.

The provider proactively engaged with the local community to improve the quality of care. At the time of our inspection the provider was participating in a project with the local authority and another local hospice. The project aimed to gain the views and experiences of carers of people with end of life needs so future services could be developed. A manager said, "This project is still on going, but we have already identified two key themes and we are already thinking about ways to improve our service as a result of this." This meant the provider was striving to improve the service and developing new methods to engage and have a key role in the local community.

There was an accessible and effective complaints process in place that enabled staff to make improvements when required. People told us they would be happy to approach staff to share concerns or make a complaint. One person said, "I've had no cause to complain, but I would tell the staff if I did". One relative told us they had raised some minor concerns and they were happy with the manner in which they had been dealt with. Records showed that complaints were managed in accordance with the service's complaints policy.

Is the service well-led?

Our findings

There was a positive and inclusive culture at the service. The staff were made aware of the service's values and philosophy through their induction and training. One staff member said, "I like that our values are about providing a quality service in a holistic way for people and their families". Another staff member said, "We provide individualised holistic care". We saw that staff applied their values when they provided care with compassion, dignity and respect to meet people's diverse needs. We saw these values underpinned staff practice.

The staff and people who used the service were empowered to share any concerns about the care at the service. All the staff we spoke with were aware of their role in reporting any concerns and they told us they would report concerns in accordance with the service's whistleblowing policy. One staff member told us, "I would follow the whistleblowing policy if I needed to and I would happily report concerns to external agencies if I needed to".

The provider involved people in the development of the service. This included people who used the service and the local population. Feedback from people was gained through patient forums, care reviews, satisfaction questionnaires and service development consultations. The provider also worked closely with other providers and charities to gain feedback. For example, the provider had worked with a local hospice and the local authority to seek feedback from the carers of people with end of life needs so future services could be developed. This meant the provider used different opportunities to gain people's views in a creative way.

There was a clear management structure at the service. The staff we spoke with were aware of the roles of the management team and they told us that the managers were approachable and had a regular presence within the service. All the managers we spoke with demonstrated they had an excellent understanding of the care provided which showed they had regular contact with the staff and the people who used the service. Senior staff acted as a role model to ensure the staff knew what excellence care looked like and promoted their values in all aspects of work with staff and within the community groups.

All the staff we spoke with told us they felt supported and enjoyed their work. One staff member said, "I love my job,

it's extremely rewarding". Another staff member said, "I get really good support from the staff and managers". We saw that staff received regular supervision and appraisals. We also saw that the effectiveness of supervision sessions was reviewed and evaluated to ensure the aims of the sessions were met. There was a mentor scheme for nurses who worked in the community. A manager said, "It can be isolating for staff who work in the community so every nurse is assigned a mentor for support". Staff could also access a counselling service to seek professional emotional support if this was required. This showed the provider demonstrated their commitment to excellence by continually assessing how they supported staff.

We saw that systems were in place to monitor the quality of the care provided. There was a clinical governance manager in post who was responsible for the overall assessment and monitoring of quality. Frequent quality audits were completed. These included; medicines prescribing and management, the hospice environment, incident reporting and national hospice audit tools. These audits were evaluated and where required action plans were in place to drive improvements. The service had innovatively implemented a nurse prescribing audit that not only assessed the recording process but the clinical reasoning behind prescribing. A staff member said, "We are thinking of writing a paper on this to share it with other services as it's something we developed to check we are prescribing consistently".

Role specific competency based assessments and observations were completed to ensure staff provided care and support effectively. Examples of these assessments included medication administration and quality spot checks for community care workers. We saw that when quality issues were identified, immediate action was taken to address them by meeting with the staff member to set learning goals. This showed the provider provided staff with opportunities to reflect on their practice in order to facilitate improvement and strive for excellence.

The provider and staff were committed to provide high quality care that was based on best practice. The service offered regular training opportunities to the staff and external health and social care professionals and also worked in partnership with the University of Wolverhampton to provide additional learning opportunities. This collaborative working ensured the

Is the service well-led?

provider could strive for excellence by using the skills of other trained professionals. The focus of the training was to improve care at the service, but also to improve end of life care that was provided by other local services.

The service used local and national guidance to drive local improvements. An example of this was how staff had devised their own local standards for the use of opioids (strong pain medicines) in palliative care. These standards were based upon the National Institute for Health and Care Excellence (NICE) guidelines, 'Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults'. A manager told us, "Implementing this led to us producing an information leaflet for people about taking strong opioids". This was a unique and individual service developed by the provider to ensure staff only used these medicines to benefit people.

The staff worked in partnership with other agencies to participate in project work and research with the aim of improving the quality of care. Project work that had recently been completed or was on-going included; advanced care planning in nursing homes which aimed to prevent hospital admissions and improve end of life care in nursing homes, a project to gain the views and experiences of carers of people who received end of life care to help design future services and a dementia project that aimed

to improve the assessment and treatment patient pathway for people with dementia. A manager said, "Collaborative working is the way forward. It's what we should be doing to provide a seamless pathway for our patients".

Staff attended multidisciplinary meetings with GP's and district nurses to discuss the end of life care needs of people in the local area. These meetings were based upon the Gold Standards Framework (GSF) which is a national organisation that aims to enable a 'gold standard' of care for all people nearing the end of life. Staff told us these meetings were an opportunity to discuss people's health needs but also to educate and promote their services to other health professionals.

The service continually reviewed the needs of the local population and implemented changes in care provision to meet the population's changing needs. By participating in project work the service had identified a gap in the provision of quality end of life care for people who were elderly frail or living with dementia in care homes. The management team were developing a service to meet the needs of these people with the aim to improve end of life care in care homes and reduce inappropriate hospital admissions, increasing the likelihood of people receiving their end of life care in familiar surroundings. A team structure for this care provision had been agreed and job descriptions were in the process of being finalised.