The East Lancashire Hospice

East Lancashire Hospice

Inspection report

East Lancashire Hospice
Park Lee Road
Blackburn
Lancashire
BB2 3NY

Tel: 01254287000
Website: www.eastlancshospice.org.uk

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Outstanding ☆
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 14, 15 and 19 September 2016. The first day of the inspection was unannounced. The service was last inspected in September 2013 and was found to be meeting all the regulations we reviewed at that time.

East Lancashire Hospice is a charity which provides a range of hospice services for adults with a life-limiting illness living in Blackburn, Darwen, Hyndburn and the Ribble Valley. The hospice is purpose built and provides accommodation on the inpatient unit for up to 10 people. The hospice also provides community services including Hospice at Home and a day service which provides creative and support therapies (CaST). The CaSt service provided at the hospice is based on a delivery model which has moved away from traditional day therapy to providing support and well-being focused on normalisation, rehabilitation, choice and independence. The aim of the service is to help people to achieve a good quality of life through patient led therapeutic activities, equip people to adapt to illness and empower them to make the most of their life. In addition the hospice offers a 24 hour telephone advice line for professionals, a range of complementary therapies, counselling, support for carers and a bereavement support group.

The hospice is close to public transport routes and is situated in a residential area of Blackburn. The hospice is set in well-maintained gardens with adequate parking and clearly defined parking areas for disabled visitors.

Services are free to people, with East Lancashire Hospice receiving some NHS funding; the remaining funds achieved through fundraising and charitable donations.

At the time of our inspection there were six people being cared for on the inpatient Unit, 142 people being cared for in the community and 67 people attending the CaST service.

There was a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the Chief Executive Officer of East Lancashire Hospice.

People told us they felt exceptionally safe when accessing services provided by the hospice. This was because of the outstanding kindness and compassion demonstrated by hospice staff and volunteers. People who used the hospice told us staff would not hesitate to go the extra mile when caring for them. We saw the importance staff at the hospice placed on supporting families and carers of people with life- limiting illnesses in order to improve the well-being of all concerned; this included the provision of carer and bereavement support, complementary therapies and counselling.

Staff treated people with sensitivity, dignity and respect. People's emotional, cultural and spiritual needs

were met by staff who were knowledgeable and confident to care for and comfort them. Families and those that mattered to the person were supported to spend quality time with them.

All staff had received training in safeguarding adults. In addition the hospice had developed a culture in which staff were supported to report any concerns, no matter how small, to senior staff. Safeguarding forums were in place to provide staff with the opportunity to discuss concerns and ensure referrals were made to appropriate agencies; this helped to ensure people who used the service were protected from harm. The professional responsible for delivering safeguarding training to the hospice told us they found staff to be extremely committed to ensuring the safety of people who used the hospice.

There were sufficient numbers of staff available to provide tailored, individual support to people, both in the hospice and in the community. Staff and volunteers had been safely recruited.

People received excellent care, based on best practice from an experienced and consistent staff team. Staff were supported through training to develop the knowledge, skills and confidence to be able to meet people's needs in an outstanding and individualised manner.

All staff and volunteers completed a comprehensive induction programme. Staff were expected to complete a workbook to demonstrate knowledge in all the topics covered. The induction workbook produced by the service was so highly regarded that it had been purchased by over 20 different hospices in the UK. This demonstrated that East Lancashire hospice was at the forefront of developing innovative resources to train and support staff working in palliative care services. An innovative and creative training programme was also in place which helped to ensure staff had the skills they required to communicate effectively with people who used the hospice, families and professionals.

Hospice staff were committed to promoting excellent end of life care for people in East Lancashire, by providing a programme of education and training for a wide range of health and social care professionals working in care and nursing homes and in the community. This helped to ensure more people received high quality end of life care from skilled staff in their preferred location and avoided unnecessary hospital admissions.

Good systems were in place to ensure the safe handling of medicines. People were cared for in a safe, secure and clean environment. People were protected because risks were identified and managed. The risks of cross infection for people were reduced through training for staff and robust infection control procedures. The ethos of the service was that people in the inpatient unit should feel that they were in a 5 star hotel and spa rather than a hospice. This was achieved through the use of high quality fixtures and fittings, aimed at ensuring people's comfort and privacy as well as the artwork on display throughout the building.

Staff were supported to develop and implement creative ways of improving the outcomes for people who used the hospice; this included both exercise and rehabilitation programmes. We saw that staff had presented the findings from the programmes they had introduced at the national conference organised by Hospice UK. This demonstrated the service was a role model for excellence in practice.

People had access to high quality food, and their nutritional and hydration needs were met by excellent catering services. We noted there was a commitment to further improving the range of meal options available to people throughout the day through the introduction of a 'light bite' menu.

People's legal rights were respected because staff understood their responsibilities in relation to the Mental capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People knew how to complain and

were confident any concerns would be taken seriously. Staff were committed to learning and responding to people's feedback and experiences.

People who used the hospice were supported to make choices and to have as much control as possible about what happened to them both before and after their death. They and their family members were consulted and involved in planning their care. People were also supported to discuss and make decisions on their preferred place of care at the end of their life. Staff were aware of the action to take to uphold a person's rights should they be unable to consent to their care and treatment in the hospice. The skills staff developed through the hospice's innovative communication training programme enabled them to have difficult conversations with people in a sensitive and caring manner.

The hospice was proactive in reaching out to communities who did not traditionally access their services, including people who identified as lesbian, gay, bisexual or transgender as well as people from minority ethnic communities. Innovative methods, including the use of social media and video messaging, had also been used to inform the local population about the services provided at the hospice in an effort to dispel myths and encourage people to access the support available to them.

People told us the leadership team in the hospice was exceptional in the care and support they offered to staff, volunteers and everyone who accessed the service. We were told there was an open and transparent culture in the hospice which encouraged people to express any concerns or complaints they had.

People received a consistently high quality of care because senior staff led by example and set high expectations about standards of care. Staff and volunteers spoke positively and passionately about working at the hospice. They told us they received excellent support and guidance from all the managers in the service. We saw staff had regular team meetings and other informal opportunities to enable them share good practice.

The leadership team in the hospice demonstrated a commitment to service improvement. Staff, volunteers and people who used the hospice were regularly asked for their views and ideas about improvements which they felt could be made. We saw that action had been taken to respond to ideas and suggestions people had made. This demonstrated people who used the service, their families and carers, staff and volunteers were all involved in shaping the future of the service.

There were robust systems in place to monitor the quality of care provided in the hospice; these included 'closing the loop' which helped to ensure lessons learned from accidents, incidents or complaints were shared across the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt exceptionally safe when they used the services provided by the hospice.

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

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

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

Is the service effective?

Outstanding ☆

The service was very effective .

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

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

The hospice provided a wide range of learning opportunities to staff employed in the service and other professionals. The communication skills training developed in the service had been particularly recognised as being innovative and effective.

Staff were encouraged to develop creative ways of meeting people's complex health needs in order to achieve best outcomes.

Is the service caring?

Outstanding ☆

The service was very caring .

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

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

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

Is the service responsive?

Outstanding ☆

The service was very responsive .

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

The hospice was proactive in reaching out to communities who did not traditionally access their services. Innovative methods had been used to inform the local population about the services provided at the hospice in an effort to dispel myths and encourage people to access the support available to them.

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

Is the service well-led?

Good ●

The service was well-led.

There was a registered manager in place. People told us the quality of leadership in the service was exceptional. The leadership team promoted an open and positive culture that

placed people and staff at the centre of the service.

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

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

East Lancashire Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14, 15 and 19 September 2016. The first day of the inspection was unannounced. The inspection team comprised two adult social care inspectors, a specialist nurse in palliative care and a pharmacist inspector.

Before the inspection we asked the provider to complete a Provider Information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Prior to the inspection we reviewed the PIR and looked at information we held about the service and provider, including notifications the provider had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the Clinical Commissioning Group which provided the service with some funding, the local Healthwatch organisation and 13 professionals who worked closely with the hospice to ask their opinions of the service; feedback from professionals is included within the body of the report.

The first two days of the inspection were spent visiting the hospice site including the inpatient unit and the Creative and Supportive Therapies (CaST) service. During these two days we spoke with 10 people who used the hospice services and four relatives. In addition we spoke with a total of 18 staff and two volunteers. These staff included the registered manager, the clinical services manager, a complementary therapist, a physiotherapist, the unit manager for CaST, three staff nurses, a healthcare assistant, the head of corporate administration, the medical director, a hospice physician, the head of community services, the head of hospice at home, the head of catering, the development and support services manager and the pharmacist who worked at the hospice on a part time basis. The third day of the inspection was used to speak by telephone with two people who used the service and four relatives.

During the inspection we looked at the care and medication records for five people using the inpatient unit. We also looked at the records for one person using the hospice at home service. In addition we reviewed a

range of records relating to how the service was managed; these included staff recruitment and training records, quality assurance processes and policies and procedures.

Good

Is the service safe?

Our findings

All the people we spoke with during the inspection told us they felt exceptionally safe when they received care and treatment from hospice staff. Comments people who used the service made to us included, "Oh yes I feel very safe here", "I feel very safe here and well looked after", "I was scared when I first came because I did not know anybody but [name of staff member] really encouraged me and I got used to it in the end", "I was suicidal before I came here. It is brilliant. I wish I could come here every day" and "Without a doubt we are very well looked after here."

Relatives also told us, "I feel [name of family member] is completely safe with the hospice staff" and "I feel very confident that [name of family member] is safe. This means that when I go out I can switch off from my caring role. When I come back he's always very settled" and "I can honestly say that hospice at home has been a lifeline to us both. It means we can be together at home and feel safe. I don't know where I would be without them."

We found there was a commitment throughout the service to ensuring staff, volunteers and board members had the knowledge and training they required to be able to protect people from the risk of abuse. We spoke with the lead nurse for safeguarding in the local NHS Trust. They told us they had been asked by the hospice to support them in developing policies, procedures and training in relation to safeguarding adults. They had also supported the service to train staff to understand the government's Prevent strategy which is aimed at safeguarding people and communities from the threat of terrorism; as a result of this training the hospice had become the first in the North West to appoint a named Prevent lead for the service. The registered manager told us that, as a result of the Prevent training, hospice staff had recognised a potential safeguarding issue; this had been referred via the Prevent lead to the appropriate local services who had conducted an investigation. This action by staff demonstrated that the hospice had robust arrangements in place to protect people who used the service from all forms of abuse.

The Trust safeguarding lead told us they had found all levels of staff in the hospice, including volunteers and board members to be extremely responsive and enthusiastic when attending the training they had provided. They also told us that hospice staff regularly contacted them for advice or support if they had any concerns regarding a person who used the service.

All the staff we spoke with confirmed they had received training in safeguarding adults and children. We saw that safeguarding was included in the training which all staff needed to complete each year. Staff were required to complete a knowledge check at the end of the training and achieve a test score of 100%. We were told that if staff did not achieve this score they were offered additional support to help ensure they fully understood the content of the training and implications for their role. These measures helped to ensure there was a high level of understanding in the service of the need to make sure people were protected from harm. Our discussions with staff showed they also recognised the important role of the hospice in preventing safeguarding issues from arising. This was achieved by providing practical and emotional support to carers and family members during times of particular stress. This support was highly praised by all the relatives we spoke with during the inspection.

The registered manager told us that they had completed work with staff to ensure they felt comfortable when raising safeguarding alerts. Having a culture of openness where staff feel comfortable about raising concerns helps to keep people who use the service safe from harm. Staff we spoke with confirmed they would feel confident to discuss any concerns they might have about a person's safety with senior staff, including the safeguarding lead within the hospice. One staff member commented, "I talked to the safeguarding lead when I wasn't sure what was going on for a person at home." Another staff member told us, "I have had training in safeguarding. It could be that a person says something about a family member or I overhear them talking to others about an issue at home or even if they are here I would report it to the manager and document it. There is a safeguarding form that has to be filled in and it gets investigated."

We noted that staff also had access to regular safeguarding forums organised within the hospice. These forums provided staff with an opportunity to discuss any safeguarding concerns they might have in a supportive environment. We were told that all staff were expected to attend at least one forum per year. A quarterly report regarding safeguarding incidents was prepared for the board; this allowed the trustees to analyse whether safeguarding arrangements within the hospice were effective. The registered manager told us they also attended the local Safeguarding Adults board to help ensure they were following best practice in order to protect people who used the service.

We checked to see if there were sufficient numbers of staff available to meet people's needs across all the services provided by the hospice. People we spoke with in the inpatient unit told us they did not have to wait to receive assistance from staff and that call bells were always responded to in a prompt manner; this was confirmed by our observations during the inspection. One person commented, "Staff are brilliant. They are there when you want them. They check on you all the time; you can't fault them." Another person told us, "When I wanted sensitive discussions I found that staff were able to make time when I was ready to talk and if I wanted anything I could ask anyone at any time."

Relatives we spoke with told us that when they had concerns one evening about their relatives deteriorating condition, they had requested staff on the inpatient unit complete five minute observations to allow them to have a break. They told us that they observed staff performing these checks while they spent time speaking to another visitor; this gave them confidence and reassurance that their relative was safe and receiving an excellent standard of care. Other relatives told us, "Staff respond to our calls night and day." People who accessed community services told us staff always visited at the agreed time and would stay for as long as necessary to ensure they received the care and support they needed. One person commented, "Hospice at home are a brilliant help. It is usually the same person who comes and they are spot on with the time. They stay as long as we need them."

Staff we spoke with told us they always had time to spend with people who used the service. This meant they were able to develop positive relationships which helped to encourage people to share any concerns or worries they might have. One staff member commented, "I spend a lot of time with the patients and I am hands on all the time." Another staff member told us, "I feel that people are quite comfortable to come and speak to me if they have a worry or need to tell me something and I will always follow up or refer them to someone else if I can't help." During the inspection we observed staff sitting and interacting with people in both the inpatient unit and CaST service.

Our review of staff rosters confirmed there were sufficient numbers of staff on duty to provide the care people required. The registered manager told us that any staff absences were covered by hospice staff and that agency staff were never used; this helped to ensure people received safe and consistent care. We noted there was also a team of 354 trained volunteers who undertook a range of roles throughout the hospice. Relatives we spoke with on the inpatient unit told us how they particularly valued the support offered by one

volunteer.

We noted that staff in the hospice had access to 24 hour medical cover. The medical director emphasised that the rotas for medical staff were organised in such a way as to provide continuity of care for people who used the service and their relatives. Staff we spoke with confirmed they were always able to access medical advice either in person or by telephone to help ensure people received safe and appropriate treatment.

We looked at the personnel files for six staff and two volunteers and noted a robust system of recruitment was in place. All the staff files were well organised and included a checklist to confirm the required checks and documentation were in place. The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire, job description and at least two professional references. Checks had also been undertaken to ensure that all the nurses who worked at the hospice had a current registration with the Nursing and Midwifery Council (NMC).

All the staff files we reviewed showed checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We saw that volunteers were required to complete an application form and provide the hospice with two references. DBS checks were also carried out in relation to volunteers who might have access to vulnerable adults in the course of their role within the hospice. These checks help to prevent unsuitable people from working with people who use care and support services.

People in the inpatient unit told us they were extremely happy with the way their medicines were managed by nursing staff. One person told us, "My pain and symptom management has been excellent." A relative also commented, "[My family member's] pain and symptoms have always been carefully assessed and managed".

The hospice had good systems in place for the safe management of medicines. There was a daily review of people's medication needs done by the doctors. There were clear systems in place for the ordering and supply of medicines which were supplied by the local hospital. There was 24 hour access to doctors and medicines which ensured people were prescribed the medicines they needed in a timely manner

The storage of medicines was safe and the main medication storage room was tidy and well organised. When nurses were preparing medication for people systems were in place to make sure they were not interrupted in order to minimise the risk of errors being made. Medicines were given to people on an individualised basis; there were no formal medication rounds. This meant people were able to have medicines at times that were best for them. Most people had their medication given to them by nurses at their request; however arrangements were made for people to look after their own inhalers and mouth care products if they wished to do so.

We saw that when medicines were prescribed with a choice of dose, there was no information recorded to show which dose to select. However, nurses were able to give good explanations of which dose should be used, especially if the medicine was indicated for different conditions at different doses. Nurses also made clear records in the nursing notes when they gave people 'when required' medication.

Medicines handling was audited on a regular basis and there were robust arrangements in place to take action on any concerns found. The findings were shared with the staff so lessons could be learned and improvements made.

The hospice had recognised that some aspects of medication handling needed to be improved and were proactive in making those improvements. The clinical services manager was aware that they needed to develop a policy about covert medication although, at the time of our inspection, no one was being given medicines in food or drink without their knowledge. A new drug chart which was clearer and easier to use had been designed and was about to be put into use. They also recognised the information given to people when they were discharged from the hospice should be more personalised; a new discharge letter and information sheet was therefore about to be implemented.

People were protected because risks for each person were identified and managed. Comprehensive individual risk assessments were completed in relation to people's risk of falling, malnutrition and dehydration and about moving and handling risks. We saw care plans had been put into place to help reduce or eliminate the identified risks.

There was a clear process in place for clinical and non-clinical incident reporting. Records we reviewed showed that all incidents were logged and discussed at clinical governance meetings. The registered manager told us the hospice maintained robust incident reporting procedures within a no blame culture. They told us they had introduced a 'closing the loop' system, which aimed to ensure that outcomes and actions from incidents were used as a learning tool to improve or change practice if required. The development and support services manager gave us an example of how practice had been changed as a result of two staff reporting incidents which had occurred when supporting a person to transfer in the inpatient unit. We were told that, following assessment, a new piece of equipment had been purchased to protect the person and staff during moving and handling procedures. Staff had also been given additional training about different techniques they could use to support the person to safely transfer in advance of the new equipment arriving at the hospice; the outcome of these interventions was that no further incidents had been reported in relation to the person's care.

We noted that the hospice been proactive in analysing the trend associated with falls on the inpatient unit. This had involved exploring the impact of medication changes and the environment of the inpatient unit, including the fact that people were used to sleeping in wider beds and the orientation of the hospice bedroom. The outcome of the analysis was that guidance was produced about the link between medication and falls risk which had been shared with medical and nursing staff. Additionally, consideration of the person's home environment and sleeping arrangements has been incorporated into the inpatient assessment. This meant the changes could be made to the person's hospice bedroom layout in order to mirror the home layout. A number of wider beds had been purchased for the inpatient unit with a planned programme to replace the remaining beds.

Records we reviewed showed the hospice participated in the Hospice UK benchmarking of patient safety indices. Hospice UK is the national charity for hospice care in the UK. The indices compared data between hospice services of similar sizes on falls, pressure ulcers and medicine errors. The data showed East Lancashire Hospice recorded lower than average across all areas in two of the last four quarters. The clinical services manager explained the action the service had taken where the benchmarking showed higher than average scores such as the numbers of medicines incidents in one quarter. The benchmarking data showed that following this action the service had recorded below average for the number of medicine errors in the last three quarters; this showed their risk reduction measures were effective.

People who attended the hospice were cared for in a clean and safe environment. We saw infection prevention and control policies and procedures were in place. Staff we spoke with during the inspection demonstrated their awareness of the actions they should take to prevent the risk of cross infection. One staff member told us, "Hand washing is one of my responsibilities. If I am baking I undertake all food hygiene;

make sure I am using the right stuff, make sure things are clean, right aprons, right colours. I also ensure I use aprons when toileting and disposing of things properly."

We looked at the documents which showed equipment and services within the hospice had been serviced and maintained in accordance with the manufacturers' instructions; these checks helped to ensure the safety and wellbeing of people who used the hospice, staff and visitors. Our inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to ensure that the fire alarm, emergency lighting and fire extinguishers were in good working order and that the fire exits were kept clear. We were told that regular table top evacuation exercises took place to help ensure staff were aware of the action to take in the event of a fire at the hospice, without distressing people who used the service. Following recent advice from the fire service the hospice also intended to introduce six monthly fire evacuation drills.

We noted that contingency plans were in place to ensure the continuity of the service in the event of staff sickness, IT failure or the loss of utilities such as water, gas and electricity.

Outstanding ☆

Is the service effective?

Our findings

People who used the service, relatives and healthcare professionals consistently praised the outstanding standard of care, treatment and support provided by hospice staff. Comments people made to us included, "All the staff I have been in contact with came across as confident and highly skilled, including the cleaners", "Staff are very well trained" and "My relative was in the hospice for seven weeks to have their medication changed. In that time the hospice did more for them than anyone had done in the community." This person also told us how the hospice had worked proactively with a range of different specialists and services to help ensure their relative's complex and rare health condition was effectively managed. As a result they told us their relative's pain management and quality of life was now much improved.

We looked at how staff were supported to develop their knowledge and skills. We looked at the induction programme that newly appointed staff had to undertake on commencement of their employment. Induction programmes help staff to understand what is expected of them and what needs to be done to ensure the safety of the staff and the people using the service. The induction training programme included topics such as health and safety, principles of end of life care, safeguarding, communication, moving and handling, infection control, equality and diversity. The programme also included suicide risk assessment as it had been recognised within the service that this was an important area for staff to consider when supporting people diagnosed with a life limiting illness. Staff were expected to complete a workbook to demonstrate knowledge in all the topics covered. The development and support services manager told us the induction workbook was so highly regarded that it was now purchased from them by over 20 different hospices in the UK with positive feedback received; we received written information to confirm this following the inspection. We saw that the induction programme had also been developed into an e-learning option to support the different learning styles of staff. This demonstrated that East Lancashire hospice was at the forefront of developing innovative resources to train and support staff working in palliative care services.

In addition to the general hospice induction, staff also received a pack which contained information relevant to the department on which they were located; this helped to ensure they understood what was expected of them in their role. Staff were also required to undertake the Care Certificate if they had not gained this qualification prior to starting work at the hospice. The Care Certificate is a set of minimum standards which care staff are expected to achieve.

The medical director told us they provided new staff with an eight week in house training programme which consisted of one full day and seven half day sessions. They told us that existing staff were also able to access this programme as refresher training. One staff member told us, "I find [name of medical director's] teaching sessions really useful and I have worked in palliative care a long time."

We saw that in addition to ongoing classroom based sessions and e-learning, staff had access to books, journals, and other online resources to keep up to date with best practice. A training matrix was used to monitor staff whether staff were up to date with their required training and showed a compliance rate of 99.08% for the previous 12 months.

We asked one staff member what training they had received in the last 12 months. They told us, "I have had six steps to end of life care, moving and handling, hand washing, food hygiene and story sharing with Hospice UK in London." We asked what the story sharing training involved and were told, "We did a power point presentation when we came back. This has been shown in the clinical governance meeting and it is being shown to trustees. It is all about people and how they can be supported to share their stories; capturing moments of people's lives through stories". We asked the staff member how they felt they could put what they had learned into practice and were told, "We have thought of doing the same thing but doing it through music; we think this would be a good thing here. The idea is that people can bring what music they want; music that means something to them and tell us the story behind it. We plan to run this for six weeks and at the end they will get a cd with all the music on at a celebration event". This showed staff at the hospice were innovative and creative in putting their learning into practice in order to deliver outstanding care which met people's individual needs.

We noted that the hospice provided training to its own staff and other professionals in areas such as bereavement support, family work and the Six Steps programme. This programme aims to guarantee that all possible support is made available to people in order to facilitate a private, comfortable, dignified and pain free death. Supporting staff to receive this training from a number of community based settings such as care homes and nursing homes helped to ensure people could receive high quality end of life care at their preferred location, which avoided people having unnecessary admissions to hospital. We noted that a number of external staff were attending this training on the second day of our inspection at the hospice. A community based lead professional commented that, "East Lancashire Hospice have worked closely with Blackburn with Darwen Community Nursing Teams to provide regular training in palliative and end of life care and have also worked in partnership to deliver bespoke training e.g. individualised care planning in the last days and hours of life. Meetings take place to share practice and opportunities. "

The hospice also provided placements to a variety of healthcare professionals, with in-house mentorship and training. This included GP trainees, medical students and student nurses. We were told the placements were always highly valued by students. We spoke with one GP who told us they had enjoyed their placement at the hospice so much they now worked there on a sessional basis.

The hospice had been innovative and creative in developing and implementing a training programme for communication skills. This CLEARER communication programme involved three levels of workshops – Care, Clear and Clearest. The aim of the programme was to ensure all staff within the hospice had the skills and confidence to communicate effectively and compassionately with people who used the service, families and professionals. As a result of the effectiveness of the programme the hospice had been awarded funding from the Clinical Commissioning Group to deliver the communication skills training to professionals across East Lancashire. When we looked at the results from the evaluation of the training delivered to date we noted participants had scored it very highly.

When we reviewed the records of people who used the service we found evidence that staff who had completed the communication skills programme had the confidence to hold difficult conversations with people who used the service and their families in a sensitive and transparent manner. An example we saw was when staff had discussed with a person the limits of treatment options available to them. This helped to ensure people had the information they needed to be able to make decisions about their care and treatment. We noted one person who used the service had commented, "The doctor was very good at explaining things in simple terms so I could understand."

The physiotherapist in the service told us how they had been supported to develop an innovative programme to support healthcare assistants to develop their knowledge and skills in relation to a

rehabilitation model. The aim of the programme was to give healthcare assistants the skills to be able to follow a plan devised by the physiotherapist. Tasks the healthcare assistants were trained to carry out included supporting people to carry out simple exercises and helping people with strategies to manage their anxiety or breathing. We were told the programme initially involved a healthcare assistant being placed with the physiotherapist for an eight week period. However, following an internal evaluation of the programme, it was determined that the placement period needed to be extended to six months; this was considered necessary to ensure healthcare assistants were supported to develop the required depth of knowledge to be able to effectively carry out the delegated tasks. The physiotherapist told us this extended programme had proved to be very effective in achieving improved outcomes for people who used the service. As a result they had been supported to deliver a presentation about the programme to the Hospice UK conference in November 2015. This demonstrated that the service was contributing to the evidence base about effective interventions in hospice care.

We received feedback from a person at the local college who had been involved with the complementary therapy department at the hospice for a period of four years. They told us, "Hospice staff have been involved with our degree validation process, playing an instrumental part in the development of modules taught on our courses. Students have been inspired by guest lectures from hospice staff and holding our end of year complementary therapies student conference at the hospice two years ago promoted further awareness of the importance of palliative care and the professional nature of the hospice itself." This demonstrated that the hospice worked creatively with professionals from a range of backgrounds to improve the experience of people who used the service.

We asked the registered manager to tell us what they understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

The registered manager told us staff had completed training in MCA and DoLS. The clinical services manager informed us that they were the lead for MCA and DoLS within the hospice. They told us that all the people currently receiving treatment in the hospice were able to consent to their care. However they were aware of the action to take should they consider that an individual might not have the capacity to make particular decisions; this should help ensure people's rights were protected.

All the staff we spoke with demonstrated a good understanding of the principles of the MCA. One staff member told us, "You have to assume someone has capacity unless it is proven by someone else that they have not." Another staff member commented, "We know what to do if we need to assess someone's capacity to make a decision."

We saw that new staff had an appraisal of their performance within a few weeks of starting work at the hospice. This helped to ensure staff were performing well in their roles and received the training and support they required to deliver high quality compassionate care. In addition all the staff we spoke with told us they received regular supervision and support from senior staff. We were told that, although notes were taken of the content of the discussions held in supervision sessions, a formal shared record was not maintained for

all staff. The registered manager told us they would consider developing a template to be used across the service with all staff.

We observed the multi-disciplinary meeting which was held each week between professionals working in palliative care services in the local area. We saw that the care and treatment needs of individuals were discussed in a sensitive manner and arrangements made to offer people services to meet their needs. We observed that staff were proactive in considering what other support people might need in addition to the hospice and were told that appropriate referrals would be made with each individual's consent. This helped to ensure people received care, treatment and support in a timely and effective manner. We also observed that staff discussed whether people had advance care plans in place and how best they could accommodate any decisions which the person had made. The need for best interest decisions was also reviewed by professionals at the meeting. A best interest meeting is where other professionals and family where relevant, decide on the course of action to take to ensure the best outcome for the person using the service; this demonstrated staff understood the legal framework in which they were working.

We were told there was a 24 hour advice line available to provide support to professionals. Calls were responded to by inpatient staff and reviewed the following day to ensure the required outcome had been achieved. We noted the strategic plan for the hospice included extending the advice line to take calls from people who used the service and their families. We looked at the most recent audit of this service and saw there had been an increase of 130% of calls received from the previous year. The audit noted the service was a valuable resource which had seen increasing use from both community and hospital teams. The audit reported evidence that appropriate advice and follow up had been given in all cases.

People who were admitted to the inpatient unit had their care reviewed on at least a daily basis or more frequently as their needs changed. We saw that care plans were updated to ensure people received the treatment they required. People we spoke with on the inpatient unit told us they were always fully involved in any treatment decisions. One person commented, "I am always asked before any procedures are done." A relative also told us, "[Medical director] and nursing staff were amazing. We had complete confidence in the staff and all our questions were answered as often as needed."

We checked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met. We saw that the service had its own restaurant which was used by people who used the service, staff and visitors. The restaurant also provided meals to the inpatient unit. One relative told us, "We were offered meals if we couldn't leave the room or we could access the main restaurant. We felt really well looked after during such a difficult time".

All the people we spoke with gave positive feedback about the meals provided in the hospice and told us staff always went out of their way to meet their preferences. Comments people made to us included, "'I had no appetite when I arrived but once my symptoms were under control I found the menu had fantastic choice. The food was excellent quality and I was able to get meals at a time that suited me", "The food was lovely. I had gone off food and was eating very little. Staff got me anything and everything I wanted to tempt me to eat" and "The food is like a five star hotel. Anything [my relative] wanted he only had to ask."

We spoke with the head of catering who had only started working at the hospice two days before the inspection. They told us they had been employed with a brief of making the catering service even more personalised and flexible. In order to achieve this they informed us that they intended to introduce a 'light bite' menu from which people could choose throughout the day. They told us, "Whatever people like we will try our best to get this for them, even if it means going off site to buy things." They told us they had already spoken with people who attended the CaST service to discuss what changes they might like to see to the

menu. They also intended to visit people on the inpatient unit to discuss their likes and dislikes so that they could provide individual meals to meet their tastes.

The care records we looked at showed that people had an eating and drinking care plan and they were continually assessed in relation to the risk of inadequate nutrition and hydration. People who were at risk of malnutrition and poor hydration had their food and fluid intake monitored to help ensure their well- being.

We asked staff how they provided reassurance to relatives who were concerned that their family member's oral intake had significantly reduced. One staff member told us, "I would explain and reassure them that their relative has a reduced need for diet and fluids at this stage when approaching end of life. I would also explain the importance of still offering diet and fluids until the patient is not able to swallow safely and would discuss comfort measures like mouth care." A relative we spoke with commented, "'The food is always high quality and there is lots of choice. Even when [name of relative] was unconscious they still brought a jug of fresh water in during the day for mouth care".

People's individual needs were met by the environment of care at the hospice. The building was light and airy. People had extremely spacious individual en-suite rooms which were accessible to people in wheelchairs. We noted the bathroom fittings were of an extremely high standard and were aimed at helping people to feel as if they were staying in a luxury hotel. All bedrooms had patio doors which opened onto a courtyard garden. This area provided a safe and welcome outside space for people and families and meant people cared for in bed could access the outdoors. We were shown evidence that the hospice had also undertaken an assessment, using a validated tool, to determine whether the environment was appropriate for people living with a dementia and any actions required to help improve people's experience. All areas of the hospice were decorated with artwork which had been made by people accessing the service with the support of other agencies, including local students and colleges.

We saw that there was a room available on the inpatient unit where relatives could stay overnight; pull out beds were also available for use in people's individual bedrooms. The registered manager told us they had recently recognised that the usual hospital beds were not wide enough to allow partners or family members to easily maintain close physical contact with their relative. They had therefore invested in a number of wider wooden beds which, while still able to perform the functions of hospital beds, were more comfortable and homely for people. This demonstrated the hospice considered creative ways of improving people's quality of life and promoting their well-being. A staff member told us, "[Name of registered manager] wants to make people feel as though they are in a spa, being pampered and cared for, rather than in a hospice." We noted that one person had commented in their patient story displayed in the hospice that, "It doesn't feel like you would expect a hospice to feel and certainly didn't fit with my own opinion of what a hospice is. It's like a hotel with the relaxed layout, atmosphere and nice big bathrooms."

Outstanding ☆

Is the service caring?

Our findings

All the people we spoke with during the inspection told us they received outstanding care from staff at the hospice. Without exception people told us staff were always extremely kind and compassionate and were dedicated to providing high quality care and support. Some of the many comments people made to us included, "Staff are absolutely wonderful. They are really kind", "Staff are absolute angels. The hospice has made such a difference to me", "The hospice and its staff are absolutely fantastic. They are so caring", "All staff are very caring and made me feel at home. They ensure that there is a nice relaxed atmosphere. This was important to me because I was really anxious about coming to the hospice as I thought it would be really depressing place", "Patients and families are treated as individuals and they are made to feel as part of the hospice family. Nothing is too much trouble and they consider the little things that are important. They always call patients by their chosen name rather than a bed or room number which we had experienced while [name of relative] was in hospital".

One relative told us how a staff member had gone the extra mile to allow their family member to express their views and wishes. They commented, "[The staff member] stayed behind once their shift had finished as [name of relative] had wanted to talk about dying which she had never wanted to do until that point."

Several of the people we spoke with told us they had been very frightened when it had been suggested to them that they might use the hospice. They told us that it had been the reassurance and outstanding support and care from staff which had allayed their fears and allowed them to make use of what they now saw as an extremely valuable service. One person told us, "I was frightened but not now. The attention to everything was so good. I trust them now. Staff were so wonderful and lovely from the lady that brought the tea round to the doctor. It was like heaven on earth." Another person commented, "The care is first class. It is not a place to go to die; it is a place to live."

We were shown a poem a person who used the CaST service had written about their outstanding experience at the hospice. This included the words, "It's behind that long wall that's too high to see, on Park Lee Road in Blackburn near the big tree. Well that's the place where only poorly folk go!! I don't think so!!!! Poorly or well the welcomes the same. They are all willing to greet you, just tell them your name No matter how you're feeling on 'your special day', there is always a smile and a kind word to say."

During the inspection we spent time on both the inpatient unit and with the CaST service. We observed staff to be extremely person centred in all their interactions with people. We noted that staff were completely focussed on asking people what they wanted to do, how they were feeling, if they wanted anything and what support they required. A relative told us, "When [name of relative] was unconscious we got upset because we had forgotten to ask what song she wanted at her funeral and we were amazed that a nurse had documented her wishes".

Due to the training they received all levels of hospice staff demonstrated exceptional interpersonal and communication skills. This enabled them to quickly establish a rapport with people and find out what mattered to them. We spoke to a person who had only been in the inpatient unit for a few days and had no

previous contact with hospice staff as they lived in a different area. They told us that staff had spent time with them since their arrival to find out how they wanted to be cared for. The person's relatives commented, "It's so lovely here. Staff have been excellent. We are really lucky to get a bed and fulfil [name of relative's] wishes." Another relative told us, "Even when [my relative] was unconscious cleaning staff always acknowledged her by name and asked if it was ok to clean her room. Nursing staff still communicated with [name of relative] while they were caring for her. This was very important us as it showed us that they cared a lot."

We asked people who attended the CaST service what the atmosphere in the unit was like. Comments we received included, "I didn't know what to expect before I came. I didn't know what went on in a hospice, but it is great. I enjoy it", "I really enjoy coming here I feel comfortable", "I come once a week and I like socialising with people here", "We are all in the same position in some ways so when we come here we feel better" and "People think when you mention hospice, oh my God, but I tell them, we have a right laugh here."

We found a very relaxed, friendly and sociable atmosphere within the CaST service. People were sat round in groups, laughing, chatting and undertaking activities throughout the day. Volunteers were a very visible presence within the service and spent time chatting with people or undertaking activities with them.

People we spoke with told us staff had been exceptional in enabling them to achieve symptom and pain management control, either through pain relief medicines or other therapies. We noted that one person had commented in their patient story, "I've had massages at the hospice which have helped me so much that I didn't need any pain relief the next day."

We saw that a patient communication initiative had been developed to help people who attended outpatient appointments at the hospice to have a better understanding of the agreed plans in place. Following appointments letters were written directly to the person attending rather than their GP using accessible language. The outcomes of this initiative had been evaluated by the hospice; the findings were that people felt empowered, that their views had been listened to and respected and they had a greater understanding of the proposed treatment plan.

People were supported to have a comfortable, dignified and pain free death. During our inspection on the inpatient unit we were informed that a person had died. We observed staff managed the situation in a calm and respectful manner, supporting the person's relatives to spend as much time with them as they wished before the undertakers attended the hospice. The registered manager told us the hospice had recently purchased a 'cool blanket.' This extended the time that people could remain in their room at the hospice following their death and meant relatives, friends and family had more time to say their goodbyes with staff support if necessary.

All the staff we spoke with were highly motivated and inspired to offer the care and support people wanted to receive throughout their involvement with the hospice. One staff member told us, "It's a privilege to work here. We keep people who use the hospice at the heart of everything we do." Staff told us how they spent time with people to find out about any particular goals or wishes they wanted to achieve and, wherever possible, took action to ensure these wishes were fulfilled. Examples staff gave included arranging for a person to see their horse for a final time before they died which was extremely important to them. They told us they had also arranged a wedding for a couple at very short notice; this had involved several staff volunteering to work extra hours to ensure the day was a success for the people concerned. We noted that in one of the 'patient stories' on display in the hospice a person had commented, "It was only when I started going to the hospice I felt someone cared. They couldn't do enough for me and went that extra mile. They noticed the little things that mattered."

Were told there were no restrictions on visiting times. During the inspection we observed children were supported to visit a family member. We saw that child friendly games and resources were available for them to use during their visit and enable them to spend time together as a family. People were also able to have visits from family pets as staff recognised this provided them with a great deal of comfort.

All the staff we spoke with demonstrated a commitment to offer support to the whole family during a person's illness and after their death, if required. Relatives and carers were able to access the complementary therapies offered at the hospice. Counselling was also available together with a bereavement support service which people were able to access for as long as necessary following the death of their family member. A carers support drop in group was also provided. Comments relatives made to us included, "The hospice team are so supportive, not just of [name of family member] but me as well. I've received both emotional and practical support as well as complementary therapies", Staff allow me to talk about my feelings which takes the pressure off at home; they have made such a difference to me" and "When [name of relative] was referred to the hospice we were very anxious and thought the hospice would be a sad place; we couldn't have been proved more wrong. We feel the hospice had treated us as part of a family and as individuals and recognised what was important to us at such a difficult time in our lives."

We saw that the hospice had a chapel available for anyone to use. The registered manager told us they would always discuss people's spiritual or religious needs with them and would make any arrangements necessary to ensure these were met. One person told us, "I'm not religious but I was asked on admission if I would like to access a vicar but I said no as it's not my thing. A vicar does pop in to say hello and I'm grateful but I don't feel that I am made to accept anything further". A staff member from the hospice at home team also told us, "We always assess people's cultural needs. We are also respectful of people's wishes about the gender of care staff people want to support them." When we looked at one person's record we noted that staff had documented the importance of the individual's faith to them and the support the person needed to help them exercise their religious beliefs.

The registered manager told us they had developed good relationships with local interpreting services in order to ensure people had equal access to the service provided by the hospice. We saw evidence of regular referrals for interpreters on one of the care records we reviewed. We also saw that the hospice had developed links with a local service for deaf people in order to help them better understand and meet the needs of people with sensory impairment.

The hospice held regular remembrance services for the families and friends of people who had died. The registered manager told us these services were very well attended by families and were supported by staff and volunteers from the hospice. We noted there was a service planned for Christmas 2016 in which people would be able to light a candle to remember their family member and would receive a card dedicated to their loved one. We were told a Light Up A Life Book of Remembrance would be produced following the event.

Outstanding ☆

Is the service responsive?

Our findings

All the people we spoke with during the inspection told us the hospice had been extremely responsive to their needs. A person who had been in the inpatient unit commented, "Staff couldn't do enough for me." A relative told us that they received regular calls from the manager of the hospice at home team to check if they needed any additional support or visits. Another relative told us how hospice at home staff would always accommodate any requests for extra care for their family member. They commented, "If something crops up they go all out to accommodate my needs. They are always available to listen or offer advice. They tell me, 'that's why we are here'".

Professionals consistently gave us exceptional feedback about the services provided by the hospice. Comments included, "The service is patient centred, offering caring input for patients, carers and clinicians alike. The outcomes are effective, achieving positive outcomes in terms of psychological improvement and symptom control. I am very pleased to have such a good service in the area for my patients" and "I have always been impressed by the caring and highly passionate nature of the staff I have been in contact with at the hospice and am looking forward to continued collaboration over the coming year."

People were admitted to the in-patient unit for a variety of reasons; for example pain relief, management of a life limiting health condition and end of life care. Staff worked with people and those close to them to develop individualised care plans that reflected how each person wanted to receive their care, treatment and support. They supported each person, if they wanted to, to develop an advanced care plan, so people's wishes about their preferred place of end of life care were documented. This meant the person's wishes were known so staff could carry them out. A staff member told us, "Care plans are reviewed every four weeks and they are all client centred, all about them as a person using a holistic approach to what they need. We also do advance care planning about what they want in the future." As a result of the training they received, staff at the hospice also had the communication skills to be able to discuss sensitive issues such as organ and tissue donation with people at the end of their life. As a result we saw arrangements had been made to fulfil people's wishes to help others following their death.

The medical director told us that, although planned admissions to the hospice inpatient unit normally took place during working hours on weekdays, they would accept unplanned admissions at any time out of hours if a family were in crisis. They told us they considered the hospice was a service which was responsive to people's needs and had an important role in helping to avoid unnecessary admissions to the local accident and emergency department.

We were told by the medical director that they had taken the decision to move away from the traditional hospital ward round in order to become more patient centred; this allows people to get up or washed and dressed if appropriate to suit them rather than staff." This was confirmed by a relative who commented, "The staff are very thoughtful. They tailor nursing care, medical reviews and discussions to the individual which has been a significant improvement to how [name of relative] was treated in hospital; care is more personal here at the hospice".

Staff in the CaST service told us about the systems in place to help ensure they were offering people the support they wanted. One staff member told us, "I continuously ask people what they would like to do. You get to find out about the person and what they like; it gives me an idea and then I discuss it with them. Just through discussions and talking to people and asking them what interests they have got. I make sure I spend time with different people." Another staff member informed us, "We have a getting to know you document. At the back of this there are people's priorities and goals; what they want to achieve. We review these after four weeks and ask people how they think they are doing and if they want to set new goals or continue with the ones they have." One person who used the CaST service told us how staff had helped him to achieve a personal goal. They commented, "The hospice arranged for me to go to Liverpool football club and go and see the changing rooms and meet the players. It was brilliant and something I will remember forever." This demonstrated that staff were proactive in responding to the holistic needs of people who used the hospice.

The registered manager told us they wanted the hospice to be the hub of the community. They told us the staff team worked tirelessly in order to provide services which promoted the concept of a hospice without walls. The registered manager told us they had recognised that people were often unaware of the range of services the hospice provided and were often of the opinion that it was used only by people at the end stages of their illness. In order to ensure people had accurate information the hospice had recently produced a short video, titled 'Making the Most of Life', which they hoped would encourage people to contact the hospice to find out more about the support available.

We saw that posters were on display in the hospice which recorded the work staff had undertaken to reach out to groups which had traditionally not accessed hospice services; these included people who identified as lesbian, gay, bisexual or transgender as well as people from minority ethnic communities. The registered manager told us how they had been proactive in contacting leaders in the local Muslim community to explain the services the hospice was able to offer and to encourage people to consider accessing those services. They told us this initiative had been extremely successful and had resulted in increased referrals for people from minority ethnic communities. They told us, as a result of the partnership working they had undertaken, Muslim leaders were now proactive in helping to raise funds for the hospice. One such leader we contacted for their view of the hospice told us, "I have been helping the Hospice to raise funds for many years. The caring and differences they're making to the patients has inspired me to continue to raise funds and awareness in the communities to show the fantastic service that is available through the Hospice." They also told us that a relative had used the service and described the staff as, 'Angels'.

Staff exceeded the expectations of their role to provide people with an exceptional service. The physiotherapist at the hospice told us they had recognised that people with life limiting illnesses struggled to access therapy to improve their physical health and well-being. As a result they had designed and introduced a specialist 'Get up and go' exercise programme which was available to all people who used the hospice and geared toward palliative rehabilitation. The programme involved people attending six sessions at the hospice. The physiotherapist told us the programme had been running for six months and had been positively evaluated by all who had attended. They gave us an example of one person who had been supported through the programme to develop their mobility and stamina; this had allowed them to achieve their goal of returning to Spain with their family for a final visit. The physiotherapist told us, "That proved to me that it is 'do-able' and we can help people achieve their goals through this programme."

Staff from the complementary therapy team had also recognised that some people on the inpatient unit might not be able to access the therapy rooms but would benefit from massage or other therapies. Because of this staff had requested training from the physiotherapist in postural management when delivering therapies to people who might have restricted movement. Risk assessments had also been completed to ensure appropriate measures were in place to protect both staff and people accessing complementary

therapies on the inpatient unit. We were told that complementary therapies had now been delivered on the inpatient unit for a month and people had reported a positive impact on their well-being as a result.

The registered manager told us they were in the process of developing links with a new local residential service which was aimed at offering care and support to people living with dementia. The registered manager told us they hoped this collaboration would enable staff at the hospice to develop their understanding of how best to support people living with dementia who accessed the service. They told us they also hoped to provide education and support to staff in the residential service about best practice in palliative care. The hospice had also developed the role of 'dementia champion' to take a lead in developing best practice across the service.

Our discussions with staff showed there was a commitment to ensuring people were able to spend time at the end of their life in their preferred place of care. We saw that arrangements were in place to ensure people were provided with the specialist equipment, support and medicines they required to receive personalised high quality care should they choose to remain at home. A relative told us, "They [hospice at home staff] rang other services to make sure we had the care and support we needed." Staff from the hospice at home team were also particularly praised for being proactive in asking people if they needed additional visits or support to help them achieve the best quality of life possible. One person told us, "They ring regularly to check if we would like an extra visit." The head of the hospice at home service told us they aimed to be as flexible as possible when providing care and support to people. They told us there had been occasions when they had provided 24 hour care to a person at the end of their life as there had been no other services involved. They commented, "Because we are quite small we can be very responsive to people's needs. We will also pre-empt things to help people to receive the most appropriate care and support."

The hospice had a positive approach to using complaints and concerns to improve the quality of the service. Information about the complaints procedure was on display throughout the hospice and people were encouraged to report any concerns, no matter how minor. The registered manager told us any concerns or complaints received were dealt with quickly and people received a written response. One staff member informed us how they would respond if they received a complaint. They told us, "I would deal with it straight away. I would ask them about the complaint and document and would take it to the lead person. An investigation would take place. I would also tell the person that it is confidential and someone will discuss it with them. I would also reassure them it would be dealt with."

We saw that outcomes from complaints were linked to change of practice when necessary. A regular report was produced for the Board of Trustees detailing any complaints received; this enabled the Trustees to ensure lessons were learned from complaints in order to improve people's experience at the hospice. We also saw a summary of the lessons learned and actions taken from risks and complaints between April 2015 to March 2016; this included the production of a checklist on the inpatient unit to familiarise people with their surroundings and equipment and minimise risk of falls as well as the introduction of an assessment for the safe use of raiser recliner chairs. This demonstrated the commitment of the hospice to service improvement.

We saw that the hospice maintained a log of all compliments received about the service; this helped them to identify areas of good practice. We noted that a total of 160 compliments had been received over the previous 12 months. We noted that one person had commented, "Thank you for what I can only describe as an outstanding level of care, support and commitment to my well-being."

We saw that people who used the service and their relatives had opportunities to influence the development

of the hospice. This was through involvement in the annual clinical audit, the completion of questionnaires following their use of the hospice, suggestions from members of the CaST service regarding the provision of activities, as well as feedback from people using the website and other social media. We were told that following suggestions from CaST members a fully equipped kitchen had been installed in the day unit; this was fully accessible to people with disabilities to help promote their involvement in all cooking and baking activities. In addition, the registered manager told us that, as a direct result of feedback from people, a social support group had been set up to help people deal with the impact of being discharged from the hospice. People who used the hospice had also been supported to record and share their stories. With permission these stories were shared with professionals to help develop a wider understanding of the services provided by the hospice and to influence the practice of clinicians; this helped to improve the palliative care experienced by people living in the community.

Good

Is the service well-led?

Our findings

There was a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the Chief Executive Officer of East Lancashire Hospice.

People who used the service and staff told us they considered the leadership of all parts of the hospice was exceptional. One staff member told us, "I have worked in two other hospices but I find it liberating to work here. We are treated as autonomous professionals who are supported to make our own decisions and be as innovative as possible." Other comments people made to us included, "The managers are all really kind and responsive", "Management are very supportive. I would not hesitate to knock on [name of registered manager] door to speak to them", "I feel very supported in my role", "The chief executive is very supportive. They want to make the hospice less clinical" and "She is very visible and will sit and have a break with staff. She comes around to do a walk around." Another comment we received was, "There is always someone you can go to, knock on someone's door. Hierarchy doesn't matter here."

Staff and volunteers spoke positively and passionately about working at the hospice. When we asked staff about the culture of the service one person told us, "There are some good dynamics. People are people and bring with them their own personalities. [Name of staff member] is my right hand man; I would be lost without her. I love it. The environment is lovely. There are pressures but they are all about evolving the service, creating a better quality of service which is what we are about." Another staff member told us, "I will work here for the rest of my life."

Staff told us they were listened to and were able to influence how the service was developed. We saw that the registered manager had introduced an initiative called 'Just one thing'. The intention of this was to encourage staff to think about one thing which they considered could improve the experience of people who used the hospice. We were shown the list of suggestions made by staff since June 2015 and noted that several had been actioned; these included the purchase of sofa beds for the comfort of relatives on the inpatient unit as well as identifying an appropriate room in which relatives could spend time when collecting a person's personal belongings and death certificate.

Feedback from professionals we contacted for their views of the service included, "I have always been able to talk to someone when needed and there is clear, positive leadership in the service" and "I have had the great pleasure of working closely with East Lancashire Hospice. They are very committed caring individuals who are brilliant at what they do. They are very professional in the way they go about their day to day business. I have nothing but praise the work they carry out as a hospice" and "Whilst working with the hospice to provide a bereavement training service I have found them to be committed and meet all the required standards with the upmost professionalism. They are a forward thinking organisation who ensures the community are at the heart of all they do."

The clinical commissioning group told us, "We have no concerns what so ever, they offer a great service and work with wider providers in the development of the Pennine Lancs End of Life Strategy." A lead professional at the local NHS Trust commented, "East Lancashire Hospice are an asset to Lancashire Care Foundation Trust's palliative and end of life provision through effective and approachable leadership, partnership working in patient care and excellent training programmes.

The hospice was managed by a board of trustees, to whom the Chief Executive Officer/registered manager reported. Trustees attended all committees including those relating to clinical governance, risk management and health and safety. A report on clinical governance, clinical risks, and complaints was presented at the quarterly meeting of the Board of Trustees. The registered manager told us the trustees were robust in challenging them about the quality of the service but supportive of initiatives to improve the quality of people's experience at the hospice.

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

We saw that the mission statement of the hospice was to 'Provide free, expert patient centred services at the right time in the right place'. The registered manager and board of trustees were aware of the importance of forward planning to ensure the quality of service they provided continued to develop. There was a strategic plan in place for the period 2013-2018 which had been developed through consultation with people who used the service, staff and volunteers. We noted this plan included a commitment to develop services to further support families and carers and to expand access to the 24 hour helpline to include people who used the hospice and their families.

The hospice had conducted a quality and development review of the service, the stated aim of which was to ensure the service was safe and well-led with visible effective leadership. The review had included a review of care records, interviews with staff and 13 people who used the hospice. We looked at the findings from the review which documented that people who used the hospice had overwhelmingly reported a 'very positive' experience of care. The review identified good practice and positive themes which had been expressed by people. These included outstanding care, excellent involvement in decision making and the view that the hospice was challenging preconceived ideas of a hospice and generating a feeling of well-being and confidence in people who used the service. The review also documented areas to be considered which may enhance the experience of hospice care. These included a focus on 'episodes of care' as opposed to discharge. This was to ensure individuals were aware they could re-access services if and when their needs changed.

Some of the numerous comments made by people during the review included, "The hospice has been a revelation. It's all about how I want things to be", "The way the staff are, the friendliness, the way they go about things; I'm going to be safe, I can feel it", "I'm absolutely happy, over the moon. I never thought I would be so well looked after; it's really extraordinary, a relief" and "Nobody goes beyond that line in difficult conversations. They listen to me when I say 'no more' they stop. The trust and the way they go about caring for me; I feel cherished."

Staff had provided positive feedback about the excellent support they received from managers in the service. Comments we saw included, "I am well supported. My line manager is approachable and is always ready to talk to me if there are any problems" and "The manager gives us reminders to read new policies"

and "Safeguarding forums and education has given me an understanding of where to go to get advice."

Staff told us there was a 'no blame' culture and that they were encouraged to report any clinical incidents or near misses. These were fully investigated and used as a learning tool to drive improvements in the delivery of care and to safeguard people from harm. We saw that regular staff meetings took place throughout the hospice. Minutes from these meetings showed that any previously identified issues were followed through and addressed.

In addition to the staff meetings the registered manager held six weekly 'Tea and Toast' sessions which every staff member and volunteer were encouraged to attend. The aim of these sessions was to share the work that people were doing and provide an opportunity for 'rumour busting'. The registered manager told us, "It's a positive, open forum. We can use it to learn from each other. We want to encourage people to come and have their ideas listened to. Staff were wary at the beginning but they enjoy it now."

The registered manager had introduced a 'cascade' system for briefing staff and ensuring they were kept up to date with service developments or key issues which had arisen from the governance systems. Each member of staff was personally given their own paper copy of the information and were also encouraged to discuss its content with their line manager. The registered manager told us the system had been well received by staff. They commented that they had been particularly pleased to observe several members of night staff discussing the content of the most recent briefing and sharing their views and opinions.

The registered manager told us the hospice was committed to ensuring it was up to date with best practice. The hospice was a member of Hospice UK which is a national organisation, the aim of which is to help hospice care providers to deliver the highest quality of care to people with life-limiting or terminal illnesses. Staff had access to regular briefings provided by Hospice UK and were supported to attend its annual conference. We saw that staff had also been supported to deliver four presentations at the most recent conference which took place in November 2015 to highlight and share the impact of service developments at the hospice; these included 'Working with people from black and minority ethnic communities', 'Raising awareness of tissue donation within the hospice setting' and 'Developing the rehabilitative model: hospice health care assistants and physiotherapy project'. This demonstrated the service was a role model for excellence in practice.

We saw evidence of regular clinical audits, for example of medicines management, safeguarding concerns raised as well as the health and safety of the care environment. These resulted in action plans to improve where appropriate. Reports from these audits were submitted to the relevant governance committee for review.

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