

North Devon Hospice

North Devon Hospice

Inspection report

Deer Park
Newport
Barnstaple
Devon
EX32 0HU

Tel: 01271344248

Website: www.northdevonhospice.org.uk

Date of inspection visit:

17 July 2017

18 July 2017

Date of publication:

13 October 2017

Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Outstanding ☆

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place on 17 and 18 July 2017 and was announced. We gave the registered manager 48 hours' notice of the inspection because we wanted key people to be available.

The North Devon Hospice at Deer Park in Barnstaple provides a seven bed in-patient unit (called the bedded unit), a team of community nurse specialists (CNS), a range of day services and support groups and a hospice to home team. Deer Park is situated on the hillside above Barnstaple, has beautiful views and is surrounded by well-kept landscaped gardens. The area of North Devon covers 1000 square miles of mainly rural countryside. They work closely with community hospital facilities and the local NHS Trust.

The hospice has an outreach centre in Holsworthy, known as The Long House. This opened in September 2015 and was a specially designed building in order to aid people's sense of well-being. From here people can see their CNS, complementary therapist and attend therapeutic support groups. This addition of this outreach centre meant that people from the lower half of the North Devon area did not have to make long journeys up to Barnstable for their care, treatment and support.

Hospice services were provided for adults over the age of 18, with life-limiting illnesses and advanced progressive conditions. At the time of this inspection 80% of services were provided to people with a cancer diagnosis and 20% were to people with non cancer illnesses. Non cancer illnesses include motor neurone disease and other degenerative neurological conditions, pulmonary and cardiac disease.

Where people's preferred place of care was their own home they were supported by the hospice to home team, the CNS and the local community district nurses. The hospice to home team helped people to stay at home longer or to die in their own home. The service also offered respite for family carers.

The staff team included the following: doctors, nurses, health care assistants, physiotherapist, occupational and complementary therapists, counsellors and volunteers. The various services provided by the hospice worked in conjunction with people's own GP's, community district nurses, and other health and social care professionals.

There was a registered manager in post. 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 director of care was the registered manager.

At the time of the inspection the bedded unit were looking after five people and the hospice to home team were providing support to about 20 people living in their own homes.

Both parts of the service provided end of life care in the last couple of weeks or during a time when they

needed care and treatment for symptom control or help during an emotional or physical crisis. The service looked after people with a cancer diagnosis (80%) and non-cancer patients (20%) but the service aimed to increase the numbers of people they were able to support with non cancer conditions. From the bedded unit 20% of people were able to go home after a short stay and may return at a later date and 80% would die in the hospice. The hospice to home service was mainly provided for people nearing the very end of their life, however they may also support people and their families during a crisis.

The service was safe. All staff received safeguarding adults training. This meant they would be able to recognise if people and children they came into contact with were being harmed and would know what to do to report those concerns. Recruitment procedures were robust and ensured that only suitable staff were employed.

Training was undertaken by all staff who assisted people to move from one place to another including the use of equipment. Staff were trained how to use equipment correctly. Any risks to people's health and welfare were identified during the assessment of care needs and were then well managed. The service had the appropriate procedures in place to protect people from being harmed.

Staffing numbers in the bedded unit were determined by the number of people who were receiving care and support and the complexity of their needs. The hospice to home team had a flexible workforce (bank staff) in order to be able to increase capacity and accommodate the demand for their service. The team endeavoured to always meet any referrals for a service and would pull out all the stops to support those in need.

The service was effective. There was a programme of mandatory training for all staff to complete and this prepared them for their job role. New staff had a comprehensive induction training programme to complete at the start of their employment and all other staff had a programme of refresher training. Additional training was arranged regarding clinical skills. This ensured the staff team had the required skills and qualities to provide a compassionate and caring service to people and their families.

People's capacity to make decisions was continually assessed and where possible they were supported to make their own choices and decisions. Staff received training regarding the principles of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Staff ensured consent was given prior to providing any care and support but worked within best interest principles where people could not provide this. Where people lacked the capacity to make decisions because of their condition or were unconscious they worked within assumed consent but checked with healthcare professionals and family members before providing care and support.

People in the bedded unit were provided with a well-balanced and nutritious diet. They were able to choose what they wanted to eat. There was a guide menu however alternatives were always prepared to meet people's individual needs and preferences. Significant improvements had been made to the catering services since the last inspection. People were also given the choice of when they wanted to eat their meals; there was no set meal time. People in their own homes were assisted to eat and drink where this was required.

Health and social care professionals referred people to the hospice service when they needed in- patient care, and provided an overview of their medical and nursing care needs. The hospice to home service received referrals from the district nurses, GPs or clinical nurse specialists. Staff worked in partnership with healthcare professionals and families to be supportive and provide an effective service.

The service was very caring. All the staff teams had the necessary qualities and skills to provide sensitive and compassionate care and support to the people they were looking after. This care and support also extended to the person's family and friends. It was evident the staff developed close working relationships with the people they looked after and their families. The staff went out of their way to meet people's dying wishes and told us about several examples of how they had made a difference to the last few days/weeks of people's lives. For example, they had arranged a third birthday party for a child whose mother was at the very end of their life and had arranged a Jamaican 'sights and sounds' experience for a Jamaican person who was dying. There were many examples of the staff going the extra mile and providing a person-centred service to each person and their family.

People received person centred care and as they moved between the different hospice services, the hospital and their GP, communication was coordinated. The hospice service provided ongoing bereavement support to families, adults and children for as long as was necessary. The service also referred families on to other relevant services where needed. All staff who worked for the hospice were emotionally well supported by their colleagues and the managers, evidencing this is a very caring service.

The service was responsive. The care and support needs for each person whether they were being looked after in the bedded unit, in their own home or attending for a treatment/counselling were provided with person-centred care. Regular reviews of people's needs ensured their care plans were revised as often as necessary. People were always involved in making decisions about their care. The hospice to home team ensured that family carers were always supported in a way that was most beneficial to them.

The service was well led. There was a robust leadership and management structure in place and all the teams of different staff were passionate about providing a high quality service that was safe, effective, caring and met people's needs. The measures in place to assess the quality and safety of the service ensured that when shortfalls were identified, that improvement actions were taken. Analysis of any events such as accidents, incidents and complaints meant any trends were identified and enabled the service to make changes and prevent a reoccurrence. There was a continual programme of audits in place to drive forward any service improvements needed.

Feedback from people and their families was used to measure how people felt about the care and support they received. This feedback was used to drive forward any improvements or to make changes to the service provided. One example was the provision of various support groups rather day hospice services.

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.

All staff received safeguarding adults training. Any risks to people's health and welfare were well managed. Recruitment procedures ensured only suitable staff were employed.

People received their medicines safely. Qualified nurses had the appropriate skills to enable them to administer end of life medicines. Improvements had been made to the records kept when medicines were administered.

Sufficient staff were employed and staffing numbers were adjusted in order to people's needs. The staffing levels on the bedded unit varied depending upon the number of people and their care and support needs. The hospice to home service aimed to meet all referrals for a service.

Is the service effective?

Good ●

The service was effective.

People were looked after by well trained staff who were supported to carry out their roles effectively. Staff had the qualities and skills to provide compassionate care and support.

Staff understood the importance of obtaining consent from people before supporting them. They were aware of the principles of the Mental Capacity Act (2005).

People were supported to have sufficient food and drink that met their individual requirements. Their healthcare needs were met and there was good collaborative working in place with other health care services.

Is the service caring?

Outstanding ☆

The service was very caring.

There was a strong person-centred culture within the service. Staff went above and beyond to provide people and their families with extraordinary memories. People were supported to

use the time they had left to live well and to achieve any specific wishes they had.

People and their families were treated with the respect and kindness and their dignity was always maintained. All staff were passionate about their role and committed to providing a kind and loving service. They ensured when people were at the end of their life they had a good death.

Families were also provided with a very caring and supportive service. Staff ensured families, adults and children, were given every opportunity to express their views and access further support. Bereavement services were available to support them at a difficult time in their lives.

The service looked after its staff and provided them with emotional support and guidance.

Is the service responsive?

Good ●

The service remains responsive.

Is the service well-led?

Good ●

The service remains well led.

North Devon 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was announced and undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has been involved in this type of service in the past. The previous inspection of North Devon Hospice was completed in January 2016. There were no breaches of the legal requirements at that time; however, there were two areas where improvements were required to be made. These were in respect of some aspects to do with the management of medicines and the consistency of the catering arrangements.

Prior to the inspection we looked at the information we had about the service. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they planned to make.

During our inspection we spoke with six people who were using hospice services and five relatives. We spoke with 18 members of staff including the chief executive officer, the director of care and registered manager, medical staff, qualified nurses, health care assistants, heads of departments and one volunteer.

We looked at paper and electronic care records for three of the five people in the bedded unit, policies and procedures, quality audits, quality assurance reports and minutes of meetings.

Is the service safe?

Our findings

People who were staying in the bedded unit said, "I feel safe here in every way. They are very gentle and have never caused me any hurt", "I feel 100 per cent safe here. The staff look in on you regularly and at night they are so quiet" and "The nurses have to use the hoist and they do so competently. They are very careful". One relative said, "It is peaceful here (the bedded unit) and (named person) feels safe and ready for their next journey".

The service had a safeguarding adult's policy in place. There were clear reporting protocols understood by all the staff, to ensure any concerns were dealt with appropriately. This included where child protection concerns were identified, although children were not admitted to the bedded unit or cared for by the hospice to home team. Staff could be supporting people who had child visitors or children were present in the homes of the people they visited. All staff received safeguarding training as part of the mandatory and refresher training programme.

All staff we spoke with knew what action to take if abuse was suspected, witnessed or alleged. They said they would report any concerns they had to a senior manager and were aware they could report directly to the local authority, the Police or the Care Quality Commission.

Safe recruitment procedures were used and prevented unsuitable staff from being employed. Appropriate pre-employment checks had been completed. Enhanced disclosure and Barring Service (DBS) checks were carried out for all staff. A DBS check allowed employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people.

When people were admitted to the bedded unit a number of risk screening assessments were completed and then reviewed throughout their stay. These included the likelihood of pressure damage to skin, falls risk, a nutritional screen and a moving and handling risk assessment. Where people needed to be assisted to transfer or move from one place to another a plan was written detailing the equipment to be used for each task and the number of staff required. These risk assessments were completed for people receiving a hospice to home service.

A personal emergency evacuation plan (a PEEP) was prepared for each person staying in the bedded unit. The nurses updated these on a daily basis and ensured they were always accurate for that time. The PEEP detailed the level of assistance they would need in the event of a fire in the unit.

The hospice premises were well maintained and all safety checks were in place and repeated as part of a planned checking system. The maintenance staff had a programme of daily, weekly, monthly and quarterly checks and actions to complete in respect of fire safety and water safety. There were processes in place to deal with any maintenance of the building. Service contracts for all equipment were in place. A health and safety and infection control audit had been completed by an external contractor at the beginning of the year and the completion of the action plan had been monitored by their care quality monitoring group.

Risk Management was embedded within the culture and ways of working at the hospice. The various staff teams regularly reviewed the work place risk assessments. There was a departmental risk register, with tailored risk assessment criteria in place. These measures ensured the safety and effectiveness of the service.

Hospice to home staff supported people in their own homes and a check was made of the person's home to make sure it was a safe place for the staff to work. This check looked for any external and internal risks to safety. The service had a lone working policy in place which staff were expected to adhere to for their own safety. All hospice to home staff were expected to report any new risks or emerging risks to the team's manager.

The hospice to home team were supporting about 20 people in their own homes at the time of the inspection. The staff pulled out all stops to meet all referrals for support and liaised closely with the clinical nurse's specialists, GPs and district nurses to coordinate people's care. The team covers the whole of the North Devon area and at the time of the inspection had 22 nurses and healthcare assistants. The hospice to home team had a flexible workforce (bank staff) in order to be able to increase capacity and accommodate the demand for their service.

The service had a major incident plan in place with action card instructions for all key staff to follow in the event the plan needed to be invoked. The registered manager told us they had completed a "desk top exercise" recently in the bedded unit and amendments had then been made to the plan. Some lessons learnt from the exercise were then incorporated into the plan.

There were sufficient staff employed by the service. The bedded unit staff team consisted of the head of care, ward sisters and qualified nurses, senior health care assistants (SHCA) and health care assistants (HCA). Staffing levels were adjusted as necessary in order to meet people's care and support needs. Staff confirmed they had enough time to spend time with each person, providing emotional support, comfort and reassurance. They also confirmed they had sufficient time to be able to support the person's family and other visitors.

The day services staff team consisted of a qualified nurse, complimentary therapists, counsellors, allied healthcare professionals and volunteers. The service was provided three days a week at the Deer Park site in Barnstable and two days a week at The Long House in Holsworthy. In addition there were drop-in sessions. Staffing levels were dependent on the number of people booked to use the services.

The management of medicines was safe. A full medicines management review had taken place in the last 12 months and had included an external audit conducted by an NHS England recommended expert.

In the bedded unit people's medicines were stored in locked cabinets by their bedside. Controlled medicines (known as CD's) were stored separately in line with regulations. There were procedures in place for the receipt and administration of CD's in to the bedded unit. Healthcare assistants had completed second checker training since the last inspection which meant they were competent in performing these tasks with the nurses. The arrangements for the disposal of CD's had improved and the service now had denaturing kits in stock. The process of destroying unwanted CD's was undertaken by staff members, who did not have day to day responsibility for the management of medicines. This was good practice. For those people who were at risk of a catastrophic bleed supplies of 'just in case' medicines were stored at their bedside to enable the medicine to be administered quickly in the event of an emergency. There were standard operating procedures in place to sign the medicines from the treatment room in and out, to the person's own locked cupboard.

Key changes had been made with the management of medicines since the last inspection. There was a service level agreement in place with the local hospital for the supply of medicines and a weekly visit by a pharmacist. New medicines forms had been introduced and these were clearer and provided greater clarity of prescribing instructions.

All medicines were stored correctly and securely. The bedded unit had the appropriate signage in place where supplies of oxygen cylinders and oxygen concentrator units were stored. Each of the seven bedrooms had a piped oxygen supply in the room. The bedded unit was a no smoking area apart from one designated room. This could only be used by people who were staying at the hospice and only when a robust risk assessment had been completed. The room was not for visitors use. A set of resuscitation equipment was located in both the in-patient and day therapy unit.

People in receipt of the hospice to home service were encouraged to retain responsibility for their medicines or their families supported them. The district nurses had the lead role in the person's care and there was always discussion between them and the hospice nurses regarding symptom control and, when needed, the setting up of a syringe driver. The hospice to home nurses were able to administer medicines when this was needed during their visit. All nurses were trained to set up syringe drivers. Health care assistants who worked within the hospice to home team were not involved with people's medicines, but would liaise with the nurses if they needed to report a change in the person's condition.

Is the service effective?

Our findings

People and their relatives were complimentary about the service they received. A number of the comments posted on the 'I want great care' website made reference to the fact that relatives appreciated people had been supported to die in their own home with their family.

The bedded unit provided a peaceful environment where people could be looked after either when they needed a period of temporary care for symptom control for example, or for their final days. Each of the bedrooms were well appointed. A local quilting group had provided bed covers and this helped to provide a non clinical feel to the rooms. Six of the seven bedrooms had access out on to a balcony area and the doors were wide enough to allow the bed to be wheeled outside.

The hospice to home team looked after people and their carers whose preferred place of care was in their own home. The team offered a rapid response service and was able to offer round the clock care. People were supported with symptom control, psychological support, personal care and practical help. The team had expanded in the last year with the introduction of three new clinical nurse specialists and five new healthcare assistants. This enabled the team to give more overnight support to people in their homes.

There were a team of clinical nurse specialists, each attached to GP surgeries. These nurses provided care, advice and emotional support for people and their families. They visited people in their own homes, were able to provide information about other services that may be beneficial and worked closely with community healthcare professionals and the other hospice services. The supportive care team helped people to "use the time they had left well" and enable them to "open their life to be more than living with a disease".

Staff were overwhelmingly positive about working for the North Devon Hospice and were proud of their role in supporting people and their families. They was a great determination amongst all the staff to get the service right for everybody and to meet any specific wishes they may have.

Newly recruited staff had an induction training programme to complete at the start of their employment. New members of staff were not generally 'new-to-care' therefore had some experience in looking after people. Their initial shifts were supernumerary to the staffing numbers whilst they settled in to their role and they were allocated a mentor to support them. Their induction training consisted of one corporate induction day, plus generic and role specific training. A number of staff we spoke with told us the induction programme had prepared them to do their job well and they were well supported.

North Devon Hospice had a programme of training all staff had to complete, organised and overseen by the head of education and the education co-ordinator. This programme included safeguarding people, equality and diversity, infection control, moving and handling, health and safety and information governance as examples. Specific clinical training was arranged regarding syringe drivers, resuscitation, anaphylaxis, catheterisation, dementia awareness and diabetes monitoring. There was also a programme of training for the team of volunteers who support the people and staff in the bedded unit and the supportive care team.

The hospice had a six step palliative care training programme module; this was akin to the Gold Standards Framework (GSF). The GSF helps improve quality through training by quality improvement, quality assurance and quality recognition. This training programme was also open to local care home providers. This approach meant the hospice were supporting other care providers to deliver good care to people who were at the end of life or in receipt of palliative care and could remain in the place have been looked after.

Staff were supported to do their jobs effectively and there was an overall view they were each extremely well supported by their colleagues. Annual appraisals were undertaken each year and they had 1:1 supervision meetings with a line manager. Weekly staff support sessions were in place for all staff (clinical and non-clinical) to attend as they needed. There were measures in place for them to talk with counsellors about how they were affected by their work and their exposure to death and dying. Nurses worked alongside the health care assistants and were always on-hand to offer advice and support.

People's ability to make decisions for themselves was assessed throughout their care, whether they were being supported in the bedded unit or by the hospice to home team. Staff received training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and understood the principles of the legislation. They understood the implications for their day to day practice. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty of people who lacked the capacity to consent to the treatment or care they needed. The hospice staff had made five DoLS applications to the local authority where the person has been too ill to consent to be looked after in the bedded unit. They worked with assumed consent when supporting people who were unconscious and at the very end of their life. Those people looked after in their own homes by the hospice to home service provided consent to being supported prior to entering the end stages of their life.

Two people had posted on the 'I Want Great Care' website saying "Amazing food and treatment" and "The meals and cooking are first class". During the inspection, people in the bedded unit said, "Sometimes I have pureed meals and sometimes my family bring me in foods I like. They will make you anything here. The texture of the food is good", "The food is very good so far. Yesterday I had the first full meal I have eaten for a long time" and "The chef is doing me a fish pie today. Nothing is too much trouble for them".

Significant improvements with the catering services had been made since the last inspection where it had been found there were inconsistencies in the quality of meals provided. For those people in the bedded unit, each person was visited every morning by the chef who discussed their choices for their individually prepared meals for the day. Individualised care plans were in place for people with nutritional and/or hydration needs. There was a wide selection of dishes available for people and each meal was tailored to their needs. Where people fancied something not on the menu, the catering team prepared that particular dish. Meals times were not set and their meals were delivered to them at a time that suited them. Taster bites were offered to people with little appetite to encourage them to eat and meal portions were always based upon the persons' wishes.

People were assisted to eat and drink where required. Nutritional needs were identified and a plan of care was recorded in their care notes. These notes included people's preferences and choices. One of the members of staff in the bedded unit had taken a lead role in nutritional support and had completed additional training. The hospice to home staff would support people with eating and drinking where needed but were not involved in the preparation of meals.

A consultant in palliative medicine and two medical officers provided medical cover for the bedded unit.

There was also a bank of doctors (mostly local GPs) with an interest in palliative care who provide medical support for the unit. The consultant provided out-of-hours on-call advice and 'ward rounds' took place every day where people's care was reviewed. This enabled pain management and symptom control to be regularly adjusted.

Clinical review meetings were held on a weekly basis with the nursing staff, the community nurse specialists, the hospice to home team, the supportive care team and therapy staff. Discussions were around the care of people who had recently passed, those people currently in the bedded unit, those being supported by the hospital to home and supportive care teams and new referrals.

For those people in their own homes who were receiving support from the hospice to home team, the nurses and health care assistants worked collaboratively with the GP, district nurses and other relevant health and social care professionals. The district nurses were the lead health care professional coordinating the person's care and support.

Is the service caring?

Our findings

People and relatives were overwhelmingly positive about the care and support provided by the hospice staff. They said the staff were exceptional and compassionate and looked after them physically, emotionally and spiritually. In speaking to people and their families and staff, we were told about many examples of how the hospice service had a strong person-centred culture and supported individuals to improve their well-being.

One person told us, "The nurse arranged for me to have some fresh air and they helped me out in to the gardens with my friends. The chef had arranged a cream tea party surprise for me – it was wonderful". The catering staff prepared regular individualised treats for people such as peppermint creams, truffles, and cream teas to make their stay special. The hospice recognised that food played an important part in each person's experience. The catering team made a fuss when there was a celebration and regularly made birthday cakes or wedding anniversary cakes. In the past they made an ice cream birthday cake for a person who could only eat pureed food.

Examples of other special events the catering team had catered for included having Christmas celebrations in July for a person and their family, mini barbeques, romantic meals, picnics, themed days, high teas and film nights. Most recently they had hosted an 'In for a Treat' candlelight dinner in the grounds at Deer Park (the North Devon Hospice in Barnstable). This was held on the terraced area and couples were encouraged to book a table. They were provided with a restaurant experience, part of their 'making memories' approach to enabling people to use the time they had left well. The service planned to repeat this experience again as the feedback had been overwhelmingly positive.

The service had a 'making memories' programme. This enabled the staff or volunteers to respond to people's specific 'dying wishes'. They told us how staff had brought a horse up to the front of the hospice building, so one person whose working life involved horses was able to stroke the animal. They also told us how they had supported people to make a 'something for you' object; drawing upon local artists support, so the person could leave a keepsake for their loved ones. Each Christmas they hold a 'Light up a Life' service at Deer Park in the courtyard, with a tea light procession into the retreat room. Once a year in the summertime they have a 'floating bye' ceremony at one of the local beaches. This is a letting go ceremony where people were able to attach a flower and a note for their relative/friend who had passed, to a large wicker heart mounted on a bamboo raft. There is then a spiritual ceremony and a choir and the raft was towed out in to the estuary. This ceremony enabled the families to come together with the hospice staff, celebrate the person's life and say their goodbyes.

All staff we spoke with during the two day inspection were passionate about their role and getting it right for the person and their family. They felt they had the "best job ever". They all had chosen to work within a palliative care environment and were highly motivated to provide the best possible service. They were fully committed to ensuring that each person received the best possible care and that any wishes they had were met where possible. They told us they had arranged a birthday party for a three old whose young mother was in the bedded unit and dying. The mother had been able to participate in the party. Another example

where the staff had gone above and beyond was when they arranged a Jamaican 'sights and sounds' experience for a Jamaican person who was dying. Staff spoke about people with genuine kindness.

The facilities team had carried out a DIY SOS style make-over of a person's home to enable them to go home to die which they had passionately wanted to do. The team had also helped another family by putting together some flat packed furniture, removing the stress of having to organise it themselves. The hospice had looked after 'a super fan' of an international celebrity and had arranged for a personal celebrity video message to be broadcast from his own home in the USA directly to the person.

To make a person's stay as comfortable as possible, the hospice could arrange to collect items from their home to make the bedroom less clinical. In the past this has included objects such as small personal pictures and photographs to larger items of favourite furniture. To support families who may have difficult journeys to make in a rural area the hospice had a fully furnished and equipped family accommodation suite. The suite consisted of a lounge, bedroom and bathroom.

The hospice had a supportive care team and the families of people who had died were offered pre and post bereavement support. Bereavement support was offered to adults and children and was tailored to individual needs. The service was either provided for a significant period of time after death or families were signposted to other relevant service. The registered manager told us how they had previously set up pre-bereavement therapeutic support groups for younger adults. The counsellors assisted these young people to work through the issues they faced and to live as well as possible despite their illness and to develop new friendships. They talked about another group where young parents who were dying were helped with "knowing how to talk to children about what was happening". The service also had a partnership with a local charity who offered support to bereaved families and an established referral pathway to get them extra support. There were also carers support groups to enable them to be supported, to discuss any worries they had, be provided with practical help and explore solutions which would help them cope.

We observed many incidences of positive interactions between staff and volunteers with people and their families in the bedded unit. A new person was admitted to the bedded unit on day two and they received a warm welcome upon arrival and were offered refreshments. It was evident the family were well looked after as well.

Within the hospice building at Deer Park there was a room called 'The Retreat'. This was a 'non-denominational' and peaceful place for reflection, meditation, prayer or just somewhere quiet and private to spend time alone. Spiritual and emotional support was an important part of the care provided by the hospice. This role was provided by all staff and in particular the supportive care team. People were encouraged to express their spirituality or practice their religion in their own way. The staff worked closely with local church ministers and other faith leaders from the local community.

Butterflies were displayed throughout the Hospice which denoted the passing of a person and sent a message to staff to be even more considerate that someone had died and grieving families were on the premises.

It was evident people were treated with great respect and dignity. Their privacy was maintained at all times. Each of the bedrooms had a curtain across the doorway and doors were also closed when personal care was being delivered. The curtain across the doorway meant that even when the door was opened so that staff could enter the room, the person's dignity was maintained.

The hospice service not only cared for the people they looked after but also looked after the staff. Staff were

emotionally well supported by their colleagues and the managers.

Is the service responsive?

Our findings

The comments made to the inspection team were extremely positive about the responsiveness of the service. They said their care was focused on their individual needs. Comments included, "It is all about you here. Nothing is too much trouble", "I told them one of my medicines didn't agree with me. The doctor changed the tablet to a capsule and that's better", "When I have had to use the call bell it is answered quickly" and "I was in two minds about coming here but it is really pleasant. The staff listen to you and take note of what you say".

People were provided with information about the North Devon Hospice. There was a range of booklets and leaflets available. These were displayed in various places in the bedded unit, the entrance to the hospice building and The Long House (outreach centre in Holsworthy Devon). Information was also kept in the bedrooms in the bedded unit. This ensured people and their families knew what was on offer from the service and what they could expect.

People's care and support needs were continually assessed and their plan of care adjusted. For those people being admitted to the bedded unit, the doctors and nurses gathered as much information as possible from relevant health and social care professionals. An electronic care planning system was used and recorded relevant details about the person's care and support needs, how they wanted to be looked after and the actions staff needed to take. From looking at a sample of the plans it was evident people were treated as individuals and received individualised care.

A handover meeting was held each morning with the night and day staff in attendance. This meant any changes in people's needs were communicated and each person would continue to receive the appropriate care, treatment and support. People and their families were always given the opportunity to have a say if they wanted things done differently or if they needed additional help in any way. This ensured the service provided to each person was responsive to their particular needs.

The hospice had a team of clinical nurse specialists whose focus was on helping people improve the quality of their life. They did this by accessing help to manage symptoms the person was experiencing, providing information about other services, working closely with other healthcare professionals and supporting the whole family.

District nurses, GPs, the bedded unit or hospital staff referred people to the hospice to home service. Often with referrals to the hospice to home team an assessment of their care and support needs was completed on the first visit. The person and their families were always included in making decisions about how best the service could support them. The service provided was based upon the person's specific needs and the support required by the family. Overnight care and care visits during the day were provided and supported people's wishes to die in their preferred place of care, their home. Information was reported back to the district nurses after each visit. These measures ensured all services were able to respond to changes in a person's condition and to instigate changes in service provision promptly.

Supportive care services had been re-designed in response to feedback from people and families who used the service. Instead of offering day hospice services which had fallen out of favour, they offered a series of 'patient' therapeutic support groups. These were led by the counsellors and ran for a six week period. They ran in both Deer Park in Barnstaple and The Long House in Holsworthy. At these groups people were able to meet with others diagnosed with a life-limiting illness and access support and understanding from within the comfort of a group environment. The groups were tailored to the needs of the people they were supporting at that time. Examples of some of the most recent groups included, 'how to talk to children about what is happening', a creative writing group, and 'tracks of our years'. Both the last two groups supported people to make memories for their families, for them to treasure after they had passed.

Each person who was looked after by the hospice services had their care and support reviewed each week in the multi-disciplinary team (MDT) meeting, chaired by the consultant in palliative medicine. The meeting also assessed any new referrals received and discussed those people who were moving between different parts of the service. The team looked at post-death analysis. This process allowed the team to look at how things had gone and identify where things could have been done differently or better.

All parts of the hospice service welcomed feedback and appreciated suggestions and comments that could be used to shape the service in the future. "You said.....we did" noticeboards were on display to show people and their families that they listened to feedback and responded. Feedback was used as a means of driving forwards improvements.

People, and their families, were asked to share their views or make comments during their stay, whilst using the supportive care services or receiving the hospice to home service. People were able to make comments on the 'I Want Great Care' website. Those comments we saw on this site included the following: "The care I have received from all at the hospice had made my life a lot happier. I enjoy meeting the other patients. Getting out twice a week has made my world a little bigger, before I was housebound", "The care understanding and help has been outstanding. The staff all understood me and my needs" and "The people here are lovely and they talk to us when we feel sad and depressed".

All the staff we spoke with told us that feedback was seen as extremely important and enabled them to be responsive and make changes where needed. People and their families were encouraged to say what was good about their care and what could be improved.

Three people in the bedded unit told us if something concerned them they would not hesitate to tell the staff. Everyone else we spoke with was confident the staff would listen to them if they were unhappy about anything and would do their best to resolve any issues. A copy of the complaints procedure was given to everyone using their services.

Is the service well-led?

Our findings

There was a robust management structure in place at the North Devon Hospice led by a chief executive officer. There was a board of trustees and a senior management team with a broad range of knowledge, skills and experience to support the various aspects of the hospice work. The service had a registered manager who was the director of care. They were responsible for the bedded unit, the hospice to home service, supportive care service, and the community nursing service.

There were two areas for improvement identified at the last inspection and the hospice staff had taken appropriate action and ensured the improvements were sustained. A full medicines management review had taken place which included an external audit conducted by an NHS England recommended expert. There was now a service level agreement in place with the local acute trust and a weekly senior pharmacist visited the bedded Unit. A new medicines chart had been introduced. Significant pieces of work had been undertaken in respect of the catering arrangements in order to ensure people were satisfied with the food and drink they were served. This showed that the service strived to ensure the quality and safety of the service was good.

The registered manager had been in post for six years at North Devon Hospice and previous to this worked in similar services managing a team of clinical nurse specialists and hospice services. They told us they did a weekly informal ward round of the bedded unit in order to keep themselves in touch with current issues.

In the bedded unit, there was a manager and a deputy manager who led and supported the staff team of qualified nurses and healthcare assistants. The hospice to home staff team were led by a team leader, previously a clinical nurse specialist. Since the last inspection the service had further developed in order to respond to increased demand and the rapidly changing needs of people wishing to receive end of life care in their own home. This expansion meant the service was able to support more people whose preferred place of care was their own home. The hospice to home team also co-ordinated care on behalf of Marie Curie in order to increase night sitting services in the area. The team said they had increased the availability and accessibility of hospice services to people with non cancer related life limiting conditions, such as heart failure, chronic lung disease and motor neurone disease.

There was a leadership training programme in place and three members of staff in key roles were currently working towards this qualification. One other senior member of staff was half way through completing their master's degree in leadership and organisational development. The measures in place evidenced that the North Devon Hospice had a strong and stable management structure in place to ensure the service was well led.

The director of care held weekly and monthly meetings with the team of clinical lead staff and looked at any incidents, complaints, any external issues and shared any information with the team. There was a daily 'capacity meeting' each weekday. These looked at referrals, any stresses and strains on the service, any people requiring one to one looking after and reviewed any 'out-of-hours' calls. Each Tuesday there was a multi-disciplinary meeting which enabled them to keep in touch with all aspects of the hospice's work.

On alternate months there was a care quality working group meeting. These looked at the feedback they had received about their services, accidents, incidents and complaints and learning points from any serious events analysis. Heads of department and key staff members attended these and enabled the service to identify trends, look for learning and strive to make any improvements. In the last 12 months the hospice service had received two formal complaints, one of which was still in the process of being investigated.

There was a range of different feedback systems in place to enable people and their families to express their views and experiences of the service they used. There included the North Devon Hospice and I Want Great Care websites where they can post comments. The service was currently looking at further ways in which the trustees could gather 'real time' feedback from people whilst they using the service. Any feedback received in complimentary cards and letters was collated on a monthly basis and reported in the care quality working group meetings.

There was a programme of yearly audits in place and this was based on national hospice guidance. Two external audits had been undertaken so far in 2017 in respect of 'the hospice environment' and infection control. All audits were based upon the CQC five questions and the key lines of enquiry. Any shortfalls that were identified in these audits were then recorded on an action plan and then tracked until improvement actions had been taken. Examples of other audits included medicines management, care audits, hand hygiene checks and clinical audits. National 'Hospice' audits were undertaken on a quarterly basis in respect of pressure damage, medicines incidents and the prevalence of falls. At the time of the inspection the service was auditing the use of anti-biotic medicines over a three month period.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the service and which the service is required by law to tell us about. This meant we were able to monitor how the service managed these events and would be able to take any action where necessary. The hospice to home team were aware notifications to CQC were only required if a person died whilst the health care assistant or qualified nurse were providing a service at the time of death.

The service has further developed community links and entered into a partnership with Devon and Somerset Fire service in order to identify vulnerable people in their own homes who may then receive a free fire safety audit and check. The hospice also had a partnership arrangement with another bereavement counselling charity who offered support to bereaved family carers. The charity used The Long House for one session per month.

North Devon Hospice were working with the NEW Devon CCG strategically and leading the Northern Locality end of life care steering group. Chaired by the hospice the meetings were attended by multi-agencies. They were also working in partnership with Petroc College to support the development of health care assistants in other work places. North Devon Hospice were developing a joint approach to transition, working with the national clinical lead for 'Together for Short Lives'. They had started discussion meetings in North Devon to support the caseload of transitioning young adults. These measures ensured the highest quality of end of life care was available throughout North Devon. There were also plans in place to enhance specialist palliative care support into the acute setting, the local NHS Trust.