

St. Leonard's Hospice York

St Leonard's Hospice

Inspection report

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Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Outstanding 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Outstanding 

Summary of findings

Overall summary

This inspection was announced and took place on 19 and 20 July 2016. Our previous comprehensive inspection was on 29 April 2014 and was part of the pilot to test the Care Quality Commission's (CQC) new inspection methodology and so although they were rated this was not published.

At the inspection on 29 April 2014 we asked the registered provider to make improvements with regard to Regulation 12 Safe care and treatment; around the management of medicines. This action has now been completed. We revisited the service on 29 September 2014 and found the service was compliant with the regulation.

St. Leonard's Hospice York provides a 20 bed in-patient hospice care unit (IPU) and a hospice-at-home service which are regulated by CQC. The Sunflower Centre, which is the day hospice is not regulated by CQC. These are based on one site. The hospice holds condition specific clinics, has a social work team, a bereavement support service, therapy services, an education department, a fundraising department and a team of volunteers numbering around 230. There is a hospice-at-home team who provide hospice care in the community to people. There is also a care homes education team who work specifically with care homes in the area. The hospice also has an on-site Chaplain who provides spiritual care to everyone using the hospice service.

The care provided by the hospice is for people that live in the York area of North Yorkshire and Ryedale and some parts of the East Riding of Yorkshire. The service is a registered charity with a board of trustees. Day-to-day the service is run by a senior management team drawn from all departments within the hospice.

The service was responsive and focused on providing a tailored service which people helped plan and develop. There were appropriate systems in place to ensure flexibility to people so that their care needs could be met either at home, in the hospice or in the wider community. In addition the service provided good support to relatives and carers.

Excellent leadership and management was demonstrated at the service. The culture was open and inclusive which meant that people received a tailored service which was flexible to their needs.

There was a registered manager employed for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was very experienced after being employed by the hospice for a number of years.

The beautiful environment was maintained by the hospice maintenance and gardening team. There were servicing agreements in place for mains services. The premises were extremely clean and tidy with appropriate adaptations in place for people who used the service. The gardens were extremely well

maintained and offered people tranquil and pleasant areas in which to sit, chat and spend time with their loved ones.

Staff recruitment processes were followed with the appropriate checks being carried out. There were a high number of staff on duty to meet people's needs in a meaningful way and the service had a team of volunteers who provided additional support. The hospice had a bank of staff who they could contact if they needed additional staff. All staff received annual appraisal and clinical supervision and staff discussion groups were in place. Staff and volunteers received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care which they demonstrated throughout the inspection.

Staff followed risk assessments and guidance in management plans when providing care and support for people in order to maintain people's safety.

Staff were able to describe what it meant to safeguard people and told us how they would report any suspected abuse. There were policies and procedures in place for staff to follow and there was an embedded culture of learning from mistakes.

People brought their own medicines with them to the service and there were systems in place to ensure they were stored and administered safely.

Staff worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff. They told us they were involved in all decisions about their care.

People were supported to receive a nutritious diet at the service. Their appetite was assessed through talking with them which led to staff being able to give the person the amount and type of food they would be able to eat. There was a choice of menu on the day we inspected and the meals we saw were of a high quality. Drinks and snacks were freely available. People and their families described the food in positive terms.

When people needed specialist healthcare support the day hospice made referrals to specialist services such as occupational therapy or the dietician.

People told us that staff were caring and listened to them. There was a spiritual care co-ordinator who was available to people who used the hospice and their families. This support was across all faiths but specific religious leaders could be accessed through the co-ordinator if a person preferred. We heard examples of the excellent spiritual support provided to people.

The seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation were well provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. These characteristics were embedded in staff training.

People were able to make decisions about the care and support that they received and told us that staff at the service communicated well with them. Confidentiality was respected through safe storage of records and by the staff who offered privacy when having difficult or sensitive conversations demonstrating respect for people's privacy and dignity. People spoke with such thankfulness about the respect shown to them by staff giving examples of how staff had helped them retain their dignity.

People helped develop their care plans which were person centred. This is when any treatment or care takes into account people's individual needs and preferences. The person's chosen place of care and place of death was clearly recorded where the person had chosen to share that information. People were given time and support to develop advanced care plans, advance directives and living wills if they wished. People received help with symptom control and management at the day hospice but could also enjoy socialising with others.

People were confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.

Staff and volunteers shared similar values and worked closely with each other in a mutually respectful way. There were regular team meetings. Accidents and incidents were clearly recorded. Where any mistakes were made these were discussed and reflected upon in order to make improvements. The hospice presented annual quality accounts which looked at patient safety, clinical effectiveness and patient experience. Audits were completed across the organisation providing a thorough and comprehensive system of quality assurance. They also took part in research projects as a means of improving their service and educating staff. The quality of the service was enhanced by these measures and this was reflected in feedback received by 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.

Staff used safe working practices and followed risk assessments and guidance in management plans when providing care and support for people. Staff were able to describe what it meant to safeguard people and told us how they would report any suspected abuse.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs.

People had their medicines managed safely.

Is the service effective?

Outstanding ☆

The service was very effective.

Staff received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care.

Staff worked within the principles of the Mental Capacity Act where appropriate. People were encouraged and supported by staff to make choices about their care and their consent was sought by staff.

People were offered a varied and nutritious diet at the service and people told us about the high quality of the food. There was an extensive and innovative choice of menu and a wide variety of drinks and snacks were provided. When people needed specialist healthcare support the hospice made referrals to those services.

Is the service caring?

Good ●

The service was caring.

People told us that staff were caring and went the extra mile. Good support was provided to people and their relatives by a team of staff and volunteers.

People's spiritual needs were supported and respected across all

faiths and the spiritual co-ordinator was on hand to offer people spiritual comfort and care. People's decisions and wellbeing were the focal points of all the care being provided. Care was person-centred and staff respected people's privacy and dignity.

Is the service responsive?

Good ●

The service was responsive.

The hospice provided flexible services to people where they could receive help with symptom control and management as in-patients, in the day centre or at home. Good support was available for people who used services from clinical specialist nurses and allied healthcare professionals who worked at the hospice and in the community. The social work team gave practical support.

People told us that they would be very confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.

People were involved in developing their care plans which were person-centred and clearly described the care and support people needed.

Is the service well-led?

Outstanding ☆

The service was very well led.

There was an extremely knowledgeable and skilled registered manager employed at the service who supported the management team with the day-to-day running of the hospice. They had extensive experience of working in hospice services.

There was willingness by everyone connected with the hospice to improve and develop. Information was shared and communicated with staff, people and their relatives through a variety of means. High quality care and support was consistently provided.

The hospice presented annual quality accounts which looked at people's safety, clinical effectiveness and people's experience. Audits were completed across the organisation providing a thorough and comprehensive system of quality assurance.

St Leonard's 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 19 and 20 July 2016 and was announced. We gave the service 48 hours' notice of the inspection because some of the services run by the hospice took place in the community and we needed to arrange to accompany staff in the hospice at home team and arrange appointments to talk to other community teams. The inspection team consisted of two inspectors, an inspection manager and one specialist advisor. The specialist advisor was a pharmacy inspector. Two experts-by-experience were part of the team. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in adult social care settings and included experience of palliative and end of life care.

In order to plan our inspection we looked at information we held about the hospice. We looked at notifications we had received. Statutory notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information they had given us to help with our planning.

The registered manager showed us around the hospice in-patient unit which is regulated by CQC and the day hospice and education unit which are not regulated by CQC. We looked at the communal areas, treatment and clinic rooms, laundry, kitchen and outside space. We spent time in the office looking at records, which included the care records for six people who used the service, the recruitment, induction, training and supervision records for five members of staff and records relating to the management of the service. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes.

We spoke with 15 people who used the service, all of whom received a regulated service from the in-patient

unit. We also spoke with 11 relatives in the hospice. We spoke with 12 staff including the registered manager, matron, health and safety and environment manager, senior sister, discharge planning co-ordinator, educational lead, catering manager, qualified nurses and care staff and spoke with five volunteers. We also interviewed the chief executive, a trustee, medical director, two members of the education team, two palliative care nurses who worked for the local Trust, a senior social worker, the bereavement support co-ordinator, a University of York lecturer and the spiritual care co-ordinator. We accompanied a registered nurse from the hospice-at-home team which is regulated by CQC on a visit to two people's homes. During the time with the hospice-at-home team we spoke with a nurse, a care worker, one person using the service, four family members and a district nurse.

Is the service safe?

Our findings

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. All the responses we received were positive about the service and staff. Comments included, "All the staff are lovely" and, "I feel safe here."

Our pharmacist inspector looked at the way medicines were prescribed and managed at the hospice. They spoke to the hospice's consultant, the Director of Clinical Services (who was also the accountable officer) and nurses, and the specialist pharmacist who visited the hospice each week. The accountable officer is the person who has a legal responsibility to ensure that controlled drugs (drugs liable to misuse) are properly managed. We found that people were protected from the risks associated with medicines because appropriate arrangements were in place to handle medicines.

Medicines were ordered from the local NHS hospital pharmacy. A pharmacist visited one day a week to provide a clinical service, reconciling people's medicines (ensuring they were prescribed all the medicines they were taking before admission, where appropriate) and checking prescription charts. Hospice staff could contact the pharmacist for advice by phone; the consultant told us that the pharmacist was always available when staff phoned.

We watched two nurses prepare medicines for one person and saw that a safe procedure was followed. Newly appointed nurses had their competency to administer medicines assessed. We looked at five people's medicine charts and saw that the prescribing and administration of medicines was recorded in the right way. Medicine charts were externally audited every fortnight (by a volunteer who was a retired GP). These checks identified prescribing issues in order to improve people's safety.

Staff were encouraged to report medicine errors, including those that did not affect people, so lessons could be learnt and practices made safer. The Director of Clinical Services reported errors to the hospice's governance committee and incidents involving controlled drugs to the local intelligence network (LIN). No errors in the preceding year had harmed people using the service.

There was a detailed medicine policy covering the different aspects of medicines management. The Director of Clinical Services was in the process of reviewing the section on controlled drugs and writing standard operating procedures. Controlled drugs were handled safely. The stock balances of the three controlled drugs we checked were correct.

Some hospice staff visited people in their homes (hospice-at-home service). They liaised closely with district nurses when arranging visits and would sometimes request or administer medicines prescribed by the person's GP.

The feedback we received from health care professionals and people using the service was that the response time from the hospice-at-home to act on requests from the district nursing teams and hospital teams was, "Second to none."

The hospice-at-home provided services between 8am to 12 midnight seven days a week. There were ten permanent staff (five nurses, five care workers) and other bank staff to call upon when needed. The area covered was North Yorkshire and Ryedale and parts of the East Riding of Yorkshire. On day one of the inspection there were two people receiving services from hospice-at-home, the staff team travelled in a hospice owned vehicle to calls. In the vehicle was the hospice-at-home box containing spare dressings, needles syringes, paperwork, wipes and any other items they felt they may need to provide care.

The hospice-at-home had good practices for risk assessment and use of medicines. Prior to visiting a person at home a nurse from the team carried out a thorough risk assessment to ensure the safety of staff within the person's home. This included making sure they had key codes to enter the property if necessary and identifying exits in the event of a fire.

Before we visited one person we were told the names of each family member so that we could address them by name. We were also given information about the person receiving care, the background to hospice-at-home becoming involved and any other involvement by professionals.

The district nurse was also visiting as they were the key worker and had responsibility for the syringe driver and care. A syringe driver controls symptoms by delivering a steady flow of liquid medicine through a continuous injection under the skin. The hospice-at-home nurse would also give medicines if it was thought to be necessary and would record on the district nurse's notes, the hospice-at-home paperwork and medicine administration record. The district nurse spoke with us before they left and said, "They (hospice-at-home staff) are absolutely fabulous. The people love them and we can't be everywhere. It is much better for people at this stage of their lives."

Staff had a good knowledge of safeguarding adults and whistle blowing and were confident of following the procedures if needed. Staff were able to tell us about safeguarding procedures and demonstrated their knowledge of the management of any abuse. They had been fully informed of the different types of abuse, when to raise concerns and who they needed to escalate their concerns to. They said they would have no hesitation in reporting any incidents. Staff had training during their induction and on an annual basis to keep them updated about safeguarding matters. There had been no safeguarding referrals made by this service in the last twelve months.

One member of staff told us, "I have had safeguarding training and there is a poster in the office. However, I have never seen anything here to warrant a concern. You have to be careful as some people bruise easily so it is important to document any care given."

There was a policy and procedure in place for safeguarding adults which had been reviewed in April 2016. This also included contact details for the police and local authorities so staff could call them as needed. Staff also had access to training booklets to refresh their knowledge as needed.

The registered manager assessed risk within the service each month. They monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and acted upon as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the management team. For example, the hospice used an 'Aid Call' system, which linked to the external doors and fire alarms. The system included movement sensors in some of the bedrooms. The registered manager was able to pull information from the system to look at times taken to answer call bells and sort out when doors were opened on a standard or emergency basis. They showed that people were confident in using their call bells and the audit looked at trends including the time of calls at peak times of the day. It also looked at accident levels to ensure there

were no patterns or trends.

Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives.

We spoke with the deputy facilities manager and looked at documents relating to the service of equipment used in the hospice. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems such as fire safety and nurse call, moving and handling equipment such as hoists and slings, portable electrical items, water, electric and gas systems.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance team for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

We spoke with five volunteers and three staff who all told us that they had undertaken health and safety training during their inductions and this included safe wheelchair handling and emergency fire procedures.

The volunteers we spoke with were all clear about their roles and responsibilities, this ensured their own safety and the safety of people using the service was maintained. They gave us examples of how they kept themselves safe but also how they help to maintain the safety of people. They told us, "When the fire alarm goes off, my role is to get myself safely out of the building because we are not able to assist patients." The permanent staff were also able to discuss the fire procedure to follow in the event of an emergency where they would assist people to evacuate the building. We spoke with the health, safety and environment manager who was not aware of the need for personal evacuation plans (PEEPs) for people using the service. PEEPs contain essential information on people who would require assistance leaving the premises in the event of an emergency. The health, safety and environment manager made sure these were put into place immediately.

Staff and people using the service were very satisfied about the levels of staff and the time taken and spent with people. Staff told us, "Staffing numbers are pretty good" and "It is a lovely place to work and we have a good team of staff." The registered manager used a 'mini dependency scale' tool to determine staffing levels on a daily basis. This meant they could adjust the staffing levels needed immediately to ensure enough staff were on duty to meet the changing needs of patients. The senior sister on duty was responsible for staffing on the in-patient unit. We were told that on admission days the service always factored in more staff. At the time of this inspection there were 20 patients on the in-patient unit and staffing levels were good throughout the day. The staff said, "The higher staff ratios means we have the time to talk to people. We can build a supportive relationship with people and we are able to speak about their life before they came into the hospice and any hopes or dreams they might wish to achieve in the time left to them."

We looked at the recruitment files of five members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. These checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions.

This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

Is the service effective?

Our findings

People had excellent access to health and social care professionals including specialists. One person told us, "As a family member the care my relative received was second to none. Over everything the patient is priority. My own needs were also important to them."

We spoke with one relative whose family member had been admitted to St. Leonard's Hospice earlier in the day. They said "What has particularly impressed me is that the doctors have spoken to [Name of person using the service] whilst they are still able to make decisions to find out exactly what they want, which I find really re-assuring in the fact that they have been able to express what they want for their end of life care."

Referrals to the hospice-at-home team came from GP's, district nurses and the hospital or via 999 calls to the ambulance service. In order to promote the service one of the nursing staff spent some evenings in the Accident and Emergency unit at York Hospital speaking to ambulance crews to let them know the service was available.

The hospice had a telephone advisory service during the daytime hours. Staff worked with and were supported by the community district nurses who took telephone calls from people using the hospice-at-home service between 12 midnight and 8am. In response to some people's needs, and if there were no available staff, night sitters had been arranged; at present that was on a needs basis. If someone was struggling to manage their symptoms the hospice-at-home team rang the hospice doctors for support or GP's could speak to the hospice doctors. If additional staff were needed quickly, an emergency text was sent to all staff.

We spoke with one of the palliative care nurses who worked for York hospital and rented offices at the hospice. Every week they attended a joint multi-disciplinary team meeting. A multi-disciplinary team (MDT) is composed of members from different healthcare professions with specialised skills and expertise. The members collaborate together to make treatment recommendations that facilitate quality patient care. The hospice-at-home team were invited to attend if any of the people they supported with complex needs were being discussed. The palliative care nurses referred people for care at the hospice. The palliative care nurse said that they would attend the hospice morning meeting as they had a person for admission to discuss and request a bed. They told us, "The hospice doctors have been brilliant over the weekend because the Trust consultant only works Monday to Thursday." They went on to say, "Hospice-at-home is a valuable addition to the service. They liaise with the district nurses and the wider team. It is very helpful in stopping admissions to hospital. The hospice-at-home team have helped us support someone until their admission to the hospice."

The palliative care nurse told us people used the hospice differently now with more symptom management taking place. The motor neurone disease nurses and heart failure nurses referred to the hospice and the medical director supported the heart failure nurses. The palliative care nurse told us, "It is helpful being based here. We are invited to education sessions and the consultant does an education session after the MDT. The consultants are very accessible. They have a good working relationship with the GP's." The

palliative care nurse said that they had used the Sunflower Centre, which offered people a bathing service and bereavement support. If they need it the hospice-at-home could also refer to the day centre. There was doctor access at the centre who gave feedback to GP's and palliative care nurses, which meant people could be seen by a medical professional quickly when needed, and any changes to their care and treatment could be implemented straight away.

The hospice had a clear vision about training and development for all staff. We received positive feedback from staff about the levels of training, support and learning they received. One staff said, "The training here is very good. We keep up to date with all the courses available to us. If any training is due then a notice is put on the staff board."

All new care staff had an induction which included the Care Certificate. Training that the service deemed as essential was completed within the first month for new starters and care staff were able to go on to do their NVQ's. Nurses received orientation training which included both corporate and clinical sessions to ensure they had the right knowledge and skills to work within the service. Each new nurse had a preceptorship booklet and their core competencies were signed off by a senior nurse once completed. Full training days for staff were held every two months and there were also evening sessions where health care professionals were invited to speak to the staff. Care staff as well as nurses were able to attend these sessions so that they could learn more about topics which were of particular interest to them.

Staff were well trained and supported by the hospices' education centre which was run for hospice staff and any other professionals who provided palliative or end of life care for people in the region. Staff told us about the training they had completed and we saw their training records which confirmed this. They had completed training in subjects which included moving and handling, use of oxygen, fire safety, dementia, safeguarding, MCA and DoLS, equality and diversity and other subjects. This training was updated annually. Volunteers also received training and each unit held a training pack to support volunteers. This covered moving and handling, safeguarding and complaints. Training helped keep people's knowledge and skills up to date.

There was a dementia champion employed within the service who supported staff when they were caring for someone with dementia. The dementia champion was an existing senior sister with a special interest in dementia and they had helped the staff make sure the hospice was 'dementia friendly' as far as possible. The dementia champion, alongside the director of fundraising who was an official 'Dementia Friends' trainer, provided training and support for staff in managing patients living with dementia. The hospice had developed a 'This is me' booklet which detailed things that were important on a daily basis to the person living with dementia. The documentation went on to describe how their illness had affected them and what things would be important to them tomorrow (or at end of life). We were shown a core care plan for dementia care, which gave staff guidance on how to produce a comprehensive and person-centred care plan encompassing all the person's needs. All staff had completed Dementia Friends training including volunteers to help them communicate with and understand the specific needs of people living with dementia. There had been a series of talks for the staff from families who spoke about their personal experience of caring for someone living with dementia, which helped the staff appreciate the difficulties faced by carers.

A person who spoke with us said they were associated with the hospice through York University and were involved on the education committee at the hospice which looked at education across the whole of the hospice. This ensured the workforce was fit for purpose and had added value to benefit patients. It ensured all staff had essential skills and used models of nursing to help support the delivery of high-quality care. The person talking with us said, "There is a core group of motivated, developed and forward looking individuals.

The critical mass of staff are starting to impact on the culture of the hospice and the hospice is moving towards education." They also told us, "The organisation is outward looking and it is good for the University to have practice links."

We spoke with the education lead who was providing care staff with confidence and courage training on the second day of our inspection. This was so staff felt able to manage difficult conversations with people and families. A clinical nurse was running the education session for staff which aimed to build the confidence and competence of care staff within the service. The session taking place included discussion about the history of the hospice and the bereavement process.

Staff and volunteers told us that they felt very supported and had lots of opportunities to discuss any concerns or worries they may have with the management team. One volunteer told us, "I feel supported as I am told to pop into the Volunteer Centre, they really want you to and they are always open to answer any questions you have or offer you support." A member of staff said, "Care staff have a monthly reflective group and clinical supervisions are being implemented. I have attended these every couple of months." We saw records to confirm staff received an annual appraisal which included a review of performance and progress within a 12 month period. This process also identified any strengths or weaknesses and areas for growth.

The hospice used evidence based practice and was involved in research studies. These research projects and studies benefited both people who used the service and staff because the results were used to improve patient safety and care, which was part of the strategy for continuous improvement embraced by the hospice.

The hospice had an important teaching role within the community. For example, the hospice provided placements for trainee GP's who changed every six months. A palliative medicine speciality trainee worked one and a half to two days per week. The hospice medical director had responsibility for supervising both trainees along with a second consultant. The GP had a set of learning outcomes which they learnt on the job. They had supervised practice and they did no on-call for the first two weeks until they had familiarised themselves with the hospice, staff and patients.

There was evidence of good communication within the service. Care staff told us, "Training has given me confidence as the work can be quite emotional and at times daunting. At times you can be really sad, but other times things are really rewarding. I have never felt more listened to or supported than here. It is a very good workplace. All the nurses when you start encourage you and build up your confidence in your abilities. I have completed training that helped me with listening skills and recognising different body language, which means I can respond better to people and families. We get feedback from the nurses about our work practice that is constructive."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that one person who used the service had a DoLS in place around restricting their

freedom of movement and two others had been applied for. Documentation was completed appropriately by the registered manager.

The Mental Capacity Act 2005 (MCA) policy and procedure included information for staff on advanced decisions, lasting powers of attorney, best interest meetings, mental capacity assessments and independent mental capacity advocates. It gave staff clear guidelines about advanced statements and decisions and was written in October 2015. This ensured staff had up to date knowledge and instruction on MCA and DoLS.

People's nutritional needs were assessed and care plans recorded their food and fluid needs. Each care file clearly described people's appetites and if they had any problems with their teeth or eating and drinking. People were referred to dieticians or the Speech and Language Therapist (SALT) as needed.

The provision of food was praised by people and staff and evidence was seen of the thought and planning that went into the meals, snacks and drinks made available by the kitchen. One person had been poorly and couldn't eat any tea the previous day, but was hungry later in the evening. "The staff could not do enough for me," they said and they enjoyed some hot soup and bread. "My quality of life has increased tenfold" they told us. Another person said, "All the staff are marvellous." One person was unable to feed themselves. They said, "It is so frustrating and I could get so angry with myself but the ladies here are so kind and they feed me and we have a chat."

We spoke to the catering manager about the menu choices for people using the service. They had introduced a smoothie menu for savoury meals, aimed at offering people with little appetite a more attractive option of taking in nutrition. The success of their inspired menu was such that it resulted in an appearance on national television where they were given the opportunity to discuss their innovative good practice and the reasoning behind their alternative meals. The catering manager told us their focus was on flavour, colour and texture. Each of the smoothies was layered to represent the food within it, for example fish, chips and peas was each represented by a layer in the glass. These were all trialled on the staff before being offered to people using the service.

It was evident from our observations and the feedback we received that the kitchen staff went to extensive lengths to ensure people had the food they wanted. The catering manager told us that if someone requested something they did not have, then they would go to the shops to get it. They said, "The budget does not impact on what I want to cook. I have made wedding and birthday cakes for people, we give out lollies and ice-creams daily and hold barbeques on occasion. We have lots of volunteers who love baking and we produce food as part of our fundraising efforts. There are special menus for Christmas and New Year."

The catering manager and kitchen staff spoke directly to people using the service to ensure they knew about any specific dietary needs or wishes. When a person had an identified food allergy one chef was designated to prepare and cook their food in a separate area of the kitchen using clean utensils to reduce any risk of contamination.

Specialist diets were catered for including lactose intolerance and all food provided was gluten free. A nutritional screening tool was used by the staff and it looked at anorexia, reduced appetite and included an action plan signed by the person using the service wherever possible. Oral and dietary requirements were documented on admission to ensure the staff were aware of any specific needs people may have and so the kitchen could ensure people received nourishment and liquids in an appropriate way. The people we spoke with said, "The meals are lovely. Beautifully cooked and well presented."

The hospice had 20 beds for people who came in on respite or at end of life. There were 12 single rooms with en-suite facilities, and two four-bedded rooms. One four bedded room was for male patients and the other for female patients. There were two assisted bathrooms and one shower room. Recent refurbishment provided people with a clean, bright environment and included redecoration, replacement of windows and roof lights and fitting of hard flooring in the clinical room. Hoist systems were put into the four bedded areas to aid moving and handling of people and recliner chairs had been purchased for the bedrooms and family room for the use and comfort of families staying with their relatives. There was a small family room provided with a sofa bed and a kitchenette where they could make drinks or snacks. The hospice also had a children's room, painted in vibrant colours and equipped with toys and a play area. Staff told us that this was also used to do therapy and bereavement work with the children.

Each of the bedrooms had double doors leading out onto a balcony overlooking the surrounding countryside. This provision enabled staff to push the beds out into the fresh air if people expressed this wish. Quiet and tranquil gardens were maintained by the gardening staff at the hospice, providing people and relatives with areas where they could sit and talk or just enjoy a peaceful moment.

Is the service caring?

Our findings

The standard and quality of care was very good. We received positive feedback about the service and staff from everyone who spoke with us. The palliative care nurse told us, "It supports people very well; not only patients but colleagues and professionals. There is open visiting and they (staff) will do anything to accommodate people." They went on to say, "They give people taxi tokens if there is any financial pressure. Patients love the drinks trolley; they are offered alcohol. Patients love it because they are normally so restricted in their medical regime."

Staff were motivated to provide compassionate care. The hospice used a holistic assessment for each person who used the service. These not only incorporated the needs of the person using the service, but those of the people who were important to them allowing relatives and people of significance to the person to express their views and share their insights. People and relatives told us that the staff were extremely caring.

One person who had been in the hospice for three weeks said they had been very dubious on coming into the hospice, but they would recommend it to anyone. They told us, "I have been able to maintain my independence and I am reassured that there is someone here if I need them quickly." Another person who had only been in a few days said that they had cold feet and when the staff came round to check on them, they commented to the staff about this. Within minutes we saw the staff had returned with another duvet and blanket for their feet ensuring their immediate comfort.

We observed some very positive interactions between people and staff. We saw two members of staff assisting one person with personal care, assisting them to get out of bed, washing, dressing and helping them to sit comfortably in a reclining chair. The staff reassured the person throughout the procedure, talking to them, explaining what they were going to do and asking if they were okay. Their dignity and privacy was maintained to a high standard throughout.

We saw a nurse taking one person's temperature and blood pressure in a competent but very caring and reassuring manner. They explained to the person what they were going to do and why. We also observed a student occupational therapist (OT) doing an assessment on a person that had fallen at their home. The student OT was very patient and spoke in a way that the person could understand. They did not rush and let them speak at their own pace. The student OT reassured them and it was clear that they made them feel at ease.

The staff showed kindness and respect towards the service users and people told us that the staff were polite, respectful and protected their privacy. We observed the staff knocking on doors and for permission to enter before entering people's private rooms. One person told us, "Staff respect my privacy and dignity. They give me and my partner time to talk alone, ensuring the bedroom door is shut and no one disturbs us. If I want to move out of the room then I only have to ask and the staff will take me somewhere different. I have been here three weeks and have a named member of staff who is looking after me; the care is excellent."

Confidentiality was respected through safe storage of records and by the practices of staff. Staff demonstrated a good understanding of the meaning of dignity and we observed the respect they showed people. Staff told us, "We treat people as we would wish to be treated, for example making sure their belongings are treated with respect and put away appropriately" and "It is the simple things that matter, such as making sure finger nails are filed so they don't catch on clothing, sitting down with a cup of tea and have a chat with people as company is what most people want."

The criteria for using the hospice-at-home service was that people must be: In their last two to three weeks of life; on a rapid discharge from hospital to go home to die; awaiting a hospice bed for symptom control or end of life care or crisis short-term. During our time spent with the hospice-at home-team we spoke to one person who was receiving care and they told us they were well looked after. We also spoke with their family. Their family told us, "We didn't know about the hospice-at-home. The district nurse asked us if we would consider having them. They arrived within half an hour. They are very good. We can't praise them enough. It's a wonderful service. We don't know how we would have got on last night if they hadn't come out." Whilst we were visiting this person the nursing staff offered the family some respite through a sitting service as they had said they were tired because they had not slept well.

We spoke with a second family member of this person using the hospice-at-home service, who told us that the service was excellent and said they were very supportive of their parent who used the service and the whole family. A hospice-at-home pack had been given to each family. It contained information about hospice-at-home, contact numbers, details of the bereavement support service, practical guidance following death, a compliments / comments / complaints form and details of the weekly drop in service at the hospice. Each person we saw had an advanced care plan with the preferred place of care identified. One said, "Does not wish to be admitted to hospital."

There were people who used the hospice service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010. We saw that those diverse needs were recognised and highly respected within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy and understanding in respect of people's needs. For example, people's spiritual needs were considered by staff at the hospice. There was a chapel available at the main hospice and a spiritual care lead who was also available to people who used the day hospice and their families.

We found that the chapel was in the process of been changed and would be called a sanctuary in order to provide a reflective space for people of all faiths or none. There was an ecumenical service each week. We saw evidence of the chapel as a multi-faith centre as there was a 'Plan of Religious and Cultural Events' on display and also a recent service named 'A time for remembrance and reflection'. We found the chapel was a restful, light and quiet space, open to everyone.

The spiritual care lead shared with us examples of what the hospice and they had done to help people achieve their goals and wishes. These included: facilitating a humanist funeral where the spiritual care lead had researched the celebrants and then asked the two people they had identified to visit the person using the service so they could choose for themselves. They had also facilitated the renewal of a couple's wedding vows. The spiritual care lead organised the setting and party afterwards, but the people chose their own minister to conduct ceremony. The person using the service was a milkman and the spiritual care lead organised at their request a film playing on the walls of the chapel which ran throughout the song of Ernie the milkman. The spiritual care lead also organised the remembrance and reflection services within the chapel and made themselves available to people on the in-patient unit as well as taking part in the MDT meetings. They told us, "Spiritual care is taken seriously and is at the centre of what we do. Emphasis is put on creativity and fluidity here." For a religious festival the spiritual care lead wrote a piece which was

displayed for anyone to read, for example at Ramadan. They also offered people communion and confession.

Throughout our inspection staff were extremely caring and thoughtful in their approach to people who used the service. They provided reassuring touches, laughed and joked with people. They worked hard to ensure that people had a good death. For example, the National End of Life Care Strategy for England [2008] defines 'a good death' as being treated as an individual, with dignity and respect; being without pain and other symptoms; being in familiar surroundings; being in the company of close family and/or friends. We saw that St. Leonard's Hospice aspired to meet these criteria in all cases. The hospice provided relatives with a bedroom where they could spend time with their loved ones for as long as they wished after death, because the hospice also had its own mortuary.

People received high quality bereavement support. Support was provided pre and post death through the hospice palliative counselling and bereavement support service. There was a team of 28 volunteers in the family support team of which 24 were trained to give one-to-one support as part of a listening model. We were told that at first contact relatives were given a booklet usually at time of death. This told them what they might experience and what to do next. Within two to three days the family support team sent the family a letter, "Letting them know we are there." They were invited to contact the team at any time if needing support.

After seven weeks a further letter was sent reminding them they were there and telling them about a lunch club and drop-in service at the day centre. At the time of our inspection there were on average 12 to 15 people attending. There was one-to-one support available for people as long as they needed it. This could be in person, over the telephone or at the hospice.

The staff offered support to children through their parents. Books were given to parents to work through with them. Children could also be seen alone but this was usually with parents. For example, the team worked with one child over a period of months. They did memory work relating to their loved one and used games and a memory jar. This was a jar filled with different layers of coloured salt and chalk. Each layer represented a memory good or bad. They chose five memories and attached a colour to the memory. This was put in the memory box supplied by the family service. The child could go to this whenever they want to talk about their family member.

The palliative care nurse told us, "We establish preferences at end of life. People may want to go home or come to the hospice. The hospice-at-home response times are fantastic. They are always accessible and available. There is nothing I can fault and I frequently suggest that the Clinical Commissioning Group should invest in the service to provide a wider service. They (hospice-at-home) attend hospital meetings and do a meet and greet of the person at home." They went on to say, "The hospice is in constant communication. A person has been admitted (to the hospice) today from the hospital respiratory team. Their condition had deteriorated. I attended the MDT and requested a bed. The consultants are so supportive. They support at weekends particularly in hospital. The staff are approachable and if things go wrong you are listened to."

We spoke with a senior social worker who worked with the discharge staff at the hospice. They told us, "We all work as a team which I find so moving." They were a trusted assessor for the City of York Council so completed assessments to access care services. Part of their role was to help with carer's assessments and finance and benefits advice. They provided people and families with support and listened to them before completing advanced care plans. These documents set out people's specific wishes about their care and treatment at end of life. They gave an example of how they helped children to communicate during their time of grief. They gave teenagers postcards to give to people. If they don't want to talk they tick one of the

listed items to tell people how they feel or how to approach them. They also helped parents write their story to help children following their parent's death. This tells them about their first home, first time they walked / talked and about holidays. One person did this and made a play list of their favourite tunes / books. They wrote labels for each item and said why they wanted the person to have it. They wrote individual letters to their partner and children. This sustained the family following death.

Is the service responsive?

Our findings

The staff approach and delivery of care was extremely thoughtful, responsive and effective. All the people we spoke with said they were more than happy with the care they were receiving. They all said they had been involved in decision making and were able to contribute to their care plans.

Staff were passionate about providing people with compassionate palliative and end of life care that reflected their preferences. People at the service received person centred care. This is when any treatment or care takes into account people's individual needs and preferences. Before admission people were invited to come in and look around the hospice. The senior nursing sister on duty told us that referral meetings were held each morning to review and decide who was to be admitted to the service. External professionals were invited to the meetings to discuss each person. The palliative care team from the local NHS hospital did a daily review for the meeting and admissions could be arranged at short notice if needed. The admissions were planned carefully to ensure there were sufficient staff on duty to meet people's needs. It was important that staff had time to spend with people to ensure their concerns were listened to and appropriate support was offered to make them feel comfortable, safe and at ease.

We looked at six care files and found these were person centred and each person's care was evaluated throughout the day and care plans were changed or updated as the person's needs altered. We saw evidence in the files we looked at that people and families were involved in discussions about the care and support being provided and people's wishes and choices were listened to and acted on at all times. The staff told us, "We have changed the way we work in that we used to work in teams, but now we each have a group of patients that we look after. It is sometimes difficult to manage and we have to discharge people who have reached a plateau. The hospice-at-home team are available to help the people being discharged."

A multi-disciplinary team contributed to the daily notes in each of the care files, including entries from nurses and care staff, doctors and the spiritual care lead. One member of staff told us, "All the staff can write in people's care notes. The care staff write in the notes kept near people's beds and the nurses write in other ones." The clinical support co-ordinator carried out audits of the care plans and any issues raised were fed back to staff through their monthly meeting.

Before the MDT, which we attended, people were asked by their named nurse for their contribution to the meeting. One person said they felt staff were very helpful and that their "Pain control was getting there." During the meeting their Barthel Index score was noted. The Barthel Index is a measure of the person's ability to perform 10 common activities of daily living. This gave an idea of how the person's disease was progressing.

We spoke to the discharge co-ordinator for the service who told us they had a specific discharge team which included the lead nurse, a social worker, an occupational therapist and a physiotherapist. They attended review meetings which were held daily and assessed each person using the information from the meetings. Prior to discharge the team spoke with the person and their family to discuss support needs and equipment needed in their own home. We were told the team could do home visits if the need was there, but this was

not usual. The discharge team was put into place six years ago as a pilot scheme to improve the discharge process and it is still on-going due to its success. The discharge team was proactive about integrated care, ensuring that the team worked closely with other contributing services such as the GP, District Nursing Team and the Community Psychiatric Nurses as was relevant to each person's needs.

People going home who were 'fast track funded' received their equipment from the continuing health care team, whilst for those receiving social care funding then the equipment was obtained from the community care team. Medicines to take home were organised by the hospice's doctors and supplied by the NHS Trust pharmacy. Each person going home was supplied with extra items such as dressings or catheters to ensure they had enough to keep them going until their own GP could prescribe the necessary items. Anticipatory or "Just in case" medicines were kept in people's homes 'just in case' they needed them. This meant they could be given a medicine to help relieve pain or other symptoms if they needed it, especially during the night.

Advanced care planning was undertaken if the person wanted it to ensure that their wishes in relation to their care were recorded. Advance care planning (ACP) is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included (National Council for Palliative Care). One person wished to be discharged home and following discussions with the hospice-at-home team a package of care was arranged. Staff gave support with the discharge process and ensured an end of life care plan was put in place. They told us, "Our focus is helping people achieve what they want, whether this is going home or staying here."

The service was responsive to the needs of people using the hospice. Staff told us, "We try to accommodate people's wishes. We bring in extra staff to enable us to support people on special occasions such as weddings, blessings and special meals. Pets are made welcome and we can help people go on home visits. People have parties here and they often have a drink or a takeaway if that is what they want. People go out with their families and they can come and go from the hospice as they please." One example of this was when one person staying in the hospice wanted to attend their son's wedding so plans from the service included liaising with another hospice to arrange care in that setting. We saw the 'Thank you' letters that were received from the relatives and other professionals who made reference to the seamless working between all parties.

When we asked about visiting times the visitors we spoke with said, "There is a guide line of 10:00 to 20:00, but if you get to the service early they let you come in and if the person you are visiting is poorly you are very welcome to stay. The bedrooms are provided with a reclining chair." Staff also told us, "We can take people in their beds to the family room or push them outside into the fresh air."

There was good use of the Sunflower Centre (day centre) to enable people to take part in social activities and complementary therapies. We spoke with the manager of the Sunflower Centre about what provision there was for people on the in-patient unit to participate in hobbies and interests. They told us, "The Sunflower Centre is a relatively new service (six months) and two in-patients have accessed it to date. At present one in-patient regularly attends the Wednesday session where they access complimentary therapies and social and creative work. Sessions are primarily for day patients but in-patients can have access if they wish, if there is a space available and staff management allows. In the future, it is hoped that in-patients will be able to access the centre on Wednesdays and Fridays."

The day centre manager went on to tell us that, "On a Friday we have a drop-in session for everyone living with a terminal life limiting condition. In-patients and family members can also access this. The drop-in facility is focused on a person-centred rather than clinical approach."

The hospice had a wonderful room especially decorated for children. It had bright walls and furnishings that conveyed happiness and warmth. There were many books and toys for the children to play with and have time out. There was also a family room with a Television, DVD player and snooker table to again allow families to have time together when needed.

There was information on how to make a complaint in the entrance hall of the hospice. Records showed that five were received in the last year. All were reported at the board meetings. Three related to the closure of the day care centre in order to review and update the service being provided. One was non- hospice related and we saw an appropriate response had been sent by the registered manager. The last one was about a discharge and the complainant received a very clear explanation of why the decision to discharge the person had been made. They had been dealt with in-line with the service policy and procedure. None of the complaints were serious and were all resolved in the appropriate time scales.

We asked a number of people and visitors, if they had any concerns did they know who to speak to and the response was they would go to the senior on duty. One person said "If you need to see anyone they would either see you straight away or you can make an appointment. There is never a problem if you need to talk to anyone."

Staff told us, "We give it 100% and keep busy when we are at work. We get lovely comments and cards from people, which are super to receive." The hospice displayed thank you cards and we picked two out to give an example of the gratitude showed. They read; "I, together with the family, would like to express our very grateful thanks for the wonderful care and respect you gave to [Name] during their short stay at St. Leonard's Hospice. It was such a relief to us to know that they were continuously being monitored and kept comfortable during those few harrowing days" and "I know you're all thanked regularly for the amazing work you do at the hospice, but me and my sibling wanted to express our gratitude for looking after our parent and making their last few weeks as comfortable and dignified as possible."

Is the service well-led?

Our findings

Exceptional management and leadership was demonstrated at St. Leonard's Hospice. Our discussions throughout the inspection demonstrated that there was an open culture with staff empowering people to plan and be involved in the high quality care provided at this service. This meant that people continuously had a say in how they wanted their care to be delivered.

The strong and positive management approach resulted in people receiving a tailored inclusive service, which focused on them receiving outstanding individualised care.

The values and behaviours expected by the hospice were clearly laid out in the staff appraisal process guidelines. They followed the six C's principle that had been identified by the registered provider as highlighting key values and vision for delivering care to patients. These included care, compassion, communication, competence, courage and commitment. The way in which the service had responded to people's needs in the development of their services to ensure that as many people as possible in the area received high quality care at the end of their lives demonstrated that the values were embedded in the culture of the service.

For example, the hospice had recognised that only a small proportion of patients in the last year of their life were able to receive direct care from their service, and that its responsibilities to patients also extended to supporting and educating colleagues in health and social services to deliver better care. The hospice decided to provide additional education and professional support to Care Homes in the region in regard to essential palliative care and the development of skills such as recognising deterioration in a patient's condition, use of medicines to manage distressing symptoms, care of the deceased and bereavement support. The impact this had on people receiving a service and other professionals was evidenced in the thank you cards and letters from professionals, families and relatives. These included a letter from another hospice who had been invited to look around and view equipment. The letters made reference to incredible staff, going above and beyond doing jobs not expected in their line of duty.

Staff were passionate about their roles when they spoke with us and during the inspection people were unanimous in their positive comments about working at the service and were very keen to tell us about their area of work. One volunteer told us, "The hospice has a wonderful atmosphere of caring and happiness and the other volunteers are a wonderful bunch of people." People and relatives who spoke with us commented, "Marvellous, caring staff", "Wonderful people" and "Absolute angels."

We sent the registered provider a provider information return (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned with the given timescales. The information in the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service. Everyone who contacted us reported they enjoyed a close working relationship with the hospice and they provided an excellent service.

There was a clear management structure with a board of trustees and an executive management team

contributing to the day to day running of the hospice. The registered manager was in charge of patient services. The registered manager had extensive experience of running the service having worked there for a number of years. The chief executive was registered with CQC as the nominated individual for the service and made themselves available to us during the two days of the inspection. One of the trustees spoke with us and said, "Trustees are there to empower the management of the hospice. They give a constructive critique of the chief executive. The meetings are very detailed with free speech which ensures everyone's contribution. I have known the hospice as a resident of York and know people who have used the hospice. It is highly respected and part of the York community. There is an informality here that allows people to relax."

A new matron had recently started work at the hospice. They described their comprehensive induction and showed us documentation to evidence this. During their induction they visited each department as well as learning about housekeeping issues and health and safety issues. They worked for two days a week shadowing carers and nurses. They showed us evidence of probationary reviews and daily meetings with the registered manager. When they started they set up one-to-one interviews with staff and invited them to identify two areas they would like to change about the hospice. They wrote a report on those findings along with their own observations. This report built upon the results of the staff survey. They identified actions required. This had been presented to the registered manager and will be presented to the executive team. They had, along with the registered manager identified areas for improvement and had developed the beginnings of an in-patient unit clinical team strategy. They had also linked these areas to the regulatory standards inspected by CQC.

During the inspection the registered manager was visible throughout the hospice and we saw they related well to staff. We asked five of the visitors if they had spoken to the management team and they said, "They are all very approachable and we have no concerns. However, you can go over and speak to any of the management, doctors or senior staff if needed" and "It's like one big happy family and they make you feel valued." The staff told us, "We can go to the registered manager with any problems; they are lovely and listen to what you have to say."

The hospice-at-home and care home education teams were managed by experienced members of staff as was the in-patient unit, day care and family care services. All of these managers were well qualified in their area of work and so understood the needs of the people they worked with clearly. They could also understand the issues staff faced day to day and were more able to give meaningful support. For people who used the service this resulted in a relevant and consistent service because the managers understood what they needed. All the people we spoke with (apart from one person who had just been admitted that day) knew who everyone was and their role in the running of the service. We observed interactions with management and staff, showing respect to each other and very good teamwork that contributed to the smooth running of the service.

The hospice offered support to its staff through the provision of a reflective group for the care assistants and an external counselling facility which gave staff a confidential service with whom they could discuss any concerns or problems they may have. One member of staff said, "If I had any concerns I would feel happy to go to [the registered manager] – they are always re-enforcing that we can go to them, they are always there for us."

The hospice-at-home service used a formal satisfaction survey and professional feedback to improve its performance. In-patients at the hospice were encouraged to complete a 'smiley face' audit which was simple and easy for them to do. It looked at issues such as cleanliness, staff attitude and catering. Other ways that people and visitors could use to give their opinions to the service included use of a suggestion box in the reception area and speaking to the senior nurse during their daily walk around of the service or to the

board members who also did regular walks around the service.

The hospice displayed a volunteer acknowledgement board which had lots of quotes from various staff members and volunteers. These comments were a powerful way in conveying how individuals felt. One comment on the board read, "Volunteers work in so very many roles on the in-patient unit and all of them add greatly to the quality of care given to our patients and families. I always describe volunteers as giving the hospice its heart as they willingly give part of themselves to support us. The human resource manager had written, "Volunteers bring a fresh pair of eyes contributing hugely when researching and reviewing policies."

Regular team meetings were held where staff were kept up to date with developments and could have discussions about the running of the service. We saw minutes of the meetings where staff had discussed training and projects that the hospice was involved with. There were also weekly multi-disciplinary team meetings for the in-patient unit and community teams where people's care was discussed. This gave staff opportunities to share their views, experiences and contribute to the way their team worked. They told us, "We have staff meetings about once a month and the meeting minutes are made available so you can read these if you miss a meeting. The majority of the management team are approachable, there are some who are more so than others."

St. Leonard's Hospice monitored the quality of care that was provided across the organisation via its Clinical Governance Committee. They presented annual quality accounts which looked at patient safety, clinical effectiveness and patient experience. The senior nurse told us that regular audits took place and the results of these went to the clinical governance group who reviewed the audits. At the moment the group was working on a draft review of clinical structure for accountability. Some of the recent audits undertaken in 2016 included use of as-required controlled drugs for in-patient unit patients, number of blood transfusions taking place and time to first consultant review following admission. Each of these audits were presented in a report format with a conclusion and recommendations, which when implemented improved practice in the hospice.

We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that internal audits on infection control, medicines and care plans were completed. This was so any patterns or areas requiring improvement could be identified. Where concerns or issues around care had arisen then the management team took action to review and learn from the event. We were provided with evidence of when this took place and saw that feedback was given to staff during their regular meetings. For example, a report had been written by one of the management team about the issues of patient and staff safety when moving and handling.

Staff said visions and values for the service were discussed at group meetings. The aim was to promote excellent care. They said, "We have the time here to go above and beyond what people expect. We are lucky that we have this luxury of time to give people so that care can be given at their pace. The care staff are always paired up with a nurse and they try to allocate us the same people if possible. Care is personalised and caring." They also said, "We can do debriefs with the team about difficult patients, reflecting on what we did and if we could have done things better."

St. Leonard's Hospice Trust had participated in a number of research projects. One person associated with the hospice through the York University courses described how the hospice had a member of staff who was developing their research skills. In addition staff completed post-registration qualifications where they carried out research and brought this back to practice. The person talking with us led the post-registration module at York University. The university had strong links with the hospice and the registered manager was

a visiting lecturer at the university. They helped plan and deliver the specialist skills in post-registration development courses. At present there were four hospice staff teaching modules on this course and one unit was taught at the hospice. There were also study days at the hospice. We were told, "This helps to break down barriers. There are still misconceptions around hospices."

In order to maintain best practice within the service the hospice had research links with Hull York Medical School and Leeds University. The hospice was taking part in an IMPACCT (Improving Palliative Care through Clinical Trials) trial run by Leeds University. This involved looking at patients with cancer diagnosis and whether earlier intervention had a positive impact. Patients were only seen if they were admitted to the in-patient unit. Hull York Medical School were looking at CS-Y (Cancer Statistics – Yorkshire). They were looking at referrals from 2008/9. Everyone who had a diagnosis of cancer was on a national registry. The research looked at which people accessed which services and where there were gaps. Family Care Survey is a national survey of bereaved people, which 25 people associated with St Leonard's, took part in. They all gave positive feedback about the support received.

Fund raising was integral at the hospice as much of their funding was secured in this way. The hospice had an extremely active fundraising team who organised a huge range of fundraising activities. Examples of the events previously and currently marketed were: It's a Knockout Challenge; Bubble Rush Experience; Rainbow Ribbons - Ribbons dedicated to the special people in your lives; Midnight Walk Pyjama party; A Night to Remember; Party at the Palace and a retail shop. There was also a small gift shop in the reception area of the hospice with all proceeds going back into the hospice charity funds. Staff told us, "This place would not be as good without the volunteers, they keep the place running" and "We have lots of open days and we get people coming along who are interested in volunteering. They get to see that the hospice is light, airy, clean and well maintained. We rely on community support and fundraising to be able to continue the work we do. People are encouraged to take part in our events and it is the best way to promote what we do by working with the community."

All of the volunteers we spoke with enthused over how much they enjoyed their volunteer role. All felt valued and well supported by their manager. Comments we received included, "Everyone is so friendly; it is just a lovely experience being here." "They (volunteer's manager) put on a wonderful celebration event for volunteers. It was just a lovely, informal way to get to know staff and other volunteers." "I feel valued and I am doing a service for patients and trying to make their lives a little better" and "I absolutely love it, I look forward to coming and it is rewarding to be a part of the hospice."