

Marie Curie

Marie Curie Nursing and Domiciliary Care Service, South West Region

Inspection report

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Date of inspection visit:
28 July 2017
31 July 2017

Date of publication:
05 September 2017

Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place on 28 and 31 July 2017. Due to the sensitivity of the care provided by the service, the provider was given 48 hours' notice of our visit. This was so people who used the service could be told of our visit and asked if they would be happy to talk with us.

Marie Curie is a registered charity which provides end of life care via nine hospices and community nursing across the country. Marie Curie Nursing Service (South West) (shortened to MCNS) is a registered provider of palliative and end of life care services to adults with terminal illnesses across the South West. At the time of our inspection there were 148 people receiving care.

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.

People were referred to the service by healthcare professionals but the main referrer source was District Nurses. Clinical Commissioning Groups (CCGs) commission the service. Staff worked as an integrated team with other health professionals such as District Nurses and GPs. Most of the care provided for people was nine hour overnight care in their own homes. Relatives told us this meant they could get some sleep at night. Feedback from commissioners was very positive.

Staff knew the people they supported and provided a personalised service. Staff used care plans provided by district nurses detailing how people wished to be supported. District nurses also provided risk assessments for any risks to the person and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person.

Everyone told us staff were very caring and they were treated with kindness and compassion. People and their relatives told us staff respected people's privacy and dignity.

Relatives told us people were kept safe and free from harm. Staff received safeguarding training for both adults and children. There were appropriate numbers of staff employed to meet people's needs and provide a flexible service.

Staff received regular training and were knowledgeable about their roles and responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs.

Systems, processes and standard operating procedures around medicines were reliable and appropriate to keep people safe. Monitoring the safety of these systems was robust.

People's capacity to make decisions was assessed and where possible they were supported to make their

own choices and decisions. The staff understood their role in relation to the Mental Capacity Act 2005 (MCA).

The registered manager and provider undertook audits to review the quality of the service provided and made the necessary improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were being protected from abuse because staff understood the correct processes to be followed if abuse were suspected.

People were protected from the risks associated with poor staff recruitment because a full recruitment procedure was followed for new staff. There were enough staff to meet people's needs.

People could expect to receive their medicines as they had been prescribed because safe systems were in place for the management of medicines.

Is the service effective?

Good ●

The service was effective.

People were supported by staff who had the skills and knowledge to meet their needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities.

People were asked for consent before staff supported them. Staff were aware of the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good ●

The service was caring.

People's needs were met by staff who addressed and related to them in a friendly and positive manner. Staff respected people's individuality and spoke to them with respect.

Staff were knowledgeable about the care people required and the things that were important to them.

People's privacy and dignity were respected and supported.

Is the service responsive?

Good ●

The service was responsive.

People's needs and wishes regarding their care were understood by staff who ensured they were followed and respected.

People received care from staff who worked well with other healthcare providers to provide a service that was responsive to their needs.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

The service was well-led.

The provision of safe, high quality care was supported because staff could safely rely on the service's written policies and procedures for appropriate guidance.

Staff were supported by their manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their manager.

The registered manager and the provider checked the quality of the service provided and made sure people were happy with the service they received.

Good 

Marie Curie Nursing and Domiciliary Care Service, South West Region

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 28 and 31 July 2017 and was announced. The provider was given 48 hours' notice so people who used the service could be told of our visit and asked if they would be happy to talk with us.

It was carried out by two adult social care inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care 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 looked at the information in the PIR and also looked at other information we held about the service before the inspection visit, including statutory notifications which the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with five people and 32 relatives. We did not visit people in their own homes because they were receiving care at the end of their lives. We contacted six commissioners of care for feedback about the service. We spoke with seven staff, a healthcare assistant, four senior nurses, three clinical nurse managers, the registered manager and also communicated with the HR department by email.

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe. Family members told us their relatives were safe and treated well by staff and said, "100%, it's like a family member in the house", "Absolutely, totally safe", "Very safe, they're our little angels" and, "Course we feel safe, I think they're brilliant."

Staff worked as an integrated team with other health professionals such as District Nurses and GPs. Feedback from commissioners and other healthcare providers included the following comments, "Everything is absolutely fine", "They're very good, there are no problems" and "They ask for certain things such as risk assessments, care plans and information sheets. The registered manager said, "We're there to supplement and compliment care in the community." Health care professionals commissioned the services for people and provided detailed risk assessments and care plans to mitigate these risks. Staff received the risk assessments and care plans before they provided care and followed the instructions provided. Staff provided feedback to the health professionals of any changes in people's needs and these were updated. Marie Curie nurses were also able to assess people and liaised with district nurses when people needed to be reassessed. One nurse told us "We had six months training to ensure we all assess the same."

The PIR said, "Staff are provided with the necessary skills and knowledge to assess a patient's needs and the appropriate actions to take. This includes dynamic risk assessments of moving and handling patients safely." The registered manager said, "People at this stage of their lives can change dramatically very quickly, staff therefore have a 'short episode of care form' to record the changes. Staff had access to support via an out of hours service as well as access to district nurses and GPs. Environmental risks such as access to the person's home and pets were also considered.

There were enough staff to provide people's commissioned care. Staff provided their availability and they were deployed to people as referrals were received. Clinical Nurse managers provided oversight of the allocation of staff to ensure that staff had the right skills to meet people's needs. There were systems in place to provide care at short notice, or when families were in crisis. Staff told us, "We have some staff who work flexibly and work as and when required."

The provider had lone working policies and procedures in place. There was a monitoring system in place whereby staff logged in when they arrived and left the person's home. The clinical nurse managers would be alerted if a member of staff failed to log in as expected. At the time of our inspection this system was not being used to monitor missed calls. The service relied on people who used the service and/or the case management team reporting missed calls. The service had not had any missed calls reported. The service had introduced a protocol for when staff were "unable to gain access" to a person's home. This protocol has been adopted by other Marie Curie Nursing Services across the UK.

Every person referred to MCNS was provided with an information pack with useful contact numbers. Staff telephoned people before they visited to introduce themselves. Relatives told us, "They always ring at 9 and get here at five to ten; they use their phone to say they've arrived" and, "They phone and introduce themselves about 9, they are very good at that."

People were supported by staff who knew how to recognise when people were at risk of harm and knew what action they should take to keep people safe. Staff recognised the signs of potential abuse and understood their responsibility to report any concerns or allegations promptly. All staff were required to complete mandatory safeguarding training of adults and children which incorporated the Mental Capacity Act 2005. Staff told us, "I have the policy and know what to do" and "There is always a senior nurse and clinical nurse manager on duty if we need to report anything." The regional management team had also undertaken more advanced safeguarding training.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. We emailed the Human Resources (HR) department who assured us that staff had the appropriate checks and references in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

People received their medicines safely. Marie Curie staff recorded when they administered people's medicines on the integrated team's medicine administration records (MAR) that were used by all the health professionals involved in each person's care. Marie Curie nurses assessed people's needs and administered prescribed oral and injectable medicines to relieve symptoms that may be experienced at the end of life, such as pain. Relatives said, "They contact the district nurse and GP if they think Mum needs anything. They have been a godsend, a night shift for the four nights, which has been brilliant" "They give paracetamol. They know where the morphine is. They document what they do all night long in the book" and "Yes they do medicines, [name's] got to be fed it in liquid form. Give them their due they document it on the hour every hour all through the night." Marie Curie nurses had access to out of hours GP services and the local end of life care teams to request assessment and assistance from them where injectable medicines were required. All staff had received training and their competencies had been assessed in the use of syringe drivers, which some people required. A syringe driver delivers a steady flow of injected medicine continuously under the skin.

Business continuity plans were in place so that in the event of anything which may affect the service, such as extreme weather, staff were aware of the processes they should follow. The registered manager told us, "In the event of anything untoward happening, we call staff twice daily to check for updates and their safety."

Is the service effective?

Our findings

People spoke very positively about the support they received from staff and told us they were confident the staff were well trained. People said, "I can't say how much of a help they have been. They are fantastic" and, "I think they look after me very well." Relatives told us, "Absolutely, no doubt they're trained. Very competent indeed" and "To be able to talk to someone with dementia, it's just wonderful. I sit there in awe. They are really lovely people."

New staff had an induction which prepared them to gain the competencies they needed to provide end of life care in people's homes. Induction training included training for care after death, palliative care, death and dying and communication skills. Staff told us, "Training prepared me for the job", "I had a mentor to do the shadow shifts with me" and "Colleagues are very supportive." The registered manager said, "For us, induction is really important." Staff were provided with handbooks which set out the key policies and the standards and conduct expected of them as employees. Staff were also provided with tablet computers which meant they could access e-learning and the provider's policies and procedures at any time.

Staff received on-going training to develop and update their skills. One relative said, "They know what they're doing, they're perfect." Staff said, "There is plenty of training to access." The registered manager received a monthly update stating which staff needed refresher training. Records showed all staff had attended the necessary training the provider considered mandatory; this included moving and handling, medicines management and oxygen therapy. Staff were provided with specialist training for caring for people with a stoma, catheter care and other specialist needs as required. One relative confirmed this and said, "As part of the care package the training [referring to the ventilator] was organised before the care started." Staff were able to link in with specialist nurses when they supported people with specific conditions such as Parkinson's Disease.

The service benefitted from having a practice development facilitator, who looked at training and issues raised during supervisions, appraisals and any complaints to determine what additional training was needed. The registered manager had recognised a gap in staff training around conflict resolution. All staff in Dorset had completed a pilot training course in conflict resolution and the training was being evaluated. Once the evaluation was complete the registered manager said the training would be shared nationally.

Staff had clinical supervisions every eight weeks with registered nurses. These provided opportunities for staff to reflect on their clinical practice as well as providing time for staff to address their own needs for support. Staff were able to access formal counselling via the organisations' confidential welfare service. One member of staff told us, "We have excellent clinical supervisions here. We all look after each other." The registered manager said, "Our burn out rate would be massive if we didn't look after our staff's resilience."

Staff had annual appraisals which included assessment of core competencies. Staff also benefited from observations by registered nurses as well as peer observations. Feedback from these observations was discussed and information shared with the member of staff's line manager and the quality group. This meant any training needs were identified. There were processes in place to support nurses with the

revalidation process to maintain their Nursing and Midwifery Council (NMC) registration. Staff received handovers from district nurses and their line managers. This ensured that important information was shared, acted upon where necessary and recorded to ensure people's needs were monitored and provided for. Feedback from other healthcare providers included the following comments, "We speak on the phone about handovers", "They'll tell me of any changes in people's conditions" and "Yes, the information they hand over is important."

Staff had a clear understanding of the Mental Capacity Act 2005 (MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

All staff were trained in the implications of the MCA and guided by the provider's policies on consent, mental capacity and advanced decisions on future treatment. Where the service worked in partnership with other care providers, jointly agreed care documentation prompted staff to check decision making arrangements. This included whether the referral had been made with the person's consent, if lasting power of attorney arrangements were in place and obtaining consent to the care plan.

The provider had a nutrition policy in place. The majority of the services provided were overnight care which meant staff had limited involvement in supporting people to eat and drink. People were assessed for their ability to eat and drink safely, and staff told us people were helped to eat and drink whatever they wished. One person told us, "They will make a cup of tea, fill my hot water bottle. If I want something in the middle of the night they get it for me." Relatives said, "They make me a cup of tea. They will help if he needs it, but there hasn't been any need. They always ask if there's anything they can do" and "They will make him a cup of tea, or a biscuit, if he wants one during the night."

The service worked closely with other health care professionals to provide people with the support they needed to be cared for at home at the end of their lives. Feedback from commissioners and other healthcare providers included the following comments, "Feedback from families is always very positive" and, "Anything I've asked them to do they've always done."

Is the service caring?

Our findings

Everyone we spoke with was very complimentary about the service and the caring nature of staff. People said, "They are indeed caring", "Yes they're caring. They are pleased to do anything for me. They make sure I'm 100% settled and comfortable before I go to sleep at a night time. If I wake up they are there straightaway for me. They are lovely" and, "If I'm in need of anything they do it." Relatives said, "They are nothing short of spectacular", "They have been brilliant" and, "When they walk in she is full of smiles and full of talk, and she's very, very happy with them." Staff told us, "We provide person centred care and respect people's wants and wishes. We help people who are struggling with their diagnoses." The PIR said, "Over the last year, 100% of people completing our survey have stated that they are likely or very likely to recommend our service to their family and friends."

People were treated with kindness and compassion throughout their care and told us they were happy with the care they received. Relatives told us, "They are fantastic. Really, really good. I am so pleased and grateful to them. From the minute they come in they check things, make sure he is comfortable, anything that needs doing they do. It's such a relief, I can't tell you how grateful I am to them. They are always so caring. They just manage and I can get a really good night's sleep" and "They are caring, really nice people, whoever comes." Other comments included, "They're the most amazing people I've ever met. [Name] is mad about animals and she only has partial sight in one eye, staff took pictures of her ferrets and made sure they were big enough for her to see, they spent so much time talking about them it was absolutely brilliant" and "Very caring and compassionate; a couple of nights ago [name] was awake all night, the carer chatted to her all night, made her a cup of tea."

The service had received many 'thank you' and 'compliments' cards. Comments in these cards included, "The staff who cared for [name] are the most lovely I have ever known", "Wonderful, sensitive help and support", "Thank you for all your support, the nurses were all kind and truly professional" and "You did a fantastic job in the last hours of mum's life. A great comfort that her death was managed so well."

Much of the service provided was to people living at home who were supported by their families. Staff provided a nine hour night cover which meant families were able to get a night's sleep. Relatives told us, "I feel confident with the care which allows me to sleep", "We get a good night's sleep", "I've got no qualms about going to bed. I know they would call me if they needed me" and, "It was wonderful, a relief." This gave staff (nurses and health care assistants) an ideal opportunity to provide 'patient centred' care which was not rushed and which was focused on supporting the person and their family. Relatives confirmed this and said, "They are very thorough and very nice which is important", "Really, really lovely. They had time for him; they made time to chat and see what was going on his life" and, "They take time to talk to him." The service was able to provide emotional/psychological support to both the person and their family.

Staff stayed with families after their relatives had died to provide emotional and practical support. Staff told us, "MCNS staff work day and night to provide hands-on care and emotional support to people in their homes" and "If people are living with a terminal illness, our staff can help people stay surrounded by their family and friends."

The provider told us people were sent an information pack before any visits were carried out. The pack contained information about the service, what people should expect and information about other advisory and support services. The people we spoke with confirmed they had been provided with written information about the service and told us they were happy with how staff communicated with them. Information booklets were also available, for example to help people plan ahead or manage pain.

People's privacy and dignity was respected by staff. One person said, "They do respect my privacy and dignity." Relatives told us, "Totally. My husband gets up to go to the toilet himself, what they don't do is try and do things for him unless he needs help. They let him have his privacy in the bathroom", "Oh yes, and they ask first, like 'Is it alright if I do this' gaining his permission" and, "Of course they do, they're so good at it." Staff we spoke with said their understanding of showing respect for people's privacy and dignity included closing doors and curtains and making sure people were covered when receiving personal care.

The expected standards of caring for people with dignity and respect were reinforced through the provider's policies, training and materials provided for staff to refer to. The health care assistants were expected to follow the provider's code of conduct and registered nurses to follow the standards set out in their NMC (Nursing and Midwifery Council) code of conduct.

The planned overnight services were delivered across a large geographical area and the provider worked with a number of different Clinical Commissioning Groups (CCGs). This meant the service provided was different across the counties, depending on what the CCG commissioned. Staff followed documentation in people's homes provided by the local key workers, usually the district nurses. The documentation included risk assessments, care plans, DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms and any other relevant information. If people's needs changed urgently during the night staff followed agreed local procedures. For example, if a person needed additional pain relief the Marie Curie staff contacted the on call district nursing service. Similarly there were clear guidelines for staff to follow if the person appeared to be in the last hours of life and if the person died during the night. Staff followed National Institute for Health and Care Excellence (NICE) guidelines when providing care after death.

We spoke with the registered manager about the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. We spoke about the protected characteristics of disability, race, religion and sexual orientation. The registered manager had a thorough understanding of how they needed to act to ensure people were not discriminated against. Staff completed death and dying training which included information about spirituality and cultural beliefs. MCNS aimed to provide a service irrespective of people's equality and diversity needs. The service monitored people they provided care for in terms of ethnicity and demographics such as the communities people lived in. This meant they were able to show that people living in deprived areas were not prevented from accessing the service because of where they lived. Where audits showed people from particular communities were not being referred, the registered manager addressed this with commissioners.

The provider also operated a befriending and volunteer support service. Although this was not part of the service regulated by the Care Quality Commission (CQC) it provided an additional resource. Staff working within MCNS were able to refer people they felt might benefit from additional support.

People were provided with a Marie Curie information booklet that gave practical advice about being cared for at home and the changes that take place at end of life. The Marie Curie booklet also provided details of other support organisations and explained the roles of people providing care from their integrated care team.

Is the service responsive?

Our findings

The primary focus of this service was to support the relatives, family carers and people receiving end of life care and care for life limiting conditions. People had previously discussed where they wanted to receive their end of life care with their integrated healthcare teams. The majority of the services delivered were nine hour overnight packages of care to people living in their own homes. MCNS provided much needed respite to family carers and relatives which enabled them to carry on caring for their loved ones at home. Relatives said, "I would probably say they were a far superior service to others, we felt completely in safe hands", "Excellent. Just Brilliant" and, "Just super people, kind, listen and understand."

People received care from staff following the care plans provided by district nurses and then provided updates to people's integrated healthcare teams. The Marie Curie nurses liaised directly with district nurses or hospice at home teams when people's needs had changed and provided detailed information of people's current care needs. Feedback from commissioners and other healthcare providers included the following comments, "People's notes show there's evidence of good care", "They respond to anything, we've not had any issues" and "We get informal feedback from people's relatives and district nurses; everyone says it's usually a very good service." Relatives told us staff always completed the records and said, "They have a care plan here. They write it up through the night" "They fill it in and say what time they've checked on her, about hourly through the night" and, "I haven't read this mornings but the last one was very accurate."

People and relatives told us staff knew how people wanted their care to be provided, what was important to them and how to meet people's individual needs. People said, "If I say 'I can manage this on my own' they will say 'okay, let me know if you need any help'" and, "They just seem to stay longer if they are needed. They never seem to be too busy to help." Relatives said, "The way they make sure she understands what they are going to do" and, "They chat with her, they take time, they don't rush."

People received care that met their changing needs. For example relatives told us staff had the knowledge and skills to provide care for people where people's health conditions were unpredictable. Relatives said, "They ask how she is doing and what developments there have been, how we are doing, what we need. They even ask us if they are doing enough for us" and "They always check the syringe drivers, they are fully informed of his condition. They are very efficient."

People received information about how to make a complaint in a booklet which was provided at the beginning of care from Marie Curie. The booklet also provided detailed information about what to do if they were unhappy about the way their complaint was dealt with. The registered manager told us they were continuously striving to improve the service by looking at complaints and learning from people's experiences. The registered manager told us the response rate to surveys was low because families were not always able to respond when they were bereaved. However, the registered manager explained about a new initiative where surveys were sent out to bereaved relatives after three months and the response rates to these were very positive. Feedback from commissioners and other healthcare providers included the following comments, "I can pick up the phone if there's a problem" and "We have no concerns."

The PIR said, "Concerns and complaints are always taken seriously, explored thoroughly and responded to in good time." Complaints and learning were discussed at monthly quality meetings and further actions such as additional service wide training were agreed. People we spoke with did not have any concerns or complaints about the service. One person said, "No complaints whatsoever. They have been lovely." The expressions "I can't fault them" and "Lovely" were used by almost everyone we spoke with. People told us the only thing that could make the service better would be if it was available for more nights than was provided at the time of our inspection. People said, "It isn't regular and we accept it can't be". This was not within the provider's control as the level of service was determined by the contract they had with each CCG.

The organisation had a duty of candour policy and staff were provided with training on this. This showed people were supported to raise any concerns about the service and their feedback was taken seriously and acted on.

Is the service well-led?

Our findings

There was a clearly defined management structure and at the time of inspection the management team for the South West was fully staffed. There were vacancies for healthcare assistants particularly in the South Gloucestershire and Bristol area. The registered manager was supported by clinical nurse managers, senior nurses, service managers and regional office administrators. The operational management team was supported by national teams, for example the Human Resources, quality and business teams. The clinical nurse managers and senior nurses were all nurses with experience in palliative care.

The provider had a national governance structure and governance meetings were held within the region. The governance groups looked at monitoring standards of quality and safety and ways to improve the service. The region followed a national and local audit plan, audit findings were reviewed and actions plans were agreed and reviewed by the governance group. In addition the service provided quarterly quality reports to the commissioners (CCGs). The governance structure included five special interest groups; professionalism, infection prevention and control, incidents and complaints, audit / quality improvement and safeguarding. These groups were made up of frontline staff who acted as champions that actively supported staff to identify, influence and implement change to drive improvement.

The service worked in successful collaboration with other healthcare professionals to provide an integrated healthcare team where people received a seamless service for their end of life care. Reports prepared for commissioners showed most people had been able to die in their preferred place of care. However, some people's needs had changed which meant the care and treatment they needed was provided in a hospital or hospice.

The provider obtained feedback from people who used the service in a variety of ways. The information pack given to people who used the service included information about how to comment on the service. This information was also available on the provider's website. For example, people could telephone the support line, use the on-line chat service or complete a survey on-line. Any concerns or reports of negative experiences were passed to a member of the management team for immediate follow up. Feedback from commissioners and other healthcare providers included the following comments, "They're a really good team and we work well with them" and "The co-ordinators and myself communicated really well."

Incidents, complaints and compliments were monitored and reported on weekly and this was monitored by the quality team. The records of accidents and incidents showed safeguarding referrals had been made to the local authority where necessary. There had been two medicines errors in March 2017. Learning from these was discussed at quality meetings and team meetings with staff. Where appropriate, learning influenced changes in training.

Various meetings were arranged for staff and managers. These included monthly regional and registered managers meetings to reflect on national changes; any learning identified was shared nationally. Staff said, "We're a widely dispersed team so team meetings and supervisions are important for getting together." Staff were invited to a forum that took place after the staff survey where they were able to discuss

improvements in relation to appraisals, supervision and other areas.

Work done by the infection control interest group identified there were some issues with the use of personal protective equipment (PPE). The registered manager made changes to the way staff were observed in practice to include observations of how and when staff used PPE. Information from the observations will be fed back to the interest group so any necessary changes can be monitored.

Staff told us about the values of the organisation. They told us, "We aim to be the leaders in our field, building on our unique skills, expertise and experience, sharing and always seeking to improve in everything we do", "I feel valued by Marie Curie" and "I'm proud to work for Marie Curie." Staff told us they felt supported by their managers and were able to raise any concerns they had.

The registered manager had recognised the challenges the service faced. They told us, "One of our challenges is around reporting; audits show we're reporting more which shows we've got away from the blame culture and want to make things better for people." A special interest group had been set up to look at complaints and incidents to clarify what should be reported.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the service. Audits provided information about the quality of the care and the administration of the service, for example, recruitment data and the timings of home visits. One audit had identified that staff had found it difficult to have conversations with families and people with chronic illnesses around any unrealistic expectations people may have. This was being addressed with communications training. Frontline staff influenced the audit plan and developed, implemented and monitored action plans with the support of the regional quality lead.

The provider also had an 'Expert Voices' group. The group was made up of volunteers who had experience of living with or caring for someone with a terminal illness. They donated their time, knowledge and experience to help Marie Curie improve future care and were involved in variety of roles.

From the information we were given, the service has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.