Sue Ryder

Sue Ryder - Wheatfields Hospice

Inspection report

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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

We carried out this inspection on 20, 25 and 28 July 2017. This was an unannounced inspection.

Sue Ryder – Wheatfields Hospice is a specialist palliative care service. It provides inpatient care for up to 18 people. The service also supports 321 people in the community whose care needs are triaged and recieved medical advice. At the time of our inspection visit there were 12 people who used the in patient service.

The service currently had no registered manager although we checked the manager in post application had been received and was being processed by the CQC. 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 services provided included counselling and bereavement support, day hospice care, family support, spiritual support, out-patient clinics, occupational therapy, physiotherapy, complementary therapies and a lymphedema service (for people who may experience swellings and /or inflammation following cancer treatment).

People were kept safe by staff who were trained in the safeguarding of adults and health and safety. They were able to fully describe their responsibilities with regard to keeping people in their care, safe from all forms of abuse and harm. There were safe systems in place to manage and administer medicines to people. Medicines were prescribed, recorded, stored, administered and disposed of in safe and appropriate ways. People received their medicines in a timely manner and in line with their preferences.

Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm.

Recruitment practices were safe and ensured staff employed were safe and appropriately skilled to care for people using the hospice.

Systems were in place to ensure records related to accidents and incidents captured the relevant information and this was considered and analysed without delay. Appropriate remedial actions were taken following such occurrences and action was taken to minimise any immediate or future risks to people.

Staffing was at a level which allowed staff to meet people's needs in a safe, timely and personalised manner.

Staff were well supported with the provision of a wide range of support in the form of training, a comprehensive induction, ongoing supervision and appraisal along with practice reflection. Learning within the service including adopting and sharing best practice was highly prioritised.

People were supported to access the nutrition they needed and were monitored for any changes in their dietary needs.

Management and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and supported people in line with these principles. Staff established consent from people before providing care and supported people to access independent advice and support when necessary.

Staff were very caring and showed people and their families kindness. Staff demonstrated they were both motivated and passionate about their work and had a clear commitment to providing the best quality care in a compassionate way. People were encouraged to remain as independent as possible by staff. Staff acted in a way that maintained people's privacy and dignity.

People were fully involved in decisions about their care, including when identifying their preferred place of death. They benefitted from the environment within the hospice which was homely and had been designed and equipped in a way that was clearly comforting to people using the service.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in developing advance care plans.

The staff team demonstrated through their input at clinical and multi-disciplinary meetings that they knew people well and understood their individual needs. People's progress including pain management, spiritual needs, emotional and psychological well-being and social support were all considered on a daily basis.

All aspects of care and treatment were assessed and discussed with the person and their family. The whole staff team could access the most up to date information about a person's treatment including changes in people's health and about how to respond when people experienced changes in their symptoms or pain levels. People spoke positively about how their care had been tailored to meet their needs and preferences.

Families were included in all aspects of the person's stay, where this was an expressed wish of the individual person. People and staff felt comfortable about sharing any concerns, complaints and ideas for improvements with management.

The manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. Regular ward and management meetings took place to discuss every aspect of the service, including staff training, incidents, service policy and development reviews.

Staff praised the provider and the leadership team for their approach and consistent, effective support. The provider had a well-defined management structure that provided strong, effective and innovative leadership. There was an extensive programme of clinical audits to check that quality of care and best practice were maintained.

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 knew how to recognise and report any allegations of abuse.

Risk assessments were centred on the needs of the individual and there were sufficient staff on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

People received their medicines from staff who were trained and qualified in safe administration of medicines.

Is the service effective?

Good

The service was effective.

Staff had effective training and support to carry out their roles. People's rights were protected under the Mental Capacity Act 2005 and no one was being deprived of their liberty unlawfully.

People were supported to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were supported in all aspects of their health and wellbeing and referrals to healthcare professionals were made promptly when needed.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate of people and their families.

Staff treated people with dignity, supporting them wherever possible to maintain their independence.

The service was very flexible and responded quickly to people's changing needs or wishes.

Staff communicated effectively with people and treated them with the utmost kindness, compassion and respect.

Is the service responsive?

Good

The service was responsive.

People and their families were fully involved in the assessment of their needs and planning how their care should be given.

People's care was personalised to reflect their wishes and what was important to them.

People knew how to make a complaint and felt confident that any issues they raised would be dealt with effectively.

Is the service well-led?

Good

The service was well-led.

The service was well-led by a management team who placed people and staff at its heart.

There was an open and positive culture evident within the service which fully involved people, families and staff.

Staff felt very well supported in all areas and felt involved, listened to and appreciated at all times.

There were systems in place to monitor safety and drive improvements in the quality of the service, including learning from accidents, incidents and complaint investigations.

Sue Ryder - Wheatfields 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.

The inspection took place on 20, 25 and 28 July 2017 and the inspection was unannounced. We last inspected Sue Ryder Wheatfields Hospice in May 2016. At that inspection we rated the service 'requires improvement' overall.

The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams and reviewing information received from the service, such as notifications. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at how people were supported throughout the day with their daily routines and activities. We reviewed a range of records about people's care and how the service was managed. We looked at three care records for people that used the inpatient unit and six records of people who were out patients. We spoke with 11 people, three relatives and one visitor. We spoke with one registrar in palliative medicine, one speciality doctor in palliative medicine, a pharmacist, two inpatient nurses, two community specialist nurses, a nursing assistant, the head chef, a physiotherapist, the spiritual care coordinator, two palliative care social workers, family support team leader, ward clerk and a medical secretary as well as the registered manager and provider. We looked at quality monitoring arrangements, rotas and other staff support documents including supervision records, team meeting minutes and individual training records.

Good

Is the service safe?

Our findings

At our last inspection we rated this key question as good. At this inspection we found the provider had continued to ensure good outcomes for people. People told us that they felt safe at the service. This was confirmed by relatives. One relative said, "Yes, he's definitely safe here. I can go home feeling confident he is in safe hands." There were safeguarding policies and procedures in place.

Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns, and were fully aware of the provider's 'whistle-blowing' policy. This included reporting issues to the appropriate authorities outside of the organisation, if necessary. All the staff we spoke with told us they would also liaise with and discuss their concerns with the wider multidisciplinary team if they needed support in relation to any safeguarding concerns, for example the social work team. Staff members told us, "We always look out for signs of abuse but I know what to do if I notice anything of concern" and "I would refer any issues about abuse or harm to my line manager and the team at the local authority, I might approach our social work team for advice too."

Training in relation to how to protect people from abuse or harm had been provided to all levels of staff within the service. Clear records were kept of all safeguarding events and reported to the appropriate external agencies.

We checked staffing levels at the service. People and relatives told us that there were sufficient staff deployed to meet people's needs. One person told us, "The staff are there for you. If I want anything, I just press the buzzer." The manager told us they used their knowledge of the needs of those people due to stay in the inpatient service and their experience to ensure safe staffing levels at all times. The hospice had its own nursing bank and if any short staffing did occur there was some flexibility across the staff team to pick additional shifts to cover any shortages. Staff we spoke with confirmed this and told us they felt the service was well staffed. During our inspection we observed there was plenty of staff on duty.

Teams consisting of nurses and nursing assistants provided care and treatment in the inpatient service. This was overseen by a senior nurse. Community specialist nurses were deployed to manage the care of those in the community.

There was 24 hour medical cover. A number of speciality doctors were present during the day and on call support was provided out of hours. We found that staff carried out their duties in a calm unhurried manner and were able to provide emotional support and spend time with people.

People told us their medicines were administered as prescribed and in a timely manner. One person said, "They are good with medication, everything is double checked."

We found there was a safe system in place for the management of medicines including controlled drugs which required stricter controls because they are liable to misuse. The hospice had introduced single nurse administration for controlled drugs. We read the Provider Information Return (PIR) which stated that the

introduction of this system had allowed nursing staff to give controlled drugs more promptly since staff did not have to wait for another nurse to witness the administration. Nursing staff had undertaken extra training and an assessment before being deemed as competent to administer controlled drugs without a second witness.

Medicines were stored safely and there were systems in place for the ordering, receipt and disposal of medicines. The hospice received pharmaceutical services from a partnership arrangement between the hospital trust and a local community pharmacist. Ten of the community specialist nurses had completed a non-medical prescriber's course. These staff were able to prescribe medicines which helped ensure that people received their medicines in a timely manner. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional's field of expertise.

Risks to people's safety had been assessed as part of their plan of care. We saw each person had an individual risk plan that incorporated control measures to minimise harm. A relative told us, "All his risks are managed well. Problems are anticipated and dealt with before they cause him pain." Potential areas of risk such as nutrition, medicines, moving and handling and pressure sore development were considered. Records showed evidence of preventative action taken by staff through the use of equipment and provision of extra support to people who for example, displayed the signs of deteriorating mobility, skin integrity, breathing and nutritional intake. These helped to mitigate those risks and protect people from unnecessary harm.

Staff demonstrated to us they were knowledgeable about the level of risk related to the people they were caring for. Regular multi-disciplinary meetings took place on site to discuss and review the rapidly changing care needs of people using the hospice. Records showed that any risk assessments were updated and reviewed regularly, using a variety of tools for the various risks.

Staff were aware of how to report incidents and accidents. Staff had adopted, learned and gained feedback from such occurrences. They could describe to us the incident procedure including making the person safe, calling for help, reporting the incident immediately, alerting the person's family and completing the incident form. A staff member described the incident procedures as, "Clear and effective." They gave an example of a person who used the service who was confused and who had had falls whilst they had been moving around unsupervised. Learning and changes to practice were implemented as a result and those people at risk of 'wandering' were given a mobile alarm pendant which they wore and meant they could be traced. This was always explained to the person with their family and permission was sought.

Staff understood how they should respond to a range of different emergencies including fire. Staff took part in regular fire drills and we saw there was appropriate signage about exits and fire equipment throughout the hospice. Fire safety equipment had been serviced and was regularly checked. Audits were undertaken to make sure all equipment and the building were checked and equipment serviced as required. Robust systems were in place for the maintenance of hoists, specialist beds and equipment. Feedback about any actions outstanding or completed were reported back to the manager and site director, to monitor that the appropriate levels of safety were in place.

Robust staff recruitment policies and procedures were in place. A staff member said, "I had to have all the necessary checks done and returned before I was able to start work here". These included enhanced checks with the Disclosure and Barring Service, checks of references provided by former employers, checks on professional registration and qualifications, identity checks and full documented employment histories. Interviews were well structured, properly recorded, and demonstrated a commitment to employing

appropriately qualified people with suitable skills, attitude and character. For those staff in a clinical position, checks on their registration with relevant regulator were checked before employment commenced.

Good

Is the service effective?

Our findings

At our previous inspection in May 2016, we rated this key question as requires improvement. We found that the provider was not meeting their legal requirement regarding the Mental Capacity Act 2005. At this inspection we found that action had been taken and the provider had ensured good outcomes for people.

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 hospices 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.

We found decisions relating to DoLS and end of life care were in line with advice published by the Department of Health in October 2015. This guidance states that if an individual had capacity to consent to the arrangements for their care and treatment at the time of their admission; if they lost capacity and could no longer consent to being at the hospice or the care provided, this would not necessarily constitute a deprivation of liberty. One staff member told us, "[Name] has fluctuating capacity; he's not wanting to leave. It wouldn't be proportionate to apply for a DoLS, he came in willingly. We have all these discussions in the MDT [multi-disciplinary] meetings. We ask is this still their preferred place for care?" Another member of staff said, "It's [DoLS] not a blanket decision, it's discussed in MDT meetings, it's become part of everyday practice." This meant the hospice had taken a proportionate approach to DoLS whereby decisions around liberty were made in the best interests of people and in line with government guidance.

We read people's care plans and saw that their mental capacity had been assessed. One staff member said, "Everyone has a mental capacity form now and it [mental capacity] was discussed during handover and we put it on the system. I think we are flagging it up now. It was an issue, but now we're on it."

We noted that consent forms such as consent to share information were completed in people's care files to confirm that their consent had been gained. This information was also recorded on people's electronic records. People told us that consent was gained before any care and treatment was carried out. One person told us, "Oh yes, they always ask before doing anything." We read staff notes and saw they contained evidence that consent was gained. One record stated, "Seen by physio with valid consent."

Staff told us that there was sufficient training to enable them to care for people effectively and meet their needs. We saw there was an annual training programme in place for all staff and also specialist training provided by internal and external experts, which was sought based on staff learning and development

needs. Staff described the management team as having 'a learning culture' and they 'encouraged learning at all levels'. Comments included, "There's opportunities for learning and I feel that I am respected" and, "Since [name of manager] started, training has improved." People and relatives spoke positively about the skills of staff. Comments included, "Even as a visitor, you see they are all doing their job properly," "They are brilliant," "Where do they get the staff from, they are so good" and, "They give you confidence." Staff who were new to the organisation followed an induction process before they worked alone.

Clinical supervision was undertaken. Clinical supervision is a formal process of professional support and learning which enables staff to develop their knowledge and competence. One staff member told us, "I have found clinical supervision really useful. I was struggling with the emotional aspect. We learned about clinical supervision and it has really helped me and it is a respected thing [clinical supervision] here, it's valued, you're given time." 'Time to reflect' sessions were organised for all staff. The manager stated in the PIR, "Having time to reflect can be really helpful. Reflecting helps us to think through and understand things, get balance in life, to find strength and ways forward."

Nurses were supported with their revalidation with the Nursing Midwifery Council (NMC). The NMC registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK. Revalidation is the process which nurses must undergo to maintain their registration with the NMC.

People and relatives were complimentary about the quality of the meals at the hospice. One relative said, "I find the kitchen staff have been great, they ask what he wants and tempt him with things. The staff bring things like ice lollies." Staff were aware of the importance of nutrition and hydration at the end of life. Records showed and staff told us people were screened on admission using the malnutrition universal screening tool and this was regularly reviewed. Staff we spoke with were aware of the individual nutritional risks relating to the people they were caring for. Care plans included any advice staff received from dieticians.

We spent time talking to the head chef. She was aware of people's likes and dislikes and any specific dietary requirements such as the need for diabetic, gluten free or fortified diet. She said, "We will make milk shakes with ice cream and cream" and, "All our custards and milk based puddings have cream added, it adds extra calories." Although a four weekly menu was followed, the emphasis was on the person and what they wanted to eat. The chef told us, "I always say, if there's something they want and we don't have it we will go out and buy it."

People and relatives informed us that people were supported to access health and social care professionals. One relative said, "He sees the doctor every day." A person told us, "I struggled to get support for equipment in my home; I mentioned this to the nurse who arranged an occupational therapist to visit straight away."

The provider employed a range of staff to ensure that all aspects of people's care were met. Staff employed included, physiotherapists, occupational therapists, medical staff, complimentary therapists, nursing staff, nursing assistants, a spiritual coordinator and social workers. The provider had employed a discharge coordinator to help ensure people's preferred place of care and preferred place of death were achieved for all people.

Community nurse specialists worked with people who lived in their homes. They liaised closely with GPs and other health and social care workers to ensure care and support was co-ordinated. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were met.

Good

Is the service caring?

Our findings

At our last inspection we rated this key question as good. At this inspection we found the provider had continued to ensure good outcomes for people.

People and relatives were complimentary about the caring nature of the staff. Comments included, "They are just so lovely" and "Nothing is too much trouble, they are fantastic, so caring." We passed a family who were leaving the hospice. A family member said to one of the staff, "We can't thank you enough, you've all been marvellous."

Staff spoke enthusiastically about ensuring that people's needs were held at the forefront of everything they did. Comments included, "It's got to be in you [caring nature] and it is in the staff here. It's got to be natural," "Someone is always here to stay with them and hold their hands," "We try and accommodate their wishes, like anniversaries even weddings, we make it special and birthdays," "We are all here for the patients," "We pick up on things and try and make memories," "When they walk in it's all about welcoming them and putting them at ease" and "I've changed the way I've worked, I've realised that listening and meeting their spiritual needs can help just as much as rushing to the medicines cupboard. Talking and listening does help to relieve their symptoms."

Most people at the hospice were very poorly and we did not want to intrude on people at this critical time in their lives. We saw that people looked comfortable and well cared for. People who used the outpatient service spoke highly of the staff and said they, "Did extras that they did not have to do." Another person told us, "They answer all my questions, I really feel like they are friends, they have such a kind way. And they listen so well." One person gave us an example that a couple lived in a flat that heated up a lot on sunny days making it uncomfortable. The attending staff organised a voucher for the purchase of blinds to keep the flat much cooler.

We saw positive interactions between staff and people. This included non-care staff. The ward clerk said to one relative, "Are you alright, don't ever think you are bothering us, how can I help?" The head chef told us, "We do go in and talk, not just about food. It all adds to their experience." Staff informed us that pets were welcome at any time. They recognised the importance that pets had on people's lives and the positive benefit seeing their pets had on people. This was confirmed by relatives. One relative said, "Pets are really welcome. One lady brought her little dog in and it slept with her."

Patients and relatives told us that staff cared for the whole family. Comments included, "It's not just [name] that they keep an eye on, it's me too," "They are so caring, they noticed I hadn't eaten and asked if I wanted something to eat" and "They care for me too and check I'm alright." People and relatives told us that they could visit at any time and facilities were available for them to make hot drinks and they were able to stay overnight. One relative said, "There's a little kitchen where I can make drinks and they have putty up beds." One room had a double bed which staff explained could be used for couples. The manager told us they had a double bed so couples could still spend the night together as they would have done at home. This was put into place following feedback from people who used the service.

People and relatives told us that their spiritual needs were met. Comments included, "They are very good with the spiritual side and practical side" and "They do ask about spiritual needs, it's a question they ask. I'm not [religious]." A spiritual care coordinator was employed; they explained that they had a very person centred role. They told us they looked at the, "Broader understanding of spirituality." He explained that he was guided by the individual and their views on spirituality and what was important to them. We noted that spiritual assessments were carried out in some of the care plans we viewed.

People and relatives told us that people's privacy and dignity was promoted. Comments included, "They are good with dignity. That's special glass [in the windows] you know. You can't see in, but the staff will still draw the curtains in case I feel exposed" and, "You've got your own private space here."

We observed that a picture of a wheatsheaf was displayed in the inpatient unit on the first day of our inspection. The ward clerk told us that this was used to highlight to staff when someone had died. This meant when staff were coming on duty, they were aware that someone had died and could make discreet enquiries before their handover.

People and relatives told us that they were provided with information about people's care and treatment. Comments included, "It's great because if I ask about anything – the staff are already fully informed and know what to say," "They tell you what is what. The other day, they said, You might be going home, but we need to do this and that, everything is organised they don't just check you out like at hospital" and "We have a catch up conversation once a week to find out what is happening."

There was literature available about the hospice for people and their families to read. There were also information leaflets about where to seek help from external support. Information about the hospice could be found on their website. This meant that people were involved and informed about the care they received.

People and relatives told us that they were involved in people's care. Comments included, "They include you in everything," "It's nice that I can give him a shower. They will just say, 'If you need any help, we are here,'" "[Name of staff member] asked if I was still happy to be here and I said yes," "They have those conversations with you. It's in his notes that he doesn't want to go to hospital."

We read one person's notes and saw they had chosen not to discuss the subject around their preferred place of death. We noted that care plans indicated whether the plan had been discussed and agreed with the person.

Good

Is the service responsive?

Our findings

At our previous inspection we rated this key question as requires improvement. There was no recognised pain assessment in use and care plans were generic and not individualised. At this inspection, we found that action had been taken and the provider had ensured good outcomes for people.

On the inpatient unit people had care plans in place which included information about their physical, emotional and spiritual needs. We noted that some care plans were more detailed than others. A 24 hour record of care was completed which related to people's care plans and provided a review of their care and treatment. One staff member told us, "We used to have pre-printed care plans, now they are all handwritten."

Community specialist nurses completed an assessment and review of people receiving care and treatment in the community on the electronic recording systems used by the provider. These could also be accessed by other health and social care professionals. The provider had extended their community specialist nursing service from five to seven days. The manager stated in the PIR, "The expansion of this service has meant that continuous advice, support and signposting can be accessed across seven working days. Crisis intervention and home visits occur which contribute to meeting the preferred place of care outcome and avoids unnecessary hospital admissions. It offers effective and responsive psychological support and timely symptom management."

A recognised pain scale had been introduced. This included a numerical and visual assessment. In addition, people could choose a phrase which best described their level of pain. This tool helped staff recognise and treat people's pain promptly. It also helped staff reassess and adjust people's pain management and monitor and review the outcomes of people's pain management plans. People and relatives told us that staff were responsive to people's complaints of pain. Comments included, "They are brilliant if he is in pain. He had a pain in his tummy and they gave him Gaviscon [antacid medicine] and when that didn't do any good they then gave him Oramorph [strong pain killer]. They act fast, as soon as they saw you had pain, they were there," "They're good with pain relief, that's why I've come in. They always ask whether I have any pain" and "He can see the doctor every day to talk about his pain."

People and relatives informed us that staff were responsive to people's needs. Comments included, "They have adapted to his condition, they change their ways [of working] depending upon how he is," "It's an amazing place, it provides you with everything you need in this situation," "It's been brilliant, they can't do enough for you" and "It's fantastic; they are there for you."

The service operated an advice line which was available 24 hours/seven days a week. This was accessed by health and social care professionals and people or their relatives. Advice was provided regarding any issue relating to palliative care such as pain control and other symptoms. For example nausea and sickness; whether particular combinations of drugs were compatible or appropriate, ways to support family members and the care available when there was a rapid change in a person's condition. Staff explained that if they were unable to respond to the enquiry, they would pass the query onto an alternative member of the

hospice multi-disciplinary team. There was a palliative medicine consultant on call 24 hours a day to seek advice from.

In addition to the inpatient unit and community service; the hospice provided a number of other services. These included family and bereavement support, a befriending scheme, rehabilitation, day services, complementary therapies and spiritual care. People and relatives told us that these services were appreciated. One relative said, "I have a counselling session once a week, it's nice to be able to open up to someone and talk to someone who knew." Another relative said, "They offered me complimentary therapies which were lovely."

People told us if they wanted to raise complaints or any concerns they knew who to speak with, but those we spoke with all told us they had no need to do so. A relative said, "Absolutely no complaints, I think they are all brilliant." One person told us they knew how to complain as information was available in leaflets, but said they had never had any concerns but felt confident that if they did staff would listen. They said, "Any small issues they have helped with immediately." A staff member said if someone wanted to make a complaint they would, "Offer them a leaflet on how to complain and talk them through their concerns."

The complaints procedure was displayed and leaflets were also freely available in communal areas. There were arrangements for recording, acknowledging, investigating and responding to complaints and any actions or changes made taken as a result. At the time of the inspection the service had not received any complaints since the last inspection. We saw the provider had received numerous compliments which contained very positive feedback and these were collated and shared with staff when they were named individually.

Good

Is the service well-led?

Our findings

At the last inspection we rated this key question good. At this inspection we found the service remained good. People and relatives were complimentary about the service. Comments included, "10 out of 10 for me" and, "It's fabulous." We spoke with one visitor who said, "I have been totally amazed by it."

Staff spoke positively about the manager and the director. The manager was an experienced member of the staff team but had only recently been promoted to manager. Comments included, "Since [name of manager] has come and the changes she has made -I feel listened too," "[Name of manager] is here, she's worked on the ward and knows what it's like. She will put her uniform on and come and help," "[Name of manager] is great, she will do anything and is really protective of nursing assistants," "[Name of director] is fabulous. She is one of the best hospice directors," "[Name of director] is superb. I cannot speak more highly of her" and, "I've seen a great deal of improvement – we have visible management." The manager consistently notified the Care Quality Commission of any significant events that affected people or the service. We requested information in the form of a Provider Information Return (PIR); this was fully completed and returned to us within the given time frame.

Staff spoke enthusiastically about working at the service. Comments included, "It's the best job I've ever had. My husband will say to me, "I've never known someone as excited to go to work," "I love my job" and "I never think I don't want to go to work."

We observed that this positivity was reflected in the care and support which staff provided throughout the inspection. Staff responded positively to any requests for assistance and always sought to be complimentary when speaking with people.

We saw evidence the service learned from past incidents and any improvements made following investigations was shared with staff. A staff member said, "There is a report generated which is shared with us, which shows key learning and the actions taken when an incident happens." Staff told us about improvements that had been made within the service following incidents and accidents. For example following a medicines incident, the service reviewed its administration procedure. All outcomes for patient and non-patient related accidents and incidents as well as medication incidents were investigated, analysed and discussed at monthly clinical governance meetings attended by senior managers.

There were various communication systems in place to ensure people received safe, compassionate, effective and responsive care. Twice daily handover meetings were carried out and multidisciplinary meetings were held. Daily meetings were also undertaken to discuss referrals to the hospice ensure the service was able to prioritise admissions on a needs led basis. One staff member said, "We look carefully at how patients' needs are best met." The provider encouraged involvement in the development of the service from staff at all levels. For example we saw staff were routinely asked for their ideas during team meetings. We observed the Multi-Disciplinary Team (MDT) meeting and this demonstrated excellent team working and showed clear, transparent communication with a holistic approach to care. There was evidence of team work with open discussion and challenge taking place. The meeting demonstrated staff understood their

own roles and responsibilities and that of the wider team.

Staff used a number of electronic recording systems that connected information about people across a number of healthcare settings. This helped ensure that people received co-ordinated care and helped staff to communicate more effectively between the different disciplines.

We found there was an effective system in place to regularly check and monitor the quality of the service. A comprehensive program of in-house audits, such as medicines, staff training and environmental was completed where the findings were fed into governance meetings and also reviewed by the senior managers. We saw action plans were put in place for any shortfalls identified and these were monitored and followed up by managers and the directors. The departmental quality performance dashboard was focused on all aspects of care and service provision including care standards, audit, incidents, complaints, patient safety and other service improvement plans. We saw action plans were put in place for any shortfalls identified and these were monitored and updated regularly by management. Quality improvement plans and actions taken based on audits and quality inspections were shared with staff so they knew what was happening. The service nominated a service improvement lead who looked at areas including 'quality in practice', 'constantly challenging ourselves' and 'change practice for the better'.

People who used the service and their friends and family were asked for their opinion. We looked at the last survey results from people which had been correlated together. We saw nearly all positive comments made by people in all aspects of their experience of the care with just a few low impact negative comments. The service had recognised the areas to improve and was working to correct people's concerns For example one person's said the WiFi could be better and the service had looked at options to address this. This showed us people's views were taken seriously and the service acted on their views.