

St Michael's Hospice (North Hampshire)

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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

This inspection of St Michael's Hospice took place on 5, 6, and 7 July 2016. The service provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver physical, emotional, spiritual and holistic care through teams of nurses, doctors, counsellors and other professionals including therapists. The service provides care for people through an Inpatient Unit, Day Service and a Hospice at Home service.

At the time of the inspection there were six people using the inpatient service and 102 people using the Hospice at Home services. The day services provided in the `Wellbeing Centre` offered a range of services to people diagnosed with life limiting conditions, their carers and families. The service provided specialist advice, courses, complementary therapy sessions and clinics. St Michael's Hospice also provided a counselling and bereavement service for people and their families if required.

St Michael's Hospice had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager at St Michael's Hospice was the Director of patient Services (DPS)

People were protected from abuse because staff were trained and understood the actions required to keep people safe. Staff had completed the provider's required safeguarding training and were able to explain their role and responsibility to protect people.

Potential risks to people had been identified and managed appropriately. Risk assessments were completed with the aim of keeping people safe yet supporting them to be as independent as possible. The Hospice at Home staff knew people's needs and proactively managed risks to people being supported to live with their illness at home, in accordance with their wishes.

The registered manager (DPS) told us department heads completed a weekly staffing analysis to ensure there were sufficient staff available to meet people's needs. Rosters were completed a month in advance and demonstrated that the required number of staff to meet people's needs was provided. Staff working within the inpatient unit told us that staffing levels were sufficient to ensure people received their care safely. People and relatives told us they had no concerns regarding the staffing levels.

Staff had undergone robust pre-employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. People were safe as they were cared for by staff whose suitability for their role had been assessed by the provider.

All staff involved in medicines administration had regular training and had undergone competency checks. Medicines were stored safely and securely. There was a system to check that all medicines were within date and suitable for use. There were medicines available for use in an emergency and these were being checked regularly.

Staff described effective processes for the supply of medicines on discharge from the hospice. We were told by staff that people going on leave were supplied with their medicines in unlabelled dosage boxes. No adverse incidents had been reported in relation to this practice because staff had ensured that people knew all of the information required to manage these medicines safely. The registered manager (DPS) and quality and governance officer ensured this practice ceased before the conclusion of our inspection.

People received effective care, based on best practice, from staff who had the necessary skills and knowledge to do so. The provider had an education and training directory which detailed the mandatory training for all staff which had to be completed annually and was up to date. The provider had enabled experienced nursing staff to take on lead roles in different specialities like Motor Neurones Disease, dementia awareness, infection control and tissue viability (skin and wound care). Clinical staff were effectively supported by the provider with their continued professional development and revalidation of their professional qualifications.

The registered manager (DPS) told us that shortly after their appointment they held a one to one meeting with all staff to introduce themselves, to discuss their expectations and find out what staff thought needed to be improved. All staff confirmed they had a face to face meeting with the new registered manager (DPS) which had been open and honest and made them feel the service was moving in a positive direction.

Staff supported people to make as many decisions as possible. We observed staff seeking people's consent about their daily care and allowing them time to consider their decisions, in accordance with their care plans.

Staff had received training in relation to the Mental Capacity Act 2005 (MCA) and were able to explain the main principles. Staff understood the importance of giving people choice in the support they received. Staff were able to demonstrate that a process of mental capacity assessment and best interest decisions promoted people's safety and welfare and protected their human rights.

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. At the time of the inspection the service had no applications or authorisations in place. However, the registered manager (DPS) knew what action to take if required to ensure people's human rights were recognised and protected.

People had nutrition and hydration assessments and plans, which were up-to-date and where necessary recording of people's intake had been completed. Staff were aware of people's dietary requirements and preferences and people were offered a range of choices to meet their nutritional needs.

People in the inpatient unit had 24 hour clinical support from doctors and nurses, with consultants providing out of hours advice where necessary. People using the Hospice at Home service had access to professional support and advice over a 24 hour period. People told us reassurance and advice provided in relation to pain and symptom management to support people with their condition was invaluable.

Complementary therapy sessions were available through a twelve week programme where people had ongoing support from physiotherapists, occupational therapists, specialist nurses and other alternative and creative therapists.

People, their relatives and friends were extremely positive about the caring nature of all the staff at St Michael's Hospice, from the registered manager (DPS) to the volunteers. People told us "From the moment you walk in you are made to feel welcome." One person told us, "You can feel it in the atmosphere here, it is all about caring and dignity."

People, or where appropriate their representatives, were involved in making decisions about their own care. People told us that when consultants and doctors thought another course of treatment was appropriate they always sought their views and acted upon them. This made people feel their views really mattered and they were in control of their treatment.

The provider had a policy to promote and maintain people's privacy and dignity. Records confirmed all staff had received dignity in care training, which we observed they implemented in practice whilst delivering people's care.

People were supported at the end of their life to have a comfortable, dignified and pain free death. Staff knew how to manage, respect and follow people's choices and wishes for their end of life care as their needs changed.

People had access to information about how to make a complaint, which was provided in an accessible format to meet their needs, before people started to use the service. During the previous year there had been no formal complaints about the service.

The registered manager promoted a blame free culture with an emphasis on "recognising when we get it wrong, apologising where required, and learning from our mistakes." Staff spoke with passion and pride about the hospice and the people they supported. They told us their job was very challenging but exceptionally rewarding. All staff recognised there was a good team spirit amongst their peers, the management team and the different departments.

People, their relatives and staff told us the management team provided clear and direct leadership and were highly visible throughout the service. The registered manager was determined to provide the best quality of palliative care possible for people using the service. She told us they had updated the five main values of the service, which were covered by the acronym PRIDE. Staff were expected to be proud of St Michael's Hospice and the service it provided; to treat people with respect and dignity; to act with integrity; to respect people's diversity; and to strive for excellence. Without exception people, their relatives, and visiting health professionals told us their experience of the whole service was consistent with these values.

The quality and governance manager effectively operated processes to evaluate the quality of service provision, including regular surveys of people, their families and staff, seeking feedback on their experience of the service.

St.Michael's Hospice has introduced the Six Steps of Palliative Care programme led by the dedicated Care Homes Facilitator. The Six Steps Education and Practice Development programme is a national quality framework which aims to support local nursing and care homes to improve end of life care for their residents and avoid inappropriate end of life admissions to hospital. There had been a 44 per cent decrease in hospital admissions for care home residents in their end of life phase and a decrease in the requests for

basic symptom management to St Michael's Hospice from the care homes. This demonstrated true innovation and that St. Michael's Hospice was extremely responsive to the needs of the people in their community.

St. Michael's Hospice Community Palliative Care Project has enhanced access to multidisciplinary specialist palliative care service for people in the final phase of their life. The project has a dedicated team including nurse specialists, social workers, therapists and family support. Communication with community GPs and nurses has vastly improved to ensure 24-hour care where needed. As a result people experiencing their preferred place of care and preferred place of death had risen from 60 per cent to 90 per cent.

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 protected from abuse. Staff had completed safeguarding training and understood the action they needed to take in response to suspicions and allegations of abuse.

Staff understood the risks to people and followed guidance in accordance with their support plans to keep them safe when delivering their care.

The registered manager completed a staffing needs analysis to ensure there were sufficient staff to meet people's needs safely. The provider completed relevant pre-employment checks to make sure people were cared for by suitable staff.

People received their medicines safely, administered by staff who had completed safe management of medicines training and been assessed to be competent to so do.

Is the service effective?

Good ●

The service was effective.

Staff received appropriate training and supervision to enable them to effectively meet people's assessed health and care needs.

People were supported to make informed decisions and choices by staff who understood legislation and guidance relating to consent, mental capacity and DoLS.

When staff were concerned that people may be at risk of malnutrition they made appropriate referrals to relevant health professionals.

Staff were alert and responsive to changes in people's needs. Staff ensured people were supported by palliative care specialists promptly when required.

Is the service caring?

Good ●

People were treated with kindness and compassion in their day to day care by staff who responded to their needs quickly.

People were actively involved in making decisions and planning their own care and support.

Staff promoted people's dignity by treating them as individuals and respecting their diversity. Staff took time to listen to people and make sure they understood their wishes.

Is the service responsive?

Good ●

The service was responsive.

Staff understood people's care and treatment needs and how people wished to be supported.

People's care was planned and delivered effectively to ensure their end of life needs and wishes were met.

A process was in place for managing complaints.

The provider sought feedback to improve the service, which they acted upon.

Is the service well-led?

Good ●

The service was well-led.

Staff spoke with pride and passion about their service and understood the provider's values, which they demonstrated in the delivery of people's care.

Staff felt they were able to raise concerns and issues with the registered manager who was always approachable and willing to listen.

The provider had established quality assurance systems which the registered manager operated effectively to monitor the quality of the service and drive improvements.

The provider had demonstrated effective partnership working with other stakeholders to support local nursing and care homes to improve end of life care for their residents and avoid inappropriate end of life admissions to hospital.

The provider's Community Palliative Care Project meant that more people in the community had access to specialist palliative care services in their own homes in the final phase of their life.

St Michael's Hospice (North Hampshire)

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 5, 6 and 7 July 2016 and was unannounced.

The inspection was carried out by an adult social care inspector, a pharmacy inspector, a specialist advisor and an expert by experience. A specialist advisor is someone who has recognised clinical experience and knowledge in a particular field. In this case the specialist advisor had expertise, skills and knowledge in relation to palliative end of life care in a hospice environment. The expert by experience was a person who has personal experience of having used a similar service and had cared for someone who had used a similar type of care service.

Before the inspection we read all of the notifications received about the service. Providers have to tell us about important and significant events relating to the service they provide using a notification. We reviewed the Provider Information Return (PIR) about the service. 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 also looked at the provider's website to identify their published values and details of the care and services they provided.

We spoke with 14 people who used the In Patient Unit (IPU), Hospice at Home and Day Care Service, ten of their relatives and two friends.

We spoke with 39 staff, including the service's clinical governance lead, the inpatient unit ward manager, the family support lead nurse, the Hospice at Home lead nurse, 13 nurses and care staff, the head of

housekeeping, the clinical psychologist, the bereavement counsellor, the pharmacist, four members of the physiotherapy and occupational therapy team, the chef, the chaplain, three service administrators and the information and technology project manager.

We also spoke with the provider's registered manager (Director of Patient Services DPS), nominated individual (Chief Executive), the quality and governance manager, the human resources manager, three consultants and two doctors specialising in palliative care. We spoke with three visiting specialist nurses, a dietician and eight volunteers.

The service is currently working in partnership with local stakeholders in relation to two projects which aimed to improve the quality of palliative care in care homes and the community. We spoke with the care homes facilitator and the lead nurse respectively involved in these initiatives.

We used a range of different methods to help us understand the experiences of people using the service who were not always able to tell us personally. These included observations and pathway tracking. Pathway tracking is a process which enables us to look in detail at the care received by an individual. We pathway tracked the care of two people using the IPU service and one using the Hospice at Home service. Throughout the inspection we observed how staff interacted and cared for people across the course of the day, including mealtimes, during activities and when medicines were administered.

We looked at twelve staff recruitment files, and reviewed the provider's training records. We reviewed the provider's policies, procedures and records relating to the management of the service. We considered how comments from people, staff and others, as well as quality assurance audits, were used to drive improvements in the service. We looked at a selection of four medication records to check medicines were managed safely.

The service was last inspected on 4 February 2014 during which no concerns were identified.

Is the service safe?

Our findings

Without exception people who used the inpatient unit, the Hospice at Home service and outpatient day care services told us they felt safe because they were supported by staff who understood their needs and knew how to meet them. One person told us, "Safe? I wouldn't want to be anywhere else. The staff are so attentive you can't help to feel safe." Another person told us, "I know I am in safe hands here because the staff are so kind and always there as soon as you need them." A person's relative told us, "You can feel it as soon as you walk in, the atmosphere is calm and relaxed. It just feels like a peaceful safe haven." A person using the Hospice at Home service told us, "I feel so safe and reassured knowing they (hospice at home staff) are available anytime night or day." A person's relative told us, "The planning for the future, organising every step and explanations about what may happen and what they will do has removed all of my worry because I know (named staff) are there for us." Visiting health professionals told us they had observed inpatient unit staff supporting people safely in accordance with recognised best practice.

The provider had identified that a national initiative 'Sign up to Safety' (NHS England) can help staff care for people in the safest possible way. This was the provider's first priority in relation to people's safety. The registered manager (DPS) had devised and disseminated a plan to identify effective solutions and any changes required to improve people's safety.

People were protected from abuse because staff were trained and understood the actions required to keep people safe. Staff had completed the provider's required safeguarding training and were able to explain their role and responsibility to protect people. Staff were able to demonstrate their understanding of the provider's whistleblowing policy. The provider's safeguarding and whistleblowing training was up to date.

Staff had access to the provider's policy and procedures and current local authority and government guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff were able to describe the different types of abuse people could experience and were able to explain how they would protect people. Staff knew of the different ways to raise concerns and where to obtain the contact details to do so. People were kept safe by staff who could recognise signs of abuse and knew what to do to protect people when safeguarding concerns were raised.

Since our previous inspection the registered manager (DPS) had promptly and appropriately reported and investigated four safeguarding incidents, to ensure people were protected from harm and abuse. People were kept safe because staff understood the local authority safeguarding policies and procedures, and the action they needed to take in response to suspicions and allegations of abuse.

Potential risks to people's safety had been identified and managed appropriately. Risk assessments were completed with the aim of keeping people safe yet supporting them to be as independent as possible. The inpatient unit multi-disciplinary team (MDT - Consultants, doctors, nurses, care staff, physiotherapists, occupational therapists, social workers) reviewed people's needs, symptoms and associated risks daily, for example; increased risk of falls, deteriorating skin integrity, diminishing nutrition, and increased emotional risk. The service also held weekly MDT meetings with external professionals from the wider community and

local hospital. Risks to people receiving care at home were discussed, including strategies for supporting people and their families with increased symptoms, for example; from the risk bleeding or choking. Risk assessments gave staff clear guidance to follow in order to provide the required support to keep people safe and promote their independence.

The Hospice at Home staff knew people's needs and proactively managed risks to people being supported to live with their illness at home, in accordance with their wishes, for example; physiotherapists and occupational therapists had arranged specialist equipment to be installed in people's homes to provide the support required.

Incidents and accidents were assessed and monitored by the registered manager (DPS), quality and governance manager and ward manager. The quality and governance manager completed a live risk register for the service, which identified the type of risk together with a description and a risk rating based on the seriousness of the incident. This register also identified the 'Lead Manager' nominated to ensure required action was taken and the date it was completed, for example; one person who was self-administering their prescribed medicines was observed by staff to do so in an unsafe manner. We noted there had been appropriate staff intervention and educational advice provided to the person and their family. Incidents and accidents were analysed and discussed in monthly clinical effectiveness meetings. The learning points from these incidents were shared immediately during staff handovers, during MDT meetings, and staff meetings to ensure similar risks to people were managed more safely in future. All staff knew and understood the provider's incident and accident reporting process to ensure all risks were identified and managed safely.

People in the inpatient unit and their relatives told us staff responded immediately when they pressed their call bell for assistance. During our visit the emergency bell sounded and we observed a very rapid response from all staff, some leaving offices and meetings to assist. People and their relatives using the Hospice at Home service told us staff always responded immediately, especially when they were called out of hours. One person's relative told us, "They (staff) never let you down anytime day or night. They (Named staff) are marvellous they talk you through it and then they're on their way. I don't know what I would have done without them."

The registered manager (DPS) told us department heads completed a weekly staffing analysis to ensure there were sufficient staff available to meet people's needs. Rosters were completed a month in advance and demonstrated that the required number of staff to meet people's needs was provided. The lead family support nurse and lead Hospice at Home nurse demonstrated how they considered requests for admissions on a daily basis, which were also considered in relation to availability of suitable staff to meet the person's individual needs. People and relatives told us they had no concerns regarding the staffing levels.

Staff working within the inpatient unit told us that staffing levels were sufficient to ensure people received their care safely. The ward manager told us that if for any reason more staff were urgently required due to unforeseen circumstances, such as staff sickness, they had autonomy to arrange cover immediately, without first seeking approval from the provider. We observed the staff ability to provide one to one care increased people's safety and reduced the risks of harm to them.

Staff from the Hospice at Home team told us that the provision of the 24 hour service was currently being maintained on the 'goodwill of the staff' who were working overtime to ensure shifts were covered. They told us these concerns had been raised in an open staff meeting with the registered manager (DPS) the day before our inspection. Staff told us they had confidence that the registered manager (DPS) would provide a solution. The provider was in the process of recruiting more staff and had increased the number of bank

staff to afford more resilience. The management team made sure there were sufficient numbers of suitable staff to keep people safe and meet their needs.

Advance rotas ensured there was a good skill mix within the respective teams, which considered the different levels of qualifications for nurses and care staff. Staff leave and absence was managed within the provider's own staffing establishment. At the time of our inspection no agency staff were being used. If required the provider had a number of bank staff they could call upon who had previously worked in the service, which provided continuity of care.

Staff had undergone robust pre-employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service and had completed relevant health questionnaires. Prospective staff underwent a practical role related interview before being appointed. The service received support from over 800 volunteers. Each volunteer had been subject to a robust pre-selection process to ensure their suitability to support vulnerable people. People were safe as they were cared for by staff and volunteers whose suitability for their role had been assessed by the provider.

The provider operated health and safety systems effectively to protect all people from harm within the inpatient unit and day service outpatient unit. Regular audits and daily checks by nominated staff ensured that the environment and equipment used was safe and fit for purpose. Environmental risk assessments identified the risk from potential hazards, for example; use of chemicals, the disposal of waste materials, slips, trips and falls. Action plans had been created to ensure action had been taken to mitigate such risks.

The service had contingency plans to manage emergencies, for example; evacuation in relation to a fire or flood. This ensured the provider had prioritised people's care provision during such an event. Staff understood these plans and knew how to access them if required. People were protected as robust processes were in place to manage emergencies.

People and relatives told us people had their medicine when they needed it and staff were quick to respond to any need they had. One person told us, "Here everybody seems to know what's going on when medications are changed they are on top of everything." All staff involved in medicines administration had regular training and had undergone competency checks. We saw there were regular medicines management group meetings involving doctors, nurses and the pharmacist. This group was responsible for medicine policy review and audit. Medicine incidents were being reviewed at these meetings. There was a system in place to deal with alerts and recalls of medicines. People and their relatives had weekly care review meetings where nurses and doctors discussed with them issues around medicines and they consulted people and agreed medicine management plans. In addition the pharmacist was currently developing a leaflet to supply to people when medicines were used outside their licence to allow people to make an informed choice about their treatment. (The use of medicines outside their license is widespread within pain and palliative care, for example; mixing medicines together in a syringe pump and given through the skin). People were supported to make informed decisions about their treatment and this was administered to them by trained and competent staff.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room. There was a system in place to check that all medicines were within date and suitable for use. There were medicines available for use in an emergency and these were being checked regularly.

Medicines were checked when people were admitted to the hospice by the admitting nurse and then the doctor continued the prescription if appropriate. Every week each person received a review of their medicines in a therapeutics meeting conducted by the doctor and the pharmacist employed by the hospice three days a week who regularly monitored the medicines prescribed.

Staff had access to up to date references which provided information about the safe and correct use of medicines. Prescriptions forms were used so that people using the hospice at home service could get medicines from community pharmacies. At the time of the inspection people using the inpatient service were not self-administering their medicines but systems were in place should people request to do so. Blue medication cards were given to people when they left the hospice which listed all their medicines and explained how to use them. If people needed help with their medicines before they were discharged sometimes medicines were put into blister packs (devices designed to help people to take their medicines). Staff ensured that people were able to administer their own medicines from these packs before they left the hospice to ensure that they could use them appropriately. This practice supported people to independently take their medicines safely as intended by the prescriber even after they left the service. Staff described effective processes for the supply of medicines on discharge from the hospice. We were told by staff that people going on leave were supplied with their medicines in unlabelled dosage boxes. No adverse incidents had been reported in relation to this practice because staff had ensured that people had all of the required information to manage their medicines safely at home. When we informed the registered manager (DPS) about the use of unlabelled dosage boxes they took immediate action to ensure this practice ceased before the conclusion of our inspection.

People were protected by the prevention and control of infection. Staff told us that infection control was a priority because many people had reduced immune systems and were vulnerable to infection. Staff understood their roles and responsibilities in relation to hygiene. Housekeeping staff maintained comprehensive cleaning schedules and were observed to follow best practice guidelines to reduce the risk of cross infection between high and low risk areas of the building. We observed staff washing or gelling their hands as they came out of bedrooms or before they went in. The service maintained and followed infection control and hygiene policies and procedure in accordance with national guidance.

Is the service effective?

Our findings

People told us they had experienced "The best possible care from such caring staff." People's relatives and friends told us, "I'm glad (their loved ones) is here. All the people working here whether they're consultants, cleaners or volunteers are wonderfully caring and so professional". A person's friend with experience of working in care said, "You can tell they (staff) know what they're doing and work as a team." One person told us, "I have been really surprised and pleased by the way the doctors and nurses have kept me informed explaining what is happening." Visiting health professionals told us they were impressed with the level of clinical expertise available at all times from the Hospice consultants and specialist doctors and how they linked in with and supported their nursing and care staff colleagues.

The service employed a broad range of healthcare professionals including input from five specialist palliative care consultants who linked daily with the specialist palliative care team at the nearby acute hospital. The hospice consultants and doctors worked in all the services provided and visited people in the in-patient unit, hospice day service and specialist out-patient clinics, for example; those providing support to people living with Motor Neurones Disease or Parkinson's Disease.

The Hospice at Home team visited and provided specialist palliative care to people in their own homes. The hospice provided a holistic approach to supporting people with their family support team, physio and occupational therapy team, chaplain, psychologist, counselling team and dedicated social worker.

People received effective care, based on best practice, from staff who had the necessary skills and knowledge to do so. The provider had an education and training directory which detailed the mandatory training for all staff which had to be completed annually. This included health and safety, information governance, fire training, infection control, safeguarding, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), moving and positioning.

Clinical staff also had to complete annual mandatory training in relation to resuscitation, symptom management, discharge planning, tissue viability and bereavement interviews. The quality and governance manager demonstrated the provider's computer records to confirm mandatory staff training was up-to-date. This ensured staff had the appropriate knowledge and skills to support people effectively and were enabled to retain and update them. Records demonstrated that the registered manager and management team had completed courses relevant to their role and responsibilities.

Staff were also supported to complete further training relevant to their role and specific to the needs of the people they supported, for example; Intravenous therapy and devices, venepuncture (inserting a needle into a vein, usually to obtain blood) and cannulation (inserting a tube into a patient's vein so that infusions can be inserted directly into the patient's bloodstream).

The provider had enabled experienced nursing staff to take on lead roles in different areas like Motor Neurones Disease, dementia awareness, infection control and tissue viability (skin and wound care). The staff fulfilling these roles were supported with more specialist training to increase their knowledge and

experience. One nurse told us, "We have a Motor Neurone clinic and I am the link. I have attended conferences on the disease and have been encouraged to develop my knowledge and understanding of the disease and to share it with my colleagues."

Nurses are required by their regulatory body to have their practice re-validated every three years. The provider effectively supported and encouraged staff with their continued professional development and to revalidate and update their training to maintain their professional qualifications. One nurse was being supported to study for their master's degree in palliative care.

The service also held a 'Lunch and Learn' session weekly for all palliative care staff where lunch was provided and a variety of topics were taught by recognised health professionals. The presentations were then made available for staff to review on the provider's computer system. Topics included living with and beyond cancer, chemotherapy, and clinical effectiveness and assessment. A member of care staff told us, "The training is really good and I like to keep up to date but the lunch and learn is the best because you don't realise just how much you're learning from people who really know their stuff."

The registered manager (DPS) told us that shortly after their appointment they held a one to one meeting with all staff to introduce themselves, to discuss their expectations and find out what staff thought needed to be improved. All staff confirmed they had a one to one with the new registered manager (DPS) which had been open and honest and made them feel the service was moving in a positive direction. Staff told us that the registered manager was always approachable and supportive. The registered manager had scheduled protected time fortnightly for staff who wished to speak with them confidentially.

Staff had received regular formal one to one supervision with their designated line manager. Supervision records identified staff concerns and aspirations, and briefly outlined agreed action plans where required. Any agreed actions were reviewed at the start of the next supervision. Supervisions provided staff with the opportunity to communicate any problems and suggest ways in which the service could improve. The service had a reciprocal agreement with another hospice for their psychologist to provide two monthly clinical supervisions to all staff.

Staff supported people to make as many decisions as possible. We observed staff seeking people's consent about their daily care and allowing them time to consider their decisions, in accordance with their care plans. One person told us, "They (staff) know what they are doing and I would just let them carry on but they always ask me first before they do anything". A person's relative told us, "All of the staff are very good at letting you know what is happening and discussing how you feel about things. They always ask what you think if changes to treatment are being considered."

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.

Staff had received training in relation to the Mental Capacity Act 2005 (MCA) and were able to explain the main principles. Staff understood the importance of giving people choice in the support they received, and observed staff always sought people's consent before providing any support. People were supported to make their own decisions where appropriate, in accordance with the MCA.

People were supported to make advanced decisions, for example; whether they wished to be resuscitated or

not. We saw examples of Do Not Attempt Cardio Respiratory Resuscitation (DNACPR) forms that had been signed by people. One person told us they had long discussions with the doctor about the decision and the implications of having this DNACPR in place. People were enabled to make informed choices and decisions regarding their life and treatment.

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.

At the time of the inspection the service had no applications or authorities in place. However, the registered manager (DPS) knew what action to take if required to ensure people's human rights were recognised and protected. Staff were able demonstrate that a process of mental capacity assessment and best interest decisions promoted people's safety and welfare when necessary. These processes and best interest decisions had been recorded effectively.

People and relatives told us the food was "Excellent" and told us that, "Nothing is too much trouble for the chef. He just wants us to enjoy what he cooks." Staff told us the chef would try to cook whatever people wished, for example; one person told the chef they "Really fancied some venison", which he then sourced from a local butcher and prepared. People praised the quality and choice of food prepared by the chef. One person told us, "The chef is so cheerful and makes choosing and eating his food fun."

People had nutrition and hydration assessments and plans, which were up-to-date and where necessary recording of people's intake had been completed. The chef was aware of people' dietary requirements and preferences and offered a range of choices which met their nutritional needs.

A dietician whose role focussed on palliative care, attended the weekly MDT meeting and visited people in the inpatient unit. Records demonstrated they had visited one person who was experiencing a loss of weight and appetite, to assist them in understanding how they could enrich their diet. We noted the dietician had visited people frequently as their condition changed. They had provided advice about how the people should be supported to avoid hunger and how to manage their gastric symptoms, which staff followed in practice.

The dietician made positive comments about the dedication of the chef to ensure people enjoyed their eating experience as much as they could, for example; finding out about people's individual experience of how different food felt in their mouth and then preparing foods accordingly. The dietician told us the chef effectively used food supplements for people with poor appetite or low food and fluid intake. We observed there was always a fresh cake available in the lounge for people and visitors to enjoy. One person told us, "I like being able to offer my friends and relatives a nice piece of cake when they come to see me."

People using the hospice at home service had access to professional support and advice over a 24 hour period. People told us reassurance and advice provided in relation to pain and symptom management to support people with their condition was invaluable. People using the hospice at home service told us, "They (staff) have been marvellous, it is just so reassuring to know they are there whenever you need advice and know immediately what you are talking about."

There is a twelve week programme where people had ongoing support from physiotherapists, occupational therapists, specialist nurses, complimentary therapists and other alternative and creative therapy

specialists. These clinics aimed to provide positive support and encouragement to people to effectively manage their life limiting condition. People told us attending these clinics was essential to maintain their health and well-being. One person told us, "They help you to look beyond your illness." People received effective on-going healthcare support.

Is the service caring?

Our findings

People, their relatives and friends were extremely positive about the caring nature of all the staff at St Michael's Hospice, from the registered manager (DPS) to the volunteers. People told us "From the moment you walk in you are made to feel welcome." One person told us, "You can feel it in the atmosphere here, it is all about caring and dignity."

People told us that staff were very kind and caring towards them, which was also extended to their relatives and friends. One person told us, "The care I have received has been marvellous. They (staff) are so kind and thoughtful, but the best thing of all is the way they treat (their loved one). I feel reassured by the way they have looked after (their loved one)."

We spoke with a specialist nurse from another agency who was supporting a person's relative at the hospice. They told us, "The practice I have observed has been very caring but I am here supporting a relative and have been really impressed with the way they have been cared for." One person's relative told us, "I will never forget the kindness of the staff here, not only to (their loved one) but to the whole family."

Staff knew people's needs and preferences well and provided care to meet these with kindness and compassion. During our inspection we observed staff introduce themselves to people and have a brief chat if they had not met them before. When new shifts came on duty, once the handover and allocation of staff had been completed, staff went to see people to see how they were and to let them know they would be supporting them for that shift. We observed staff saying goodbye to people and their relatives when they had finished their shift.

Without exception staff told us it was a "real privilege" to work for the hospice and support people to have the most dignified and peaceful end to their life. One staff member told us, "Until you come here you don't realise what an inspiring place this is. I love working here because I get time to be a proper nurse." Another member of staff told us, "The thing I enjoy most here is when people are happily smiling and leaving us to go home."

Staff had developed positive caring relationships with people. Staff told us they wanted to know as much about people they were supporting so they could provide the best quality care for them. Staff took time to engage people in conversations about things which interested them, that did not just focus on the person's support needs, for example; one person enjoyed working in the garden, whilst another who was a keen sportsman enjoyed physical exercise. We observed people were relaxed and happy in the company of staff and chose to spend time with them. Healthcare professionals told us that on their visits to St Michael's Hospice staff had always been attentive while supporting people.

People, or where appropriate their representatives, were involved in making decisions about their own care. People told us that when consultants and doctors thought another course of treatment was appropriate they always sought their views and acted upon them. This made people feel their views really mattered and they were in control of their treatment.

People told us they were impressed how the Hospice at Home service, the family support team and social worker compassionately prepared and supported them to make important decisions, for example about their preferred place of death. One person's relative using the Hospice at Home service told us, "The care and support we have received from (named staff) is second to none. Since they started coming they have been like members of our family. I only hope everyone could experience the special care we have received when they need it."

People were provided with information about the services provided by St Michael's Hospice before they started using the service. People had access to St Michael's website and there was an information hub within the hospice. People were able to access the internet, computers, and reading materials from this hub to find information about their illness and how they could be supported by St Michael's Hospice. People were supported to have access to information relevant to them to help them make decisions about their care.

Peoples' spiritual needs were met by St Michael's Hospice experienced chaplain, who was supported by two trained volunteers. The chaplain offered support to meet the multi-denominational spiritual needs of all people and their family members. The chapel is integral to the in-patients unit, easily accessible, and available for people of all beliefs. The chaplain told us, "It is all about the person in the moment. If people wish I will pray for them or just be with them. I am here for people." Records demonstrated that the chaplain had taken services, weddings, confirmation, baptisms and funerals when people had requested.

Bereavement support was available to people and their families or friends. This provided emotional support to those who required it. A pre-bereavement, post-bereavement and counselling service was offered to all people and their families as appropriate. Family members who had used the bereavement counselling praised the service for the emotional support provided to them. The provider had successfully piloted an early intervention befriending service currently led by 18 volunteers serving the local community.

The registered manager (DPS) told us due to personal experience they were passionate about ensuring families were also supported with kindness and compassion. In this regard they told us they were proud of the hospice 'Holding Hands' initiative to support children who had loved one's receiving care at the hospice. We reviewed the St Michael's Hospice social story workbooks 'Holding Hands' designed for children aged between 4 and 12. These were told in two parts entitled 'What's it all about' and 'What happens now'. These engaging stories explored the feelings children may be experiencing and questions they may have. The stories are told through the eyes of Sophie, Sam and Sausage (the dog).

The provider had a policy informing staff how to promote and maintain people's privacy and dignity, in accordance with their dignity in care training. Records confirmed all staff had received dignity in care training. Staff were able to explain how they respected people's privacy, which we observed in practice whilst delivering people's care.

People and their relatives told us staff always respected their privacy and dignity, which we observed in practice, for example; staff always knocked on bedroom doors and waited for a response before entering. When staff were providing care to people we observed staff closing doors and curtains to ensure people's privacy and dignity were respected. Staff also used appropriate signs to indicate the room was in use and to prevent the person being disturbed. One person told us how the staff supported their wishes to see as many of their friends and family as possible but sensitively intervened as requested on their behalf, when they were tired and needed to rest. We observed staff at the day centre support a person to move into a treatment room. The staff later told us, "'Dignity and respect is important. We needed to attend to a lady's catheter so we took her to a private treatment room."

People and relatives told us that conversations about their ongoing care needs were always held in private and discussions were completed in a sensitive, empathetic manner. One person told us, "The staff know how to talk to people, they explain things clearly with compassion and understanding." One person's relative said, "We have seen several different doctors but all have known mum without asking us again, all have had consistent messages and treatment plans which makes us feel confident in mum's care". Another person's relative told us, "The staff are really able to read us, they are not in our faces or patronising but have been sensitively advising us and listening to us." People were treated as individuals by staff who knew them well and understood how to promote their privacy and dignity.

People were supported at the end of their life to have a comfortable, dignified and pain free death. At the time of our inspection we observed staff providing end of life care in accordance with NHS guidance (Priorities of care for the dying person) to three people. At this time people's care was subject to Achieving Priorities of Care (APOC) care plans in accordance with NHS guidance. We found care and treatment was developed to meet the person's own needs and wishes in relation to how their care should be managed, including any treatment preferences they may want to express. People's APOC plans included attention to symptom control, for example; pain relief and the person's physical, emotional, psychological, social, spiritual, cultural and religious needs. People were supported to eat and drink as long as they wish to do so, and their comfort and dignity was prioritised. Prompt referral to, and input from, palliative care specialists was available if required. Care plans documented consistent information about people's needs and wishes, which was shared with all those involved in the person's care and available at the time the information was needed.

At the time of our inspection one person had been unconscious for over 48 hours. Prior to becoming unconscious staff had a long discussion with the person and their family about their wishes, including spiritual care, which had been recorded in detail. We found the person's wishes were being followed. The person's wishes in relation to resuscitation had been discussed, established and effectively recorded in a timely way. Decisions regarding whether the person wished to go home or remain at St Michael's were discussed. We reviewed one entry where the doctor had clearly and sensitively recorded how the person withdrew from a conversation about this topic so the doctor ceased the discussion. The person had their needs reviewed twice daily by a specialist palliative care doctor and at least once per day by a specialist palliative care consultant, to ensure all of the person's symptoms were managed appropriately. The person was receiving symptom relief through a syringe driver and was subject to hourly checks. All regular observations had ceased at the appropriate time and replaced via the APOC. Skin assessments, pain and symptom assessment continued every 3 hours. During the 48 hours prior to our inspection there had been comprehensive documentation of discussions with the person's family and the MDT regarding best interest decisions about aspects of their care, including symptom management. The service ensured staff knew how to manage, respect and follow people's choices and wishes for their end of life care as their needs changed.

Is the service responsive?

Our findings

People received person centred care that was focussed on the individual's needs and wishes and responsive to any changes. People told us that staff listened to them and involved them in the development of their care plans. People's relatives told us that they had been encouraged by staff to voice their opinions, which made them feel their views mattered. A relative of a person receiving support from the hospice at home service told us, "They (staff) involve us in all decisions about (their family) members care and ask us what we think before any changes are made."

People and relatives told us staff involved them in regular reviews of their care plans and risk assessments. During the inspection we saw a person whose health was deteriorating discussing their care plans with a specialist palliative care doctor. The person told us they appreciated the ability of staff to provide them the information they needed to make choices about their treatment. One person using the inpatient unit told us, "When they (specialist doctor) asked me what I wanted and my wishes about my care and stuff, I told them, simple, just be honest with me. And to be fair that's exactly what they have done. They have been very caring and sensitive but have explained everything to me in simple terms so now I can make choices."

Staff were aware of people's care plans and knew people's likes, dislikes and preferences. People's changing needs were assessed and discussed by staff daily and more frequently if required. Care plans we reviewed contained comprehensive documentation detailing people's choices and their families involvement where requested this. Records detailed the benefits and potential risks associated with different treatment choices offered and the person's responses and decisions.

We spoke with one person who had made an advanced decision which was contrary to the advice given by medical staff. They told us that the doctor had fully explained the potential consequences of their decision and discussed other options. These discussions had been sensitively recorded detailing all of the options available and the person's choice. Whilst the person's choice was not consistent with the treatment proposed by the doctor we noted that processes had begun immediately to endeavour to facilitate the person's wishes and achieve their chosen outcome.

The person told us, "I understand everything they have told me but I am a fighter and that's (their decision) what I have chosen to do. To be fair the doctors have been very good at explaining everything and I know they'll do their best to make things happen."

A person's relative told us, "As a family we feel very supported and included in the choices and decisions we are having to make on behalf of our mum". People and where appropriate their relatives, were supported to have as much choice and control over their care and treatment as possible.

During the inspection we observed and spoke with people whilst they were participating in a wide range of therapies that were provided as part of St Michael's holistic approach, complementing people's medical support. Complimentary therapies included yoga, aromatherapy, massage, reflexology and music therapy. People were able to try and choose the therapies they preferred and when they wished to have them.

Records demonstrated during the previous year people and their families took advantage of over 3500 treatments.

People who used the day service told us that they looked forward to visiting St Michael's Hospice not just because they enjoyed the therapies but because they met their friends and staff, which was good for their social well-being.

During the day we saw people taking part in exercise sessions led by the physiotherapist and a yoga class. We observed one person taking part in the yoga class by moving their fingers. This person enjoyed the yoga classes and had been encouraged to participate by staff despite having limited mobility. One person told us, "Coming here has made a massive difference to my life, and given me the strength to carry on."

People and their relatives were supported to participate in any of the activities or therapies taking place, including visits from the hairdresser. Most people we spoke with attending the day centre spoke highly of the hairdresser and their dog 'Rudi'. Due to the positive impact of 'Rudi' on people using the service, staff had made him an honorary 'Pets as Therapy' dog.

People took part in art therapy sessions where people were supported drawing, colouring and producing cards. Volunteers supporting people during these activities were chatting with them and making sure that they had snacks and drinks to hand. We observed one volunteer support one person who had limited dexterity with patience, whilst they made a card for their loved one. Other people had been supported to make bird feeders, bags and jewellery for sale at the hospice summer fete.

The service had effective communication with other partner agencies such as community nurses, adult services and clinical commission groups. Information was shared during various meetings, for example daily meetings held by the lead family support nurse which considered people's suitability for referral to the service and the urgency. Prospective referrals were also considered at the weekly MDT meeting.

We listened to an in depth discussion at the MDT meeting about a person living with an invasive cancer who had chosen, supported by their family to be treated at home. Due to the progression of the cancer, plans were required to support the person with potential emergencies. Management plans had been discussed with the person and their family to support their psychological needs as well as their clinical needs. The meeting also discussed the need to ensure that the family were also supported with their emotional and psychological needs whilst supporting their loved one.

People who were using the in-patient unit were supported to maintain relationships with people who were important to them to avoid social isolation. We observed friends and relatives visited regularly and there were no restrictions on the times or lengths of their visits.

The provider sought feedback from a people, their relatives, staff and community professionals using various different methods, which was positive. People told us staff were quick to respond especially if their needs changed, which we observed in practice. We observed all staff working together to ensure people's requests for attention were answered as quickly as possible. A visiting health professional told us, "As soon as people want something the staff seem to appear by magic. They are attentive and very responsive."

The service employed a social worker whose role was to support people and their families with their care planning and discharges to their home. They told us they supported people and families with their worries and fears for the future. The social worker worked closely with the family support lead nurse and the bereavement support team.

People's families were encouraged to engage with the hospice bereavement counsellor if they wished and were invited to remain and visit the hospice. Families were supported to attend groups and socialise with others who had similar experiences to ease their grief. One person told us, "You can see why they have so many volunteers, who want to give something back. The staff gave (their loved one) the best possible care and have been so kind to me since. They have really helped me to cope and picked me up when I was down." The service provided emotional support for families as long as they required.

People had access to information about how to make a complaint, which was provided in an accessible format to meet their needs, before people started to use the service. During the previous year there had been no formal complaints about the service.

Staff knew the provider's complaints procedure but told us they dealt with small concerns as soon as they arose to prevent them escalating. The registered manager (DPS) spoke with people and their relatives whenever they walked through the hospice to find out if they had any concerns or whether there were any improvements required. The registered manager (DPS) and staff were responsive to people's concerns and complaints.

One relative told us they had raised a concern to the registered manager who had responded promptly and taken steps to address the issues raised. The registered manager had apologised and informed the family of the action taken and ascertained whether they were happy with the outcome. Necessary learning from these concerns was implemented to prevent the risk of a recurrence and to improve the service.

Where people had raised concerns these were recorded on the service risk register, together with the action taken, for example; the registered manager completed a review in relation to feedback received about the delay in one person being referred to the hospice. This incident was subject to a root cause analysis which identified learning to prevent a future recurrence. The registered manager then implemented an action plan to ensure such referrals were expedited.

Is the service well-led?

Our findings

There was an open and transparent culture within the service which originated from the nominated individual (CEO) and the registered manager (DPS). Staff told us they were a very effective team, mutually supportive of one another and the whole staff team. One senior staff told, "There is always one of them here to talk to if you need to talk something through." Without exception staff told us all of the management team were approachable and supportive.

The registered manager (DPS) and nominated individual (CEO) were keen for all staff to be responsible for driving improvement across the service. Staff told us they were open to new ideas and suggestions to improve the service, which they encouraged at bi-monthly CEO forums, to which all staff were invited. The nominated individual (CEO) had also established a monthly Employees Forum, with elected 'Employee Champions' from different departments and reported to the CEO forum. This allowed staff to raise issues in a different forum with representatives they knew and trusted. A member of staff told us, "The forums are really good for us to raise concerns and suggest ideas to improve things." Minutes of the last meeting detailed staff concerns regarding the safe storage of cleaning equipment. One of the Employee Champions had been nominated to investigate the concerns and provide proposed solutions to the management team to improve the storage. Staff were actively involved in developing the service.

The registered manager (DPS) had been in post for 7 months at the time of our inspection. Staff confirmed that she had arranged a face to face meetings with individual staff, and where this had not been possible had also arranged group meetings.

All staff told us the registered manager (DPS) was approachable, supportive and set very high standards, particularly in relation to the quality of people's care. One staff member said, "She is like an old school matron with modern day management skills." Another staff member said, "She has vast experience as a nurse, so knows her stuff but accepts she doesn't know everything, and is always willing to ask those that do."

We reviewed documents which had recorded staff concerns and grievances, involving different parties. We found the registered manager acted with integrity and impartiality whilst resolving these issues and ensuring people's rights were protected.

Staff spoke with passion and pride about the hospice and the people they supported. They told us their job was very challenging but exceptionally rewarding. All staff recognised there was a good team spirit amongst their peers, the management team and the different departments.

The service had forged strong links within the local community through various projects to improve the quality of palliative care in the community to arranging visits from local schools. Pupils from local schools interact with people and staff, learning about the work of St Michael's and talking to people about their life experiences. Local community volunteers play an important role in the life and work of St Michael's. A network of over 800 volunteers support a number of charity retail outlets, act as volunteer drivers, tend the

gardens and support staff in the day centre.

The registered manager was determined to provide the best quality of palliative care possible for people using the service. She told us they had updated the five main values of the service, which were covered by the acronym PRIDE. Staff were expected to be proud of St Michael's Hospice and the service it provided; to treat people with respect and dignity; to act with integrity; to respect people's diversity; and to strive for excellence.

Without exception people, their relatives, and visiting health professionals told us their experience of the whole service was consistent with these values. Staff were able to describe the service values, which we observed being demonstrated in the delivery of people's care and the support of their families. The provider had a clear set of values, which were reviewed, understood and promoted by all staff and volunteers.

During our inspection we observed the registered manager (DPS) and quality governance manager deal with an incident involving poor practice. The registered manager provided immediate feedback to the staff member to prevent a recurrence. We spoke with the staff member involved later who told us the registered manager (DPS) had given them constructive feedback in a manner which motivated them to improve.

People, their relatives and staff told us the management team consistently provided clear and direct leadership and were highly visible throughout the service. Staff told us the nominated individual (CEO) frequently walked through the service and spoke with them. People and their families told us they were surprised by the level of individual attention they received from the consultants and palliative care specialists. We observed the registered manager (DPS), quality governance manager, and family support, who were all nurses provided support within the in-patients unit to afford resilience for the ward manager if required. The registered manager told us this enabled them to build positive relationships with people and staff. The quality governance manager told us this gave them the opportunity to observe the support provided and seek direct feedback from people and staff.

The registered manager cultivated a blame free culture with an emphasis on "recognising when we get it wrong, apologising where required, and learning from our mistakes." The nominated individual stated in their annual quality account 'We take the duty of candour very seriously and we have made it a key component of our face to face mandatory training for all staff'. This was confirmed by staff and the provider's training schedules. The 'duty of candour' is the professional duty imposed on services to be open and honest when things go wrong. Senior staff were able to provide examples where they apologised to people and their relatives, in accordance with the 'duty of candour' which had been recorded in the services' risk register. Where necessary we observed action had been taken to prevent a future recurrence.

The inpatient unit was well led clinically, with daily and weekly MDT which considered incidents and identified good and poor care practice, with recommendations for urgent action where required. We observed effective communication between care staff, nurses and clinical staff. Communication was particularly effective in regard to planning for people's admission and discharge. Admission and discharge was subject to close scrutiny during MDT meetings and any lessons learnt were addressed immediately. Staff assumed responsibility and accountability for their actions.

The Board of Trustees (The Board) played an active role in the leadership of the service providing clear directives. The provider had a clinical governance framework which identified the board and different manager's responsibilities and accountabilities. A clinical governance committee met twice yearly and provided minutes and action plans to inform the board. The service had an effective governance system in place which ensured people received high quality care.

There was a management structure with senior staff allocated in recognised lead roles which were clearly understood by staff. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards.

The registered manager and quality governance manager worked effectively with other organisations providing a similar service to St Michael's to promote good practice through shared training and learning events. This enabled the management team to continually review the quality of the service provided and drive improvement, for example; the development of disease specific clinics such as the Motor Neurones Disease clinic and cardiac palliative care clinic to provide early intervention and support to people with these needs. The provider also proactively promoted learning and development within the wider medical community, providing development opportunities for student nurses and doctors.

The management team consistently operated systems to ensure they shared information with external organisations effectively, in a timely way, for example; safeguarding incidents, accidents and incidents were reported to the relevant authorities, including the CQC. The registered manager (DPS) had promoted an open and transparent culture.

Records accurately reflected people's needs and were up to date. Detailed care plans and risk assessments were fully completed and provided necessary guidance for staff to provide the required support to meet people's needs. Other records relating to the running of the hospice such as audit records and health and safety maintenance records were accurate and up-to-date. People's and staff records were stored securely, protecting their confidential information from unauthorised persons, whilst remaining accessible to authorised staff. Processes were in place to protect staff and people's confidential information.

The quality and governance manager effectively operated processes to evaluate the quality of service provision, including regular surveys of people, their families and staff seeking feedback on their experience of the service, for example; the service completed Department of health PLACE assessments (Patient-Led Assessments of the Care Environment) and Voices (Views Of Informal Carers Evaluation of Services). St. Michael's Hospice submits data to the National Council for Palliative Care to facilitate data comparisons across hospice services. The quality and governance manager completed detailed analysis to identify actions needed to improve the service. The Voices survey of relatives of people who used the inpatient service demonstrated that 99 per cent of those surveyed rated the care provided by Doctors and Nurses at St. Michael's hospice to be exceptional, excellent or good. The national average for this survey was 83 per cent. This survey also demonstrated that St. Michael's Hospice inpatient unit and hospice at home service performed significantly better than the national average in relation to the management of pain.

The quality governance manager operated an effective system of audits for the whole range of hospice services provided including infection control, medicines, incidents and accidents, training, care records and health and safety, for example; an audit identified an improvement priority in relation to tissue viability. The provider held a full organisational review and implemented an action plan based on the conclusion, for example direct input from a tissue viability nurse to support improvements in pressure ulcer prevention and care. The service implemented new documentation and trialled and purchased new equipment. A subsequent benchmark audit identified an overall 30 per cent improvement in tissue viability care in the inpatient unit. The provider has ensured this improvement is sustained by appointing a link nurse for tissue viability and mandatory training for all clinical staff. The hospice' pressure ulcer working party continues to complete quarterly monitoring to ensure progress continues and becomes embedded. The management was responsive to the needs of the people in their community and services offered by the hospice were developed to meet these needs.

The provider was an integral member of representative national organisations and were committed to improve their quality of service and continually striving for excellence. The service had supported, in partnership with the Care Commissioning Group, a Care Homes Facilitator. This post has provided teaching, mentorship and support to all the care homes in the north Hampshire area. This support has focussed on improving palliative care for all, starting with people in care homes living with dementia. St. Michael's Hospice has introduced the Six Steps of Palliative Care program led by the dedicated Care homes Facilitator. Six of 13 care homes have now completed their accreditation. The Six Steps Education and Practice Development program is a national quality framework aims to support local nursing and care homes to improve end of life care for their residents and avoid in appropriate end of life admissions.

St. Michael's Hospice has implemented the Six Steps programme, supporting their Care Home Facilitator to work within care homes teaching by example. St Michael's Hospice at Home staff also directly support local nursing and residential homes. As a result of this initiative there had been a 44 per cent decrease in hospital admissions for care home residents in their end of life phase and a decrease in the requests for basic symptom management to St Michael's Hospice from the care homes. As a result more care home residents had their wishes met in relation to their preferred place of care and preferred place of death. This demonstrated that St Michael's Hospice was responsive to the needs of the people in their community.

The Care home Facilitator has now been asked to act as the quality assurance lead for a new course at Basingstoke College (Level 2 Principles of End of Life Care) which is a recognised course of the NHS QCF framework, demonstrating the provider's commitment to improving end of life care in the community. The quality assurance provided by the Care Home Facilitator in this role will ensure people in the community have access to more care staff with the enhanced skills to meet their end of life care needs appropriately.

St. Michael's Community Palliative Care Project has enhanced access to multidisciplinary specialist palliative care service for people in the final phase of their life. The project has a dedicated team including nurse specialists, social workers, therapists and family support. Communication with community GPs has vastly improved to ensure 24-hour care where needed. The care for people with a non-malignant diagnoses has tripled. People experiencing their preferred place of care and preferred place of death had risen from 60 per cent to 90 per cent. The pilot had a dedicated team of waking night sitters to support people and their families at home. The dedicated therapists had expedited equipment needs such as lifting aids to support people to remain at home. This had led to a dramatic increase in the avoidance of hospital and hospice admissions, enabling people to receive support in their homes.