Care Quality Commission

St. Wilfrid's Hospice (South Coast) Limited

St Wilfrid's 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?	**Outstanding** ☆
Is the service well-led?	**Good** ●

Summary of findings

Overall summary

St Wilfrid's Hospice is a charity which provides specialist end of life care and support to adults living within the local area. It provides a 14 bedded In-patient beds unit, a day hospice services and a community service. A range of other services are also provided including occupational therapy, physiotherapy, counselling and spiritual care.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were cared for by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, emotional and neglect.

Systems were in place to identify risks and protect people from harm. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. Risk assessments were centred on the needs of people and were reviewed daily by nursing staff. When people's risk had changed the assessments were updated to reflect these changes.

People being cared for at the hospice were protected against the risks associated with medicines because the provider had appropriate arrangements in place for the proper and safe management of medicines.

The registered manager compiled a report on accidents and incidents and these were reviewed by the chief executive and reported to the provider's governance team. There was an audit of accidents and incidents which identified trends and patterns, all clinical incidents were reviewed by the registered manager and following investigation an action plan was agreed.

There were sufficient numbers of staff with the required skills and experience on duty to keep people safe and meet their needs. We reviewed the staff rota that confirmed this. Staff told us they felt there were enough staff on duty. People's needs were responded to in a timely way.

Staff had undertaken appropriate training to ensure they had the skills and competencies to meet people's needs effectively. Staff received regular supervision and an annual appraisal to ensure that any issues with staff practice or areas for development could be identified and responded to.

People's rights were upheld as the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) had been adhered to. The registered manager told us that at the time of our inspection no-one was subject to DoLS.

People spoke positively of the food and told us their food likes and dislikes were taken into consideration including their preference on portion size. For people who needed a pureed diet the chef created "moulded meals". This involved moulding pureed food into the shape of recognisable food. This improved the experience of meal times for people.

There was always a doctor on call including at weekend and overnight. People told us that the community nursing team had regular contact with other professionals involved in their care. This ensured that people received the support and advice they needed and changes to people's health was monitored and responded to promptly.

People and their relatives spoke overwhelmingly positively about the caring approach of staff. An example of what people told us was "the care you get is exceptional". People valued their relationships with the staff team and felt they often "went the extra mile".

Staff were highly motivated to offer care that was kind and compassionate. They placed a high value on building relationships with people and there were examples of how they supported people in a way that ensured they felt understood and valued.

Staff had an in-depth appreciation of people's individual needs around privacy and dignity. Staff responded to people in an empathetic way while encouraging people to build on their strengths and maintain their independence. People and relatives spoke highly of the focus on promoting people's dignity.

Bereavement services were tailored to people's individual needs and were provided for as long as needed. Staff were highly motivated in ensuring that people remained as independent as possible. People were encouraged to set goals and to focus on these goals. Staff felt supported by colleagues and the management team. Staff had the opportunity to reflect on the emotional aspects of their work which helped them to manage their own stress.

People told us that staff were "exceptional" at responding to changes in their needs. People's care was planned in partnership with them to ensure that their wishes were central to the care provided. Staff also had a good understanding of how people may feel when considering the planning of their care, and they ensured that they responded in an understanding and compassionate way.

People told us that staff involved them in decisions about their care and listened to them if they preferred things done another way.

People and family members were encouraged using a variety of methods to give feedback on the services offered. Feedback was gathered through an Inpatient Unit survey, VOICES survey and evaluations forms from day services and the rehabilitation group.

There was an effective leadership team responsible for the running of the hospice that included the chief executive (the provider), the registered manager and the medical director. Staff spoke positively about the registered manager's style of leadership and told us they led by example. Staff felt valued and motivated to provide a high level of care.

There was an extensive programme of clinical audits including infection control and medicines to ensure that the quality of the care provided was maintained. There was an open culture about reporting and investigating incidents. This ensured that people were kept as safe as possible as risks were identified and measures put in place to reduce the risk of reoccurrence.

The hospice worked in partnership with other organisations to ensure they provided a high quality service. The community nursing team also worked alongside local care homes to ensure that standards of end of life care were upheld for people using these services. The education department ran a series of workshops "Six Steps Programme" which staff delivered to care homes in the local area to improve their understanding of end of life care and improve the outcomes for people receiving end of life care.

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.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Risk assessments were in place and were regularly reviewed to ensure that they reflected people's current level of risk.

People were protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage people's medicines safely.

Is the service effective?

Good ●

The service was effective.

Staff had received training as required to ensure that they were able to meet people's needs effectively

People were supported to maintain good health and were referred to health care professionals when needed

People's rights were protected as the principles of the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards (DoLS) were followed

Is the service caring?

Good ●

The service was caring.

People and their relatives spoke positively about the caring approach of staff. People described the caring manner of staff as "exceptional" and "wonderful".

People were treated with kindness, respect and dignity at all times.

Staff focused on enabling people to remain independent.

Family support is seen as key to people's wellbeing and bereavement services were tailored to people's individual needs and provided for as long as needed.

Is the service responsive?

Outstanding ☆

The service was outstandingly responsive.

People told us that staff were "exceptional" at responding to changes in their needs and told us that "nothing is too much trouble".

People's care and support was planned proactively with them.

Health professionals spoke highly of the hospice response to meeting people's needs and preferences which enabled people to live as full a life as possible.

People who use services were actively encouraged to give their views and raise concerns. The services viewed concerns and complaints as part of a drive for continuous improvement.

Is the service well-led?

Good ●

The service was well led.

There was an open culture and people and their relatives were positive about the quality of care delivered.

Quality assurance and clinical governance systems were in place and were used to improve the service.

The service worked in partnership with other agencies to ensure good outcomes for people.

St Wilfrid's Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Before the inspection, we checked this information and other information that we held about the hospice and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We reviewed feedback from two healthcare and social care professionals. We used all this information to decide which areas to focus on during our inspection

This inspection took place on 19 and 20 April 2016 and was carried out by one inspector, a registration inspector, a pharmacist inspector and a specialist advisor. A specialist advisor provides specialist clinical advice to the inspection team.

We spoke with a member of the board of trustees, chief executive, the registered manager, three relatives, four people and eleven members of staff. We looked at six care records, four staff records, medication administration record (MAR) sheets, staff rotas, the staff training plan, logs of complaints, quality assurance audits and other records relating to the management of the service.

The service was last inspected 1 October 2013 and no concerns were identified.

Good ●

Is the service safe?

Our findings

People and relatives felt they were safe and well looked after. A relative told us, "I think he is safe he is more relaxed here, I feel my mother and I are comfortable to speak with staff if we felt something was wrong or we had concerns". People were cared for by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, emotional and neglect. Staff were aware of their responsibilities in relation to keeping people safe. The registered manager was able to explain the process which would be followed if a concern was raised. The senior management team were aware of the learning from any safeguarding investigations and allowed them to review the support people may need. This ensured that people were kept safe and staff were updated on actions which could be taken to reduce the risk of harm to people.

People and relative told us risks were well managed while focusing on maintaining their independence. A relative told us, "Appropriate levels of care have been given to my father, he wants to maintain independence, staff allow him this even when they are making sure that he is safe to do things for himself". Systems were in place to identify risks and protect people from harm. Where someone was identified as being at risk, actions were identified and guidance provided for staff on how to reduce the risk; and referrals were made to health professionals as required, for example, in relation to pressure ulcers and falls. Risk assessments were centred on the needs of people and were reviewed daily by nursing staff. When people's risk had changed the assessments were updated to reflect these changes. Staff were aware of how to manage the risk associated with people's care needs and how to support them safely. Falls were reported daily and analysed monthly to identify any patterns and triggers. This monitoring system helped reduce the occurrence of falls for people. Staff made sure that people's call bells where in easy reach to ensure that they could call staff when they needed help.

The registered manager reviewed the reports on accidents and incidents and carried out investigations when needed. The registered manager compiled a report on accidents and incidents and these were reviewed by the chief executive and presented to the service's governance team. There was an audit of these events which identified trends and patterns. Staff are given a monthly summary which details any changes to guidance and signed these to confirm that they have read and understood any changes to practice.

There was an effective system in place for obtaining medicines including those required in an emergency on the inpatient unit and day hospice. Dedicated prescription and administration charts were used for prescribing including the administration of medicines via a syringe driver (portable pumps that are used to provide a continuous dose of medicine through a syringe). There were processes in place to allow doctors to pre-approve a range of discretionary medicines for the nurses to administer these without delay. This allowed nurses to respond in a timely way to treat people's symptoms. Records of medicines administration were clearly documented on the chart by nurses. Appropriate processes were in place for the disposal of medicines, including a waste exemption certificate. Policies, guidelines and references which provided information about the safe and correct use of medicines were available.

All medicines were stored safely and securely. Medicines requiring refrigeration were kept within their recommended temperature range. Even though the hospice's requisition book did not fully satisfy the criteria(in accordance with requirements of Misuse of Drugs Regulations 2001) with regards to the information required when ordering controlled drugs. There was no evidence to suggest that people had experienced any negative outcomes as a result of this shortfall. We discussed this with the registered manager and they assured us this would be addressed to ensured that the met the criteria when ordering controlled drugs.

The service and local GPs used the same system for their electronic patient records. This allowed staff to share pre-agreed sections of the patients' records such as the recording of medicines. This helped to ensure continuity of care.

Complementary Therapies were offered including the availability of cleansing and moisturising creams containing essential oils to people using the in-patient service. There were guidelines for the use of these oils and creams and risk assessments had been carried out to mitigate any risk when using these. There was also a policy and procedure on the use of complementary medicines. Therefore complementary medicines were managed in a safe way.

Safe recruitment practices were used and appropriate checks had been undertaken before staff began work to ensure that staff were suitable to work with people. These included criminal checks such as Disclosure and Barring Service checks (DBS). DBS checks allow the provider to check whether staff are suitable to work in a care setting. Staff files contained evidence to show, where necessary, staff were registered with appropriate professional bodies such as the Nursing and Midwifery Council. The Nursing and Midwifery Council regulate nursing staff and ensure professional standards.

People and relatives told us there were enough staff to meet their needs. A relative told us, "There is a good amount of staff, they answer the bells promptly". There were sufficient numbers of staff on duty to keep people safe and meet their needs and the staff rota that confirmed this. Staff told us there were enough of them on duty. People's needs were responded to in a timely way. We observed that staff were available to help people and they received unrushed care. The staff rota included details of staff on annual leave or training and shifts had been arranged to ensure that staff absences were covered. We observed staff were available to help people depending on their wishes and people received unrushed care from staff that were patient and caring. There were three consultants in post one of whom was the medical director. Each consultant also worked alongside the community palliative care team which was divided in catchment areas. The hospice participated in a General Practitioner training programme. Trainee GP's spent four months at the hospice to enhance their knowledge of palliative care.

Throughout the hospice equipment was regularly maintained and serviced. There was as a system in place which identified when repairs where needed and recorded any remedial action that had been taken. The system ensured that maintenance issues were responded to in a timely way. These records were reviewed and when equipment needed regular maintenance it was replaced in a timely way. This ensured that equipment was safe to be used and any issues were identified and resolved in a timely way.

The hospice had emergency procedures in place for emergencies such as fire. Guidance was available for staff on how to manage these emergencies. Staff were aware of how they should respond and took part in regular fire drills to maintain their knowledge. Fire safety equipment was regularly checked and serviced. The premises were secure for people because there was a robust security system in place. This system identified visitors and monitored access to the In-Patient Unit.

The hospice was well maintained and clean throughout. Infection control policies were in place and reflected national guidance. There were supplies of protective equipment such as gloves and aprons and staff wore appropriate personal protective equipment when needed. Staff washed their hands before undertaking any procedures, there was hand gel available for staff and visitors at various points throughout the hospice. Bathrooms, toilets and sluices rooms contained all the items necessary to maintain good infection control practices. Therefore people were as much as possible protected from the risks of acquiring an infection while at the hospice.

Good ●

Is the service effective?

Our findings

People told us that staff were well trained and knew how to meet their needs. One person told us, "There's loads of staff, they know what they are doing they have the skills, not only the employed staff, the volunteers as well". Staff had undertaken appropriate training to ensure they had the skills and competencies to meet people's needs. All staff's essential training was up to date and included safeguarding, food hygiene and moving and handling. There was also specific clinical practice training such as anaphylaxis (acute allergic reaction), medicine management and wound care management for clinical staff. Staff received additional training around end of life care and specific health conditions such as dementia. This ensured that people were cared for by staff who had received the necessary knowledge and had the skills to carry out their role effectively.

Staff spoke positively of the one to one supervision provided and told us that this enabled them to carry out their roles effectively. A member of staff told us ,"You can say how you feel not what you think they would like to hear". Therefore people were cared for by staff that were focused on continuously improving their practice and received the support they need to achieve this. Staff received clinical supervision which gave them the opportunity to discuss the emotional aspects of their role and ensured that they received the support they needed. Additionally, staff had access to an external counselling service which was funded by the provider. Clinical supervision and the availability of counselling services allowed staff to ensure their own emotional wellbeing to allow them to continue to support people and family through difficulty times.

New staff undertook a comprehensive induction programme which included essential training and the shadowing of experienced care staff. Staff had completed the provider's induction checklist which involved staff familiarising themselves with the layout of the building, fire safety procedures, policies and procedures and reading through care plans. There was a formal one to one supervision and appraisal process in place for staff and actions which had been agreed were recorded and discussed at each supervision meeting. This allowed them to identify any issue with staff practice and ensure this was resolved promptly. The annual appraisal focused on staff performance development plans. There was an extensive library room for staff that was fully stocked with reference books and up to date journals on palliative care to enable them to do research and expand their knowledge. The clinical nurse specialist team ran a journal club every two months and clinical staff are invited to attend. During session research articles and their impact on end of life care are discussed. This ensured that staff had the resource to keep up to date on best practice and increase their understanding of how to care effectively for people. .

Volunteers provided support in a variety of areas within the hospice. Clinical volunteers attended training specific to their role such as infection control and safe escorting techniques such as how to support people using mobility aids. Clinical volunteers provided support to be in the Inpatient Unit. Non clinical volunteers also attended training specific to their role such as dementia awareness and communication training. All volunteers attended safeguarding training and this was followed by a yearly update to ensure that all volunteers were clear on their responsibilities in relation to safeguarding.

Consent to care and treatment was sought in line with legislation and guidance. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the hospice was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority to protect them from harm. The registered manager told us that at the time of our inspection no-one was subject to DoLS. People were able to make day to day choices and decisions, but where decisions needed to be taken relating to finance or health, for example, then a best interest decision would be made for people who lacked capacity. A best interest decision is where care professionals and relatives would make a decision on the person's behalf, taking into consideration their needs and wishes. Where possible, the person would also be invited to the meeting. Staff demonstrated a clear understanding of the need to ask for consent regarding care provided and also when sharing information with others. They also knew about the importance of ensuring that people's consent was appropriately recorded.

People spoke positively of the food and told us their food likes and dislikes were taken into consideration including their preference on portion size. One person on the Inpatient Unit told us, "I cannot fault the catering, three course meals, lots of choices and I can have something not on menu, such as jacket potatoes, omelette, sandwiches. There is always something different to have". For people who needed a pureed diet the chef created "moulded meals". This involved moulding pureed food into the shape of recognisable food. This improved the experience of meal times for people and also increased the amount that people at risk of malnutrition may eat.

People's hydration needs were met within the Inpatient unit and day service. People were offered regular hot and cold drinks throughout both days of our inspection. Food and fluid intake charts were completed by staff at meals times to record and monitor how much people ate and drank. This information was recorded onto people's electronic records. The Malnutrition Universal Screening Tool (MUST) tool was used to identify whether people were at risk of malnutrition. This ensured that people were protected from the risk of poor nutrition.

External health professionals spoke highly of the health professionals involved in people's care. One health professional told us, "I have been impressed by the direct contact I have had with both Consultants and Nurse Specialists and we have very much worked as a team". The service employed a range of healthcare professionals including a team of doctors who visited people on the Inpatient unit and also worked with people at the day hospice service and the community teams. There was always a doctor on call including at weekends and overnight. People told us that the community nursing team had regular contact with other professionals involved in their care. This ensured that people received the support and advice they needed and changes to people's health was monitored and responded to. The ward sister attended daily ward rounds and there were four ward handovers between staff each day. The consultants carried out a ward round twice a week. At weekly multidisciplinary meetings a member of staff from each department attended and staff were encouraged to contribute their views on how to best support people and meet their needs. This ensured that staff responded effectively when people's health needs changed.

There was a discharge coordinator who was responsible for facilitating people's discharge home or to a care home. They told us they had been in post for a year and this had, "Increased communication, understanding and support with the community nursing, continuing health care team and nursing home managers". This ensured that it was clear which member of staff was responsible for coordinating people's discharge and people had a well-managed discharge.

Good ●

Is the service caring?

Our findings

People and their relatives spoke overwhelmingly positively about the caring approach of staff. People told us, "The care you get is exceptional", "It is absolutely wonderful, I've never met nurses as kind and considerate" and "They are a unique breed of nurses, I can't think of anything they could do better". Health professionals also spoke highly of the care provided. We were told, "I have always found the staff at St Wilfrid's to be excellent at providing advice and care to end-stage heart failure patients" and "The care patients receive as an in-patient is exemplary".

People valued their relationships with the staff team and felt they often "went the extra mile". One person told us, "I can't speak highly enough of them". They spoke with us about the practical and emotional support they received while on the Inpatient Unit. Their husband had passed away while they were staying at the Inpatient Unit. Two members of staff had accompanied them to the funeral and ensured that they had access to any health care equipment they needed. The person told us they appreciated that the consultant on duty had stayed later on their shift to talk through the day and ensure that they received the support they needed. Someone on the Inpatient Unit told us about the emotional support they and their family members had received and said "They have been brilliant, it is hard but they make it easier being here". A relative also spoke highly of the emotional support they had received from staff and told us "Staff have been kind to both me, my sister, brother and father. My sister went into the kitchen crying and a staff member put her arms around her in a hug which calmed her down. As I stayed the night staff gave me shampoo and soap so that I could have a shower, the receptionist took me to the bathroom to show me how it worked".

Two members of the rehabilitation team spoke with us about their focus on empowering people and supporting them to achieve their goals. They spoke with us about someone who had set the goal of being able to go shopping. Prior to becoming unwell the person enjoyed shopping and felt that the difficulties they were experiencing meant they were no longer able to carry out this activity. They felt that this negatively impacted their emotional wellbeing. Due to the breathlessness caused by their health concern this had become more difficult. Staff worked with this person on how to respond when they felt breathless including breathing exercise and positions to reduce breathlessness. They also looked at resolving practical issues such as ensuring that the person knew where to park close to the shop to reduce feelings of anxiety and possible breathlessness when they arrived at the shop. This meant that the person was able to carry out activities they enjoyed and allowed them to feel empowered and in control.

Staff also spoke with us about someone the rehabilitation team had worked with whose goal was to reduce their use of a hoist and to stand up independently. Staff spent one to one time with this person focusing on improving his mobility and building their confidence. A handrail was fitted into the person's home to allow them to practice exercises safely at home. They then decided to attend the exercise group and their family also came along to allow them to support with exercises at home. With the support of the staff, the person was gradually able to reduce their use of the hoist and after a period of time they were able to achieve their goal of standing independently.

A member of the clinical specialist nurse team spoke with us about a situation in which they felt they "went the extra mile". They told us about someone they were supporting at home whose daughter was getting married. Due to the person's health condition they required ongoing supervision and the person's family member and carer were concerned that they would not be able to attend the wedding. Following discussion with the person and their family the decision was made to admit the person to the inpatient unit for a period of respite on to allow their family to attend the wedding. Although the person's health was stable and they needed limited input from the hospice the period of respite allow the family members to attend the wedding while knowing their loved on was well cared for. The person's emotional wellbeing was also maintained as it alleviated their worries about the family being unable to attend the wedding due to their health.

Staff were highly motivated to offer care that was kind and compassionate. They placed a high value on building relationships with people and supported people in a way that ensured they felt understood and valued. Staff spent time speaking with people and sharing appropriate jokes while supporting them. People appeared comfortable with staff and enjoyed these interactions. People were gently and kindly encouraged when walking from one room to another. Staff knew which people needed equipment to support their independence and ensured this was provided when they needed it. Staff took time to make sure people understood what had been said or asked by making eye contact and repeating questions if needed. We saw that staff were gentle and friendly when they spoke with people and were quick to respond to requests in a kind and pleasant manner. There was a focus on people's wellbeing and on providing emotional support. A relative said that in order to reduce their family member's anxiety when they were on the Inpatient Unit, staff had suggested the person's dog come into the hospice to visit. The person greatly appreciated this and the family member felt it had a positive impact on the person's wellbeing and comfort. Staff also offered companionship to people who stayed in their bedrooms when people did not wish to be on their own.

Staff had an in-depth appreciation of people's needs around privacy and dignity. Staff spoke with us about the importance of respecting people's personal space and allowing them to spent time alone when needed. Interactions between staff and people were respectful at all times with a focus on people as individuals with a life history and significant relationships rather than focusing on their diagnosis. People and relatives spoke highly of the focus on promoting people's dignity. One person told us, "Privacy here is very good; everyone knocks on the door before entering". A relative told us, "They maintain my father's dignity and respect his wishes". Another relative told us, "Staff talk to him and say '(named person) we are going to do this or just going to move you'. They always appear calm and always talk prior to touching him". Staff responded to people with genuine empathy while encouraging people to focus on their strengths and encourage them to be as independent as possible. Staff maintained people's privacy during the inspection and knocked before entering people's bedrooms. Staff knelt down when talking to people so that they were at the same eye level.

Bereavement services were tailored to people's individual needs and were provided for as long as needed. People's families were encouraged to remain involved with the hospice after their family member had reached the end of their life. Following the death of their loved one family members received a bereavement pack which contained information from the patient and family service team about the bereavement services available including support groups. The hospice held a memorial book and when people passed away their name was added to the book. Relatives were able to visit the hospice and look through the memorial book and remember their loved one. There were a variety of support groups for people following bereavement. There was a "Safe Haven" group which provided emotional support for relatives. Relatives usually attended for up to six months and received emotional support from staff and also peer support from one another. There was also an "Open House" group which took place once a week and was a more informal drop in group where relatives were encouraged to support one another and discuss topics such as coping strategies. While there were approximate timescales for attendance at group's staff told us that they were flexible and their focus was on ensuring that people received the support they needed.

People's spiritual needs were considered in the care that they received. Chaplaincy support was available for people and their family. Relatives were invited to a remembrance service "Light up a Life Service" once a year. At stages throughout the year recently bereaved relatives were invited to a "Time to Remember" service which involved poetry readings and songs. They were also able to light a candle in memory of their loved one. This provided family members with an opportunity to remember their loved one while spending time with people who had also lost someone.

Family and friends were able to visit without restriction. Relatives were made to feel welcome and felt comfortable discussing any changes or updates to the care their relative received. A visiting relative told us that they visited and often called into the hospice for an update of their family member's health. They told us, "We can visit whenever we want, I feel confident that staff would call me if he deteriorated". One person we spoke with told us, "Visitors can come anytime; the staff are just brilliant with people". A relative told us, "We slept over here one weekend on the sofa bed in the room; we had no hesitation in staying. We are able to visit anytime and staff encouraged us to phone whenever we want even at 3am in the morning". Relatives also felt supported by the staff. A relative told us, "Staff have palliative care skill and they also care about us. My mum was having a hard time over the weekend and was not able to accept what was happening to dad, but staff took the time to talk to her". Another relative told us that they felt comfortable bringing their children into the hospice and that staff had a good understanding of how children may feel. They told us "There is a small play area where children can play when difficult conversations are underway".

Staff were highly motivated in ensuring that people remained as independent as possible. They focused on promoting people's independence. People were encouraged to set goals and to focus on these goals. A visiting relative told us "My father's care has been discussed with us and him, it is provided in a manner acceptable to him so that he can feel he remains independent". The rehabilitation team was made up of physiotherapist and occupational therapist and their focus was on promoting people's independence and improving their quality of life. Staff visited people at home, on the Inpatient Unit and also at the day hospice. The rehabilitation team also ran a relaxation and breathe easy group twice a week. This group provided emotional support and practical guidance on living with breathlessness. The evaluation forms from February 2016 reported that eight people had returned the evaluation. Three people had rated the group as excellent and 5 had rated it as good. One of the comments read, "The section on breathing was exceptional for me. I have learned so much from it". The physiotherapist also ran a group exercise group which focused on improving people's mobility and allowing them to remain as independent as possible. People also received guidance on exercises they could carry out at home which would improve their mobility. At a relaxation and breathing group the member of staff knew each person well and was aware of the goals they set and the challenges they faced. People were given encouragement through the group and the focus was on what people were able to do. One person living with dementia took part in the group and they had support from a member of staff to ensure they were involved. The relative of someone also attended the groups so that they could support their family member at home with the exercises. Following the group one person told us, "I've had a jolly good workout. I've learned a thing or two today".

People in the Inpatient unit had a pain management programme. Staff spoke with people about the benefits of medicines and ensured that they were aware of side effects which may be experienced. Staff ensured that people were involved in discussions about their symptoms and pain management. They were encouraged to express their views and preferences with regard to the care they would receive at the end of their life. These discussions were recorded in advance care plans, to ensure that family and professionals involved in their care had clear information on each person's wishes. Staff spoke with us about the importance of ensuring that people's individual wishes were respected. People were proactively supported to express their views and staff were skilled at giving people face to face information and explanations they needed and the time to make decisions. The doctors held discussions with people and tactfully presented a range of options to people outlining the positive and negative aspects of each option.

Staff felt supported by colleagues and the management team. A member of staff told us, "Everyone is so caring and encouraging". Time was spent during one to one supervision sessions, exploring the emotional aspects of their role. Staff were able to access an external counselling service. This gave staff the opportunity to talk with a counsellor who was not connected to the hospice. Staff were also able to participate in Schwartz rounds. Schwartz rounds are an opportunity for staff from the departments within the hospice to come together and talk about the emotional and social challenges of caring for people. The Schwartz round on the day of the inspection was well attended. Staff told us they found participation in Schwartz rounds highly beneficial as it gave them the opportunity to reflect on the emotional aspects of their work which helped them to manage their own stress. They also told us it helped them have a greater understanding of the conflicts and demands faced by their colleagues on other departments. Staff were also able to access the complementary therapies available at the hospice such as aromatherapy. This allowed staff time to focus on their own wellbeing and showed they were valued by the service so they could, in turn, provide this care to patients.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. A wide range of 'patient information' leaflets was displayed in the service covering a variety of topics. For example, there were leaflets which detailed the support available through each of the departments such as the inpatient Unit and the Day Hospice. They contained information on the referral process, transport and activities. There were also leaflets which detailed the support groups which were available. Following an increase in referrals for people with Polish as their first language, the information leaflets had been printed in Polish. Staff had used an interpreting application on an IPad to communicate with people whose first language was not English.

People spoke positively of the practical and emotional support offed by the psychosocial team. One person told us, "They're very very caring; we can talk about things even the things that sometimes make us cry". The psychosocial team offered emotional and practical support for people and their family. The team consisted of qualified counsellors, support visitors who are trained volunteers and the spiritual care team. There was specific staff with the skills to understand the needs of people and their family in relation to the emotional support need and also with practical assistance such as benefit advice and housing applications. A member of the team spoke with us about the services they offered and told us, "We try to be flexible". They spoke with us about someone who had been discharged to a local care home and the staff had difficulties managing their emotional aspects of the care. The psychosocial team were involved and visited regularly providing support for the person and also advice and guidance from the staff within the nursing team. This collaborative working ensured that good outcomes were achieved for this person who as a result received the care they needed.

Outstanding ☆

Is the service responsive?

Our findings

People told us that staff were "Exceptional" at responding to changes in their needs. We spoke a relative about the response to their family members changing health needs and were told "It's outstanding, warm friendly, nothing is too much trouble". One person spoke with us about a visit from a clinical nurse specialist when their health had deteriorated. They told us that once the member of staff realised that their health had changed they arranged for medicines to be prescribed through the GP. They then rearranged their visits for the afternoon to ensure that they had the support they needed that afternoon. A relative spoke with us about the deterioration in their family member's health and prompt response from staff when they had difficulties pressing the call bell. They told us, "They have ensured that Dad has access to a bell; they had made sure that he has a bell which is more sensitive as he could not press the button on the normal bell". The staff responded quickly to people's changing needs or wishes which ensured people's needs were met in a personalised way which allowed people to feel valued and listened to. Health care professionals also spoke highly of the response to people's health needs. A health professional told us, "The hospice team are excellent at managing the distressing symptoms of end-stage heart failure, organising care at home, supporting the family and provide a 24-hour helpline service" and, "I have had to make several urgent referrals to the palliative care team and my patient has always been seen quickly, either by a Consultant or Nurse Specialist. The team is organised and well-run".

People had regular contact with the community teams and felt able to contact them with any concerns or requests for advice and guidance. The clinical nurse specialist team provided a triage service. This was a telephone contact service where people, their relatives, external health professionals and local care homes could call for advice or support. This ensured that if people's allocated clinical nurse specialist was unavailable that they had access to the support and guidance they needed. This service also ensured that advice and support was provided to the community health staff effectively. The hospice at home team provided short term practical assistance to people whose preferred place of death was their home. Staff offered care overnight when needed.

The chief executive spoke with us about the End of Life Care Collaborative hub in which they were working in partnership with a local health commissioning team, another local hospice, Sussex Community Trust, MacMillan Cancer Support and Western Sussex Hospital Trust. The decision was made to implement the service to ensure that people had access to the support and guidance needed. This was to co-design a rapid response team, establish a palliative register and ensure more people in the local area could access a clinical nurse specialist and a consultant on call 24 hours a day. Advice and guidance would be available to people, relatives and health professionals. The intention was that the End of Life Care Collaborative hub would be operational by October 2016. Once implemented this would ensure that there was a rapid response to people's changing care needs and advice and support would be available round the clock.

There was a day services team which ran a variety of groups and workshops. The Orchard Supportive Care Clinic offered a range of specialist clinics which supported people offering advice and support on living well with their health condition and promoting their independence. A member of staff spoke told us that as people were living longer with illnesses they focussed on providing emotional support and helping people to manage their symptoms. There was also an art group. Art students from the local university regularly visited and supported people with art projects. People on the Inpatient Unit were also able to access the day services to meet their social and emotional needs. One person on the Inpatient Unit told us, "I went to the day centre today to do physio, I come here each week when I am at home. You are made to feel welcome, can use massage and physio services no charge". Once a week the day hospice ran "Wellbeing Workshops" designed to support people to maintain a sense of wellbeing and develop coping mechanisms. The workshops introduced people to therapeutic techniques such as mindfulness, complementary therapies and creative arts.

Complementary services such as aromatherapy and massage were available. People from the Inpatient unit or day services were able to choose if they wished to take part in these therapies. This was in addition to the medical support that they received and focused on reducing symptoms people experienced and improving people's sense of wellbeing. People valued this time and they felt an enhanced sense of wellbeing. These services could also be used by relatives of people. We spoke with a family member who was at the day service while their loved one was attending a relaxation and breathing session with the rehabilitation team. They spoke with us about how they were able to enjoy their massage while being reassured that their loved one enjoyed their relaxation session. They told us that the staff within the complementary services made sure that the time of their session coincided with the relaxation session as this allowed to feel more relaxed.

The registered manager spoke with us about the importance of listening to people's views and promptly responding to changes in their wishes in the care they received such as their preferred place of death. They told us about someone who chose to die in the hospice but in their last few days told staff their preference would be to die in the hospice garden. The person had complex health needs. Staff ensured their health needs were met and facilitated this in a way that was safe and respectful and allowed the person to spend their last hours in the garden.
One of the rooms on the Inpatients Unit was being refurbished and it was planned that it would become a "dementia friendly" room. A dementia friendly environment is an environment which takes into consideration the needs of people living with dementia and allows them to find their way around safely and independently. The registered manager spoke with us about the increase in the number of people admitted with dementia and the importance of ensuring the design of the room took into consideration their needs. They told us they had ensured that handrails were contrasting colours to the walls and that there was clear signage on the doors and ensuite. This room was in the process of being refurbished and the intention was that the room would be completed by September 2016. The hospice planned to adapt other areas within the hospice to ensure that the design took into consideration the needs of people living with dementia. As part of their personal development plan, a member of staff had been given time to carry out training and research in how the hospice could best meet the needs of people living with dementia. They had been involved in the design of planning of the dementia friendly room and also the design of the new build hospice to ensure it was "dementia friendly". Therefore the staff member had been empowered to be involved with this improvement and influence change.

There was a "walk and talk group" once a month which was a guided walk which relatives could attend following bereavement. This group gave people the opportunity to maintain a link with the hospice following the death of a loved one. It also allowed people to meet with other bereaved relatives and receive support from their peers. As the group was outside and relatives spoke while they walked this allowed people to receive support in a more informal way than other groups provided through the hospice. Staff told us the service aimed to provide support for people in a variety of ways to ensure that as many people as possible received support when they needed it.
As people living in the community often found it difficult to access the equipment they needed such as mobility and bathing aids the hospice loaned equipment such as reclining chairs. This reduced the anxiety

people experienced when attempting to source this equipment when they were at home.

Staff knew people well and understood how they liked to be supported. Care plans included information on people's key relationships, personality, preferences, wishes, likes and dislikes. They also contained information on people's social and physical needs and on people's life histories which gave staff information about the person's life before their admission to the hospice. Staff were aware of people's preferences such as what time people liked to have their breakfast or whether they preferred a bath or shower. People's care was planned in partnership with them to ensure that their wishes were central to the care provided. A relative told us, "Dad consents when he is able, nurses will always talk to him first". A health professional told us, "Patients and their families are always included in the decision making process". Staff also had a good understanding of how people may feel when considering the planning of their care, and they ensured that they responded in an understanding and compassionate way. The clinical nurse specialist team provided support to people in their homes and they completed a wishes and preferences form which focus on how people would like to receive their care. This document was continually reviewed and discussed with people to ensure that any changes to preferences were recorded. This ensured that when people receive care at home, the Inpatient Unit or the local hospital that there was a written recorded on how they wanted their care to be delivered.

Each care plan was person centred to ensure that people felt valued and understood. People and those that mattered to them were involved in their advance care plans to ensure that the care they received at the end of their life was as they wished. Records contained clear information about people's wishes about resuscitation. There were strategies in place on how to manage people's pain and symptoms and staff reviewed these on a continuous basis to ensure people's needs were met. When the support people needed changed this was recorded, which ensured that people received care that reflected their current needs. Additional care plans were updated hourly when people approached the end of their life, to allow staff to respond to their changing needs and to monitor their comfort closely. The care plans were centred on the person, included food and drink, symptom control and psychological, social and spiritual support. Sensitive communication took place between staff and the person, and those identified as important to them. Staff spoke with people about what information they would like shared with their family and ensured that people's wishes were respected. A visiting relative told us that their family member had asked that any sensitive information was shared with them when their family was present. They told us, "They like to talk to me and my wife, daughter and son as a unit".

Admissions to the Inpatient Unit were normally Monday to Friday but there was flexibility for planned admissions at the weekend if needed, as well as urgent admissions. People were admitted to the Inpatient Unit when they needed additional support to manage their symptoms, pain relief or respite as well as end of life care. All rooms were single rooms with access to an ensuite bathroom. Bedrooms in the IPU had a ceiling track hoist to enable people to go from their bed to the bathroom. All beds could be wheeled outside if people wanted to access the garden. There were two family rooms which family could use to stay overnight. This ensured that family felt able to visit without restriction and people were supported to maintain relationships with their loved ones. There was also a quiet area within each ward which allowed relatives a space to spend with other family members to have sensitive conversations. One of the quiet spaces had a variety of toys and children's books. This ensured that children were made to feel welcome and comfortable.

People's families were encouraged to stay involved with the hospice for as long as they felt necessary. People were able to plant a sunflower in the gardens of the hospice as a memory of their loved one. People could also remember their loved one through memory leaves. This was a stainless tell leaf with their loved one's name engraved on it. People could either keep this at home or hang it in the hospice garden.

People told us that staff involved them in decisions about their care and listened to them if they preferred things done another way. When people had been admitted to the Inpatient Unit for respite or to have their symptoms managed staff ensured that the hospice at home team had the information they needed to plan the support and care they would need at home. This ensured that people received consistent care by staff that had the most up to date information on the support they needed. One person on the Inpatient Unit who was planning for their discharge home told us, "They asked me about my care needs, I said I had problems getting out of the bath so they sorted it for me, they have also got me a cushion for home. The hospice and the occupational therapist work well together as a team, the hospital and GP are like a network, they keep everyone informed. When I am at the day centre they know already if I've had to call a paramedic, it means that I don't have to keep explaining things over and over again".

People knew how to complain and told us they would feel comfortable raising any concerns. People told us, "There is a complaints booklet on how to complain. I would feel comfortable about making a complaint should I have to". We were also told, "We were told about the complaints procedure, we feel we can go and talk to any of the nurses all are friendly and open". A visiting relative spoke with us about a concern they raised relating to noise from the refurbishment to a room on the Inpatient Unit. They told us, "There is a complaints procedure written and in my father's room, I would feel comfortable raising a concern. My brother raised a concern about banging, in the next room. I think they are altering the layout or something. As soon as he said it was causing his father to be disturbed they stopped straight away". There was a complaints policy in place. All complaints whether formal or informal were investigated according to the hospice complaint policy. Staff told us they respond promptly to any concerns or complaints; we were told "we take it very seriously if there is an issue. We speak to family when there are small things, it's very important".

People and family members were encouraged to give feedback on the services offered. Feedback was gathered through an Inpatient Unit survey, VOICES survey and evaluations forms from day services and the rehabilitation group. There was also a suggestion box within the hospice which people or relatives could post comments or suggestions anonymously. From November 2015 to January 2016 thirteen people had completed the survey and 100% of people had confidence in the staff caring for them, 100% felt that staff explained what they were doing. 100% felt the staff made an effort to meet individual needs and wishes 100% felt they were treated with respect. Any issues from the feedback were reported to the chief executive. An action plan was compiled which highlighted comments and suggestions for improvement.

A staff survey had been carried out in 2015 and the next survey was due on the summer of 2016. The 2015 staff survey showed that 98% of staff are happy with the standard of care the hospice delivered and 97% enjoyed the worked that they do. An action plan had been compiled to address concerns from the survey. Staff felt improvements could be made between departments and with the senior management team within the hospice. The action plan detailed that an emphasis would be placed on the staff forum and a summary of each staff forum meeting would be made available for staff.

The provider continuously reviewed the service they provided to ensure that the care and support provided reflected the changing needs of the community. In 2015 19% of the people they supported had a non-cancer diagnosis and the hospice was focusing on increasing the number of patients they supported with a non-cancer diagnosis to ensure they reached a wider range of people in the local community. The provider was planning to build a new hospice in the area which would accommodate more people. The registered manager told us that the new building would be sensitive to the needs of people living with dementia and the plan was that the new building would be completed Autumn 2018. A new build committee had been set up to focus on the design and layout of the new building and the importance of ensuring the needs of future patients was reflected in the design. Ongoing consultation was taking place with staff from all departments to ensure that their views were gathered on how best to meet people's needs.

Good ●

Is the service well-led?

Our findings

There was a positive and open culture and people spoke with us about the relaxed atmosphere. People spoke positively of the care and support provided by the hospice. One person told us, "The atmosphere is relaxed and easy going here. No one seems to panic, everything seems to be under control". We were also told, "The hospice has a quiet, peaceful and tranquil atmosphere, this gives me confidence that my father is being looked after, and that the nurses are dedicated".

There was an effective leadership team responsible for the running of the hospice that included the chief executive (the provider), the registered manager and the medical director. There was a board of trustees with 12 trustee members with a variety of experience. A member of the board of trustees told us that time had been spent ensuring that they had trustee members with a variety of skills relevant to the hospice. Trustee visits took place twice a year. At the last trustee visit two trustees had visited the clinical nurse specialist team. They spoke with staff members and checked on areas such as staff training and the referral process. This ensured that staff had the support they needed and checks were carried out to drive improvement.

All staff spoke positively about the registered manager's style of leadership and told us they led by example. Staff felt valued and motivated to provide a high level of care. One staff member told us, "Staff are here for years which is reassuring and we all are fiercely passionate about our work". Another member of staff told us they were proud of "Making a difference" "It's very rewarding".

Resources and support were available for the development of the staff team and there was an awareness off the importance of ensuring the emotional wellbeing of staff to allow them to continue to support people at the end of their life. Staff felt that challenges were well managed by the senior management team as they received emotional support through supervision, the external counselling service, Schwartz rounds and debrief sessions.

There was an effective system of communication between the chief executive and the board of trustees. They met monthly and updates were given to trustees on areas such as the care provided, finances and quality assurance. They also met monthly to monitor strategic risk and plan for the long term future of the hospice. There was a variety of board subcommittees which met four times a year which focus on specific areas such as resources and board development. There was an organisational risk register which considered risks to the hospice such as reductions in funding. Therefore potential risk which could compromise the quality of the care provided could be monitor and responded to by the hospice.

There were robust systems in place for monitoring accidents and incidents; this ensured that information was responded to in a timely way to minimise the risks to people's safety. There was an extensive programme of clinical audits including infection control and medicines to ensure that the quality of the care provided was maintained. Quality assurance processes had identified that it would be beneficial to have an audit of pain management and the use of controlled drugs, and as a result this had been implemented to ensure that they adhered to national guidance. There was an open culture about reporting and investigating incidents. Staff told us there was not any blame culture about incidents and that learning was shared with them so they could change any practices they needed to. The registered manager spoke with us about the future plans to get staff more involved in the schedule of audits. They felt that this would develop staff understanding of quality assurance and ensure another perspective to the auditing process. They planned to start later this year and it would be incorporated into staff personal development plans. Staff were positive about their upcoming involvement in the audit process and told us, "We always have a culture of wanting to improve".

The hospice worked in partnership with other organisations to ensure they provided a high quality service. They worked in collaboration with Continuing Health Care (CHC), local authority departments and local hospital teams. The community nursing team also worked alongside local care homes to ensure that standards of end of life care were upheld at those services. The education department ran a series of workshops "Six Steps Programme" which staff delivered to care homes in the local area to improve their understanding of end of life care and improve the outcomes for people receiving end of life care. The education department also ran university accredited course and study days including, dementia sessions symptom control in end of life care and Sage and Thyme Communication skills (training designed to staff how to listen and respond to people who are distressed). These courses were open to health and social care professionals. A member of the education team told us, "Our aim is to share knowledge". A no fee study day had been arranged for ambulance crew in the local area which focused on the response when they attended to people at the end of life in the home. This aimed to improve the outcomes for people who received end of life care in the local area.

The hospice was involved in the local community and focused on building a strong positive profile in the community. The registered manager participated in fund raising events in the community.

Volunteers and staff also contributed to the fundraising events and were encouraged to take part in the local events. There were a variety of fundraising events planned including a Moonlight walk and a Santa sprint and Stroll. There were also regular events held in the community such as the local hospice lottery and coffee mornings. These events contributed to fund raising and also raised the profile of the hospice in the local community. People in the local community felt involved in the hospice. Days at local events and venues such as garden centres were also arranged to raise awareness and improve people's understanding of the care the hospice provided. Therefore alleviating people's anxieties about involvement with the hospice.