St Barnabas Hospice Trust (Lincolnshire)

St Barnabas Hospice - Specialist Palliative Care Unit

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Good** ●
Is the service responsive?	**Good** ●
Is the service well-led?	**Good** ●

Summary of findings

Overall summary

We inspected St Barnabas Hospice – Specialist Palliative Care Unit on 29 March 2016. The inspection was unannounced. St Barnabas Hospice is a registered charity covering the county of Lincolnshire.

St Barnabas Hospice – Specialist Palliative Care Unit provides a wide range of services for people who have advanced, progressive illnesses and where the focus is on palliative and end of life care. The services are provided within four settings; an in-patient unit, a day therapy centre, hospice at home services and a palliative care co-ordination centre. Holistic services are delivered by a team of medical, nursing and social work staff, occupational and physiotherapists, counsellors, and chaplains.

There was a registered manager in post at the time of our inspection. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of the inspection no-one using the services had any legal restrictions placed upon freedom. We saw that where this had been a necessary action prior to the inspection the provider had acted in accordance with legal guidance in order to protect people's rights.

People were unanimously positive about the services they received from St Barnabas Hospice – Specialist Palliative Care Unit. Without exception they praised the staff for their personalised and caring approach.

People were the focus of and at the heart of the service. They were central to the planning and reviewing of their care packages and those who were important to them were fully consulted. Support for people's spiritual, cultural and emotional needs was an integral part of their care package.

People privacy and dignity were respected in all of the hospice care settings. Their consent was sought before any care was provided. Their views and those of people who were important to them were respected and used to help improve the quality of the services people received.

Staff understood people's needs, preferences and wishes and provided support that took all of these things into account. Staff were well trained and supported to provide care and treatment that was sensitive, warm and respectful. They were knowledgeable about their specialist field of care and took account of how a person's wider medical needs impacted upon their life limiting diagnosis. They were supported to keep up to date with current good practice and research within their specialist field of care

People were supported to stay safe by staff who knew how to recognise and report signs of abuse. Staff also knew how to assess and manage risk in a way that did not limit a person's lifestyle.

People received all of the healthcare support they required. Doctors and therapists who specialised in palliative and end of life care provided support alongside people's GP, community nurses and NHS Trusts. People's nutritional needs met in a personalised way that took account of their preferences and wishes.

People who used the service and those who were important to them praised the way the service was run. Effective leadership and management systems supported a culture of openness and close team working. There was a strong emphasis on providing care that was based on current good practice guidance and relevant research. There was also an emphasis on continuous service improvement which was supported by effective quality assurance systems, close liaison with partner agencies and the local community.

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 supported in a way that minimised risks to their health, safety and welfare. Staff knew how to identify and report any concerns for people's safety.

There were enough staff, who were safely recruited, to ensure people's needs and wishes were consistently met.

Medicines were managed safely.

Is the service effective?

Good ●

The service was effective.

People received all of the healthcare and nutritional support they needed.

Staff had the specialist skill and knowledge to provide effective care and support.

People were supported to make their own decisions about their care and staff knew how to support those who were unable to do so.

Is the service caring?

Good ●

The service was very caring.

People were treated with respect and dignity. Their diverse personal needs and preferences were met with sensitivity and warmth.

Staff recognised and understood the emotional and psychological impact of life limiting illness upon people who used their services and their loved ones. They provided care and support in a proactive way to help people manage that impact.

People were supported to have as much control over their lives and the support they received as they were able to, including how they were cared for at the end of their life.

Is the service responsive?

Good ●

The service was responsive.

Effective systems were in place to ensure people received care and support that was responsive to their complex and changing needs at any time of the day or night.

Care planning and review systems ensured that people were fully involved and were able to determine how and when their care and support was provided.

People's care packages were personalised, well co-ordinated and monitored to ensure consistency for them. They benefitted from support to maintain social and personal interests.

Systems were in place to respond to any concerns or complaints raised with the service.

Is the service well-led?

Good ●

The service was well-led.

People were able to be involved in how the service was run and contribute their views about how the services could be improved.

Effective leadership and service management promoted an open and inclusive culture in which people who used service and staff felt valued.

An approach of continuous improvement and the use of best practice was embedded within the culture of the service.

St Barnabas Hospice - Specialist Palliative Care Unit

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 March 2016 and was unannounced. The inspection team consisted of two inspectors, one of whom was a pharmacy specialist, a specialist advisor with experience of palliative and end of life care and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone has used this type of care service.

Before we visited St Barnabas Hospice – Specialist Palliative Care Unit we reviewed the information we held about the service, such as the statement of purpose for the service and notifications we had received from the provider. A notification is information about important events which the service is required to send us. We also asked the provider to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our planning.

During the inspection we spent time observing how staff provided care for people so that we gained a better understanding of their how they experienced care. We spoke with seven people who used hospice services and four family members. We also looked at five people's care records which included medication administration charts.

We spoke with the Chief Executive Officer for the provider organisation, the registered manager, a team manager and a team co-ordinator, seven nursing staff, a cook, a housekeeper and two volunteers. We also spoke with external healthcare professionals who had regular contact with the service.

We looked at a range of records including six staff personnel files, quality assurance documents, staff training records and reports of surveys carried out with people who used services and others who were important to them.

Good ●

Is the service safe?

Our findings

People who used the service and those that were important to them universally told us they felt safe when receiving services. One person told us, "I feel safe and secure. Nothing's too much bother. Even when it's busy, busy it's okay." Another person told us, "I have a very high opinion, I feel safe." A relative said, "[My loved one] feels safe with them. I can't say enough."

Staff demonstrated a very clear understanding of how to keep people safe from harm. They had received introductory and on-going training about this subject and knew how to report concerns for people's safety both within and outside of the provider organisation. They understood their role when working with other organisations to keep people safe. A member of staff told us, "There's always someone to get hold of for advice." Up to date policies and procedures were in place to guide staff in their practice and a regular news letter was published to ensure their knowledge was kept up to date. Each part of the service had an identified link nurse to provide support and guidance for staff about keeping people safe.

Information within the PIR indicated to us that maintaining people's safety and the reduction of risk was embedded within the culture of the service. Examples were given such as how the provider monitored and reviewed risk through their risk management committee. The PIR also described how incident investigation was supported by a clinical audit support group. During the inspection we saw that the provider and registered manager carried out analyses of the cause of incidents in order to promote improvements in practice.

Link nurses for areas such as infection control and tissue viability were identified for each service area to ensure staff's knowledge and skills were kept up to date and they had access to specific guidance and support. The provider had a business continuity plan in place which was supported by an emergency preparedness plan. This meant that they would be ready to respond to any potential emergency situation, including alternative premises for providing care if the in-patient unit needed to be evacuated. During the inspection we found that risk assessments were in place and they had been conducted in consultation with people who used the service. Risk management plans were person centred and took account of people's wishes and preferences. Throughout the inspection staff demonstrated they were aware of the risks identified for each person and followed the guidance of the management plans that were in place. Staff spoke to us about ensuring that people were supported to maintain their usual routines and ways of living and were not restricted by the risk management measures that were in place.

We saw how people's safety was an integral part of everyday care. For example, within the in-patient unit call bells were placed were people could easily use them, hoists and other people-moving equipment were readily available, bedrails were in place where people wanted or needed them and all clinical and non-clinical staff consistently observed infection control procedures.

The provider followed safe systems to recruit new staff. We saw that checks were carried out about potential staff member's identity and work history, and previous employment references had been obtained. Disclosure and Barring Service (DBS) checks had been carried out to ensure that they would be suitable to work with the people who used the service. Checks were also carried out with governing bodies for nurses and doctors to ensure they were appropriately registered to practice. The provider had a system in place to check the suitability of volunteers who wished to work within their services. Staff confirmed to us that these checks had been carried out before they were interviewed and offered employment.

There were sufficient numbers of staff employed in appropriate roles to provide care for people in the in-patient unit, hospice at home services and day therapy services. The roles included nursing, medical, chaplaincy and welfare specialists. A large number of volunteer workers also supported people in roles such as befrienders and counsellors. People consistently told us there were enough staff to provide whatever care and support they needed and wanted. One person said, "There's lots of volunteers, an abundance of staff. Everyone is helpful, friendly." Another person told us, "There's always enough people, they can't go out of their way enough."

The provider had systems in place to calculate how many staff were required to provide appropriate levels of care and support for people. The calculation tool took into account people's need for spiritual, psychosocial and cognitive support as well as their physical care needs. Staff working within all areas of the service told us staffing levels were appropriate for people's holistic care needs. A member of staff from the in-patient unit told us, "There's a high patient to staff ratio, we have time to spend with people." A staff member from the hospice at home service said, "I like the fact that calls are not constrained by time, you can ask for other staff to cover your next call if a patient needs extra help." A relative told us, "Hospice at Home was very good, very efficient, very pleasant, it didn't feel rushed. A relative of ours was amazed how much time they spent; over two hours." The registered manager told us how they ensured that any short notice staffing requirements due to situations such as sick leave would be covered by the provider's bank staff system.

Medicines were consistently managed by staff in a way that was safe. Accurate records were kept of medicines prescribed for and given to people. These showed us that people who used the service received their medicines at the times they needed them. Medicines, including oxygen and controlled drugs, were correctly stored so as to protect people using the service and to ensure that the medicines would be effective when used. When people wished to self-administer their own medicines independently they were supported to do this and the risks of them doing so where assessed. To protect people with limited capacity, the correct procedures were followed when medicines need to be administered covertly. One person told us, "My meds come on time, the syringe driver is changed quickly." Another person said, "They always check meds if they are qualified to do, including the syringe driver even though it's changed by the district nurse."

Good ●

Is the service effective?

Our findings

People who used the services and those who were important to them told us, without exception, they received all of the care and support they needed from the staff who looked after them. A person told us, "They're doing everything, taking the pressure off me." A relative said, "Hospice at Home has been absolutely brilliant, I can't fault them, being there when we've needed them, help, questions, everything's been done." Two other relatives told us, "They liaise with the district nurse and others and help on the care side if [my loved one] is feeling a bit sick" and "They're pretty efficient at what they do and they record stuff well."

People told us they thought staff were well trained and one person said, "Oh they know what they're doing, that gives me confidence." Another person said, "The attitude is brilliant, cheerful, not over the top and obviously very knowledgeable. We mention things and they know what we're talking about."

New staff told us, and records confirmed they received a programme of induction training which included observing more experienced staff before they began working directly with people. An example of this was seen in relation to medicines administration. New staff received training in the handling of medicines and had their competency assessed before working independently. Staff said the introductory training prepared them well for their job role and they felt well supported by the teams they worked with. The registered manager explained that new staff underwent a probationary period of one year. The provider organisation and the registered manager had recognised that working within palliative care and hospice services could be stressful for new staff. They said the probationary period helped new staff members to regularly evaluate their progress within their role and receive the support they needed.

The provider and registered manager had systems to ensure a comprehensive staff training programme was in place each year. Staff told us they received a programme of on-going training which included regular updates for key topics such as medicines management, keeping people safe and infection control. As well as other key topics such as palliative care processes, pain management and syringe driver management, we saw the training programme included topics such as dementia awareness, Parkinson's awareness, and spirituality and well-being. The registered manager told us they were planning training about learning disability and mental health awareness to further enhance staff skills and knowledge. This meant the provider recognised the importance of staff having an awareness and understanding of how people's wider needs impacted upon their palliative and end of life care needs. There were newly developed roles for a clinical educator and a project lead to ensure registered nurses were supported to maintain their registration with their governing body. There was also a system in place for 'link nurses' to provide staff with further support and expertise in specific topics such as diabetes, blood transfusion, syringe driver management and tissue viability. The link nurse role was designed to ensure all staff were kept up to date with current good practice and any research initiatives within their field of care.

Staff told us they were well supported with regular supervision sessions which took into account their development needs and gave them an opportunity to discuss any issues they had. During the inspection we saw that supervision arrangements were in line with the provider's policy and the supervision process included nursing and medical staff and volunteers. We saw that supervision arrangements were separated into clinical and management supervision sessions with clear guidance as to what each session should focus upon. Management supervision sessions focussed upon giving staff feedback about staff work performance and development; clinical supervision sessions focussed upon supporting and educating staff to help them deliver a high standard of care. Staff also told us about debrief sessions that took place. These sessions helped staff to, for example, reflect upon significant events and learn from their experiences.

The registered manager and staff demonstrated a clear understanding of the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff told us and records showed that they had received training about this topic. People's personal records showed that they were supported to make informed decisions about their care and support. An example of this was a person who had decided, after being supported to be fully aware of the risks, that they did not wish to use a pressure relieving mattress. We saw that staff had complied with their wishes. Another person told us, "They always ask me what I want and help me to make a decision, they'll give me information to help me as well."

Records showed us that people who were unable to make decisions for themselves were supported appropriately to ensure their rights were protected, and people who were important to them were consulted. Staff were conversant with the requirements to assess people's ability to make a decision if there was a query about their ability to do so. They also knew how to ensure any decisions that needed to be made on behalf of a person were made in their best interests. We observed that staff within the in-patient unit staff asked for permission before they carried out care or support for people and explained what they were going to do. People told us this gave them the opportunity to decide how and when they wanted the support provided.

The registered manager and staff were also aware that 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 are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection no-one within the in-patient unit was subject to any restriction to their freedom. Records showed us that the registered manager had followed appropriate application procedures when required.

We spoke with people in the in-patient unit about how they were supported with eating and drinking. They told us there was "excellent" flexibility and personalisation with the provision of food and drink depending upon how they were feeling and menus were discussed with them individually. They also told us staff helped them with, for example, cutting up food and holding cups for them to drink from if they were feeling tired or in a weakened state. Some people required their food to be softened at times to make it easier for them to eat and people told us this was always done and was presented nicely. They said staff, including the cook, took time to understand their needs and preferences and made sure the food and drinks available were in line with this. The cook told us that no-one staying within the in-patient unit currently had any cultural or medical dietary needs but they were confident that they could provide for such if required.

The cook had a clear understanding of how people's appetite may fluctuate and had developed flexible menus to support this. The cook described how they took into account portion sizes for individual people as some may feel overwhelmed by food. One person told us, "I came in not eating. I still can't eat much but it's well presented. I've just had a jacket potato, really nice and some mousse." The cook said they also made sure there was a variety of provisions for those who did not want to or could not eat a meal but wanted a refreshing taste in their mouth, for example, lollipops and ice creams.

We saw that a nutrition and hydration assessment tool was in place which incorporated a system for daily monitoring and evaluation of people's needs. Staff told us that this tool had been developed to specifically meet the needs of people using the service. This was because other, nationally recognised, tools could impact upon people's self-image which may already be compromised by their health status.

People indicated to us that they received all of the healthcare they needed and wanted. Medical staff were employed by the provider and were available within the in-patient unit each day. Medical staff also provided palliative and end of life expertise to people receiving hospice at home services and to those cared for within local general hospital settings. We saw that there was close liaison between the hospice staff and people's GP's and district nursing teams. People told us that they had access to a range of other specialist healthcare professionals and their care plans showed where referrals had been made to, for example, speech and language therapists and tissue viability specialists. People's care plans gave clear details about how staff should support them with needs such as caring for catheters, symptom management and medication. A person said about nursing and medical staff, "They seem to take note of what patients are saying, for example if they have quite a lot of pain and they understand their needs."

Good ●

Is the service caring?

Our findings

People we spoke with and others who were important to them were unanimous in their views about the caring, thoughtful and pleasant nature of the service. These views were echoed in surveys we carried out prior to the inspection. People said that staff understood their needs and they had positive relationships with them. People repeatedly used phrases such as, "They can't do enough" and "Very caring." A relative told us about the in-patient unit, "When [my loved one] came in they could see I was upset. They sat me down, talked to me. I can't praise them enough." Another relative said, "Always introduce themselves and ask what [my loved one] would like to do …. foot soak, shower, sit in a chair." A person staying in the in-patient unit said about the catering, "They're willing to produce anything; they will go out of their way." Another person said, "I think they're wonderful, I had a stint in hospital but the interaction with staff is better here.

Other things that people told us were, "It's been wonderful. My first time, it's perfect I can't fault it"; "There's a happy atmosphere. People you meet outside think this is a sad, sombre place but it's not at all. I can have a laugh with people"; "I couldn't find fault with this place" and "It's wonderful what they do, if everyone gets what I get they'd be pushed to keep pace with it." We found the atmosphere within the in-patient unit was welcoming, friendly and inclusive of everyone who stayed, worked or visited there. The friendly and knowledgeable welcome began at the reception area where staff made sure people were comfortable, offered refreshments and were given any information they needed. There was a comfortable room with facilities for people to make their own drinks and take snacks if they wished to whilst they were visiting.

The in-patient unit was comfortably furnished and decorated with fresh flowers and plants. We observed that staff interacted with people in a genuinely caring, warm and respectful manner. One person said, "People always ask, 'do you mind' or, 'would you prefer'." Staff addressed people by their preferred names and sought permission before providing any personal support. We saw staff used caring body language and appropriate touch to convey understanding and warmth to people. Examples of this were seen in that staff made sure they were at the same level as people who were in beds or chairs when they spoke with them; they maintained a focus on the conversations they had with people so as to demonstrate active listening; they gently held a person's hand or repositioned their hair when this was appropriate. One person said, "Sometimes all you need is to hold someone's hand, no conversation, they'll do that for you." Another person who used hospice at home services told us, "They support me by just being there." A person using the in-patient service told us, "The cooks come and do their utmost to accommodate." Examples of this were shared with us such as arranging a person's favourite take-away meal to be delivered. We also saw that volunteer staff demonstrated the same caring and warm approaches towards people. An example of this was a volunteer going to each person to say good bye and wish them well before finishing their shift.

We saw that staff displayed the same caring and warm approach with relatives and other visitors. A relative told us, "If I come then they make me a cup of tea. There's a relatives' room if I wanted to stay overnight." Relatives also told us that staff went the 'extra mile' to ensure that people could celebrate key family events within the in-patient unit. We heard about examples where cakes, champagne, and chocolate refreshments were provided for key events such as birthdays and anniversaries. We saw comfortably furnished and private flat let areas had been set aside for relatives to stay within the in-patient unit. The registered manager told us how it was important to ensure that relatives had their own private space to use; not only for their practical convenience but also when they needed to have private time to explore their own emotions and feelings. Counselling services were provided for relatives as well as people who used the hospice services. Staff told us this service could be used to help people who used the service and their relatives manage their anxieties and fears or cope with situations they may not have faced before. The service was also available to help the bereaved to come to terms with their loss and they could use this service for as long as they needed to. This service was provided across the county of Lincolnshire so that people could access the service in the areas they lived in.

People were supported with their cultural needs and these aspects of their care were included in care plans. An example of this was for the provision of meals related to a person who had specific cultural preferences. The cook told us about searching for recipes on the internet and sourcing the right foods to provide for their requests. The day therapy centre provided support for people to maintain their self-image. An example of this was a once weekly group where people could get support and information about issues such as hair loss as a result of treatments. Trained staff offered help with styling their hair or providing hair pieces to help people feel more confident in their appearance. A staff member told us they saw people leave these sessions 'smiling with their heads held high'.

The registered manager told us they had systems in place to support people whose first language was not English. They told how they could produce written information in other languages and had access to translation services if needed. Following a report from another agency they had also improved the way signage was presented within the in-patient unit and day service centre to aid people's orientation. Staff said that adding pictures to go with written signs helped people who may not be able to read English, who may have reduced vision or those who may experience confusion or memory loss.

People were supported to experience a pain-free, dignified end to their life. They were supported to develop 'advanced care plans' which enabled them to set out their wishes so that those who are important to them know what they want when they may no longer be able to express such. People had access to spiritual support across their belief systems. A non-denominational chaplaincy service was maintained to provide support within the in-patient unit, day service provision and hospice at home. A private area away from the main in-patient ward was maintained to enable the recently bereaved to spend time with their deceased loved one. Staff told us this meant that any cultural, spiritual or religious preferences the person had in life could be observed in private.

People told us their privacy and dignity was respected at all times. One person staying in the in-patient unit said, "They always make sure the curtains are closed and I have a towel over me when being washed, even if I feel too ill to care." Another person who used hospice at home services said, "Dignity, yes, definitely. They make sure your modesty is covered." In the in-patient unit we observed staff routinely closed screens before caring for a person; they spoke with people in lowered voice tones to avoid others hearing their discussions and discussions between staff members were held in private areas. There were comfortably furnished rooms available within the in-patient unit where people who used the service and their visitors could go for privacy if they wished.

Effective communication systems were embedded in the culture of the service which meant that people were able to express their views about their care and have control over how their care was delivered. People told us they had confidence in the staff who cared for them and felt listened to because of this. A person who used hospice at home services told us, "People listen; I do believe that what they say they'll do, they'll do." In the in-patient unit we observed medical and nursing staff discussed care and treatment options with people and gave them the information they needed to make decisions and be fully involved in the planning and delivery of their care. We also saw that staff communicated people's changing needs and wishes in a timely and respectful manner to ensure that people received their care in a consistent way. An example of this was where a person requested care be delayed until they were better able to cope with it. This was relayed to other staff quickly so that the person's wishes were adhered to.

There was a range of clear and comprehensive information available to people who used the service and visitors about the services provided. Information included who the medical and nursing staff team comprised of, how people could be supported with group or individual therapies and also the outcomes of surveys and audits. Information was available about such topics as life limiting conditions, side effects of medicines, advanced care planning and financial welfare and benefits. The service had also produced a directory showing palliative care and end of life services throughout Lincolnshire so people knew what was available to them and where it was situated. The directory contained clear information about what types of advocacy support was available across the county and how people could access them. These services are independent of the hospice and can support people to make and communicate their wishes and opinions.

Good ●

Is the service responsive?

Our findings

People we spoke with praised the responsiveness of the services and the staff who supported them. These views were echoed in surveys we carried out with people prior to the inspection and within the information we received from other health and social care services. We observed and were told that there was a culture of seeking out and pre-empting what people needed as well as responding quickly to requests for support. A person staying within the in-patient unit told us, "I know what's coming next, what to expect, they talk to me about all of this." Another person told us, "They're very thoughtful with good ideas. They always help out."

The provider had also received comments about the responsiveness and person-centred approach of staff through their programme of survey questionnaires. People made comments such as, "They seem to go that little bit further and go out of their way to help you" and "Overall experience under the circumstances was excellent. Staff really friendly and helpful. Couldn't do enough to help and advise."

People told us they felt able to contact the service at any time, including outside of normal working hours. A person said, "When at home if there was a problem we could phone any time, even in the middle of the night." One person told us how hospice staff had arranged additional support from other palliative care agencies at 3am one morning when their loved ones needs had changed. Another person told us how staff had arranged medical support in the early hours of the morning and made sure they were available to speak with doctors in support of the person and their family. People who used the service and those who were important to them consistently told us how medical and nursing staff spent as much time as people needed discussing care and treatment to ensure they had understood all of the information and had their questions answered. A person told us, "It's very relaxed and easy going, whoever you speak to they just say, 'speak to me if you need anything'."

The hospice's palliative care co-ordination centre developed, and arranged funding for, bespoke care packages drawing on a range of health and social care services across the county. This meant that people could have confidence that they would have continuity of care. A relative of a person staying within the in-patient unit told us, "They won't let [my loved one] go home until all the package is set up and everything is in place. They're sorting out the oxygen today. Not like a discharge from hospital." Another relative said, "Hospice at home was arranged by the discharge nurse after [my loved one] decided to end chemo. They were there on the day she came out and have been every day since." The provider organisation had also acknowledged the complex, holistic needs of the people who used their services. With this in mind they had developed services such as a 'welfare team' of staff who could advise on financial and benefits matters. A system was also in place whereby the hospice services would be informed when a person known to them was admitted to a general hospital setting. This meant that hospice staff such as counsellors could provide support for the person and help ward staff to manage people's needs and anxieties more effectively.

Care plans demonstrated that they were developed and reviewed in close consultation with people who used the service and those who were important to them. They set out the person's decisions about what they want to happen as they reached the end of their lives, including their instructions about resuscitation. We saw that some people who were new to hospice services had not yet developed an advanced care plan.

Staff told us they gave people time to feel settled and develop trust in the staff team before discussing such sensitive and often very private subjects with them.

Care plans included clear guidance for staff about how people wanted needs such as catheter care and wound care to be managed. They highlighted assessed risks and how they should be managed. Where referrals had been made to other health and social care professionals, there were clear records about what support they were providing for people to ensure there was no duplication of support and for consistency within the care package. Symptom management was a priority for most people who used the service, including effective pain control. People told us this was often a difficult process due to complex pain issues but medical and nursing staff persevered to get it right. Care records showed that pain was well managed. Pain assessments were carried out and the outcome of treatment monitored so that doses of medicines could be changed if needed. A person said, "The doctor is [adjusting] my medication to get it right, he wondered about something new this morning. If I do need a booster I can get something if I need it." Another person told us, "My pain killers are being adjusted…. we're getting there eventually, they're just upped to see if I can tolerate it."

We saw care plans were monitored and reviewed regularly. Staff told us the timing of care plan monitoring and reviews was dependent upon individual needs. We saw, for example, some people had their plans reviewed on a daily basis whilst some people had theirs reviewed weekly. Staff demonstrated a creative approach to the information derived from care plan monitoring and review in order to develop more effective care pathways for people. For example, we saw that they had developed new assessment guidelines to support people who started to use the service and were in need of wound care.

All of the staff we spoke with demonstrated knowledge and an understanding of the likes, dislikes and personal preferences of the people they cared for. Staff in the in-patient unit knew, for example, how people liked their pillows arranged, where they liked to eat and what sort of activities they liked to engage in.

People who used the hospice services were supported to develop and engage in meaningful social activities and interests of their choice. The hospice day therapy centre co-ordinated an activity programme and many of the activities were supported by occupational and physiotherapy services and volunteers. Activities relating to well-being were offered such as Tai Chi, Reiki, reflexology, therapy dogs and mindfulness sessions. Other activities such as art therapy, knit and natter groups, flower arranging and craft groups were also provided. Staff told us about their 'Blooming Marvellous' group in which people who could no longer safely garden at home were supported to tend and grow flowers and vegetables at the day centre site.

The provider had a policy in place to ensure any concerns or complaints raised with the service were addressed quickly and appropriately with a focus on resolving the issues. None of the people we spoke with had found a cause to raise issues or make a complaint. A person told us, "Complaints? Well, I guess if I needed to I'd find out what to do, but I've never even thought of complaining." Another person said, "They encourage us to seek help, encourage us to air issues." The registered manager told us they had responded to one complaint raised within the previous 12 months. Records showed the complaint had been resolved in line with the provider's policy and service adjustments were made as a result of the learning they gained through the process. Concerns and complaints were logged in a computerised system which allowed the register manager to analyse any trends that may arise and take swift action to reduce risks.

Good ●

Is the service well-led?

Our findings

All of the people we spoke with had positive things to say about the way the service was run. These views were echoed in surveys we carried out with people prior to the inspection and within the information we received from other health and social care services. The provider also carried out regular surveys with people who used their services. One person told us, "We've had a feedback form that [my loved one] filled in, all was excellent." The reports of survey outcomes showed the same positive responses. One person staying within the in-patient unit described how the efficient running of the unit meant they had a restful time and had full confidence in the staff who provided their care. Other comments were made to us and in surveys such as, "All of the team have been before we got [care package] in place. They came before the carers to see how things were and afterwards to see how it had gone", "It's an absolutely wonderful system, I didn't know it existed for heart failure", "In my opinion nothing [can be done better] as they do everything they can. Their support is priceless." Where people had suggested ways in which their experience of the service could improve the provider demonstrated through action plans that they had listened and taken actions to improve services, for example, in the way hospice at home visits were planned.

There was a clear organisational management structure in place which included the registered manager, and the Chief Executive Office for the provider organisation. Staff were aware of the organisational management structure and each of the roles. They told us those managers were accessible and 'open' in their management style and they felt able to speak with them when they needed to. We saw the registered manager had regular 'back to the floor' days arranged whereby they worked with in different parts of the service to enhance their visibility and monitor the quality of the services provided.

Each part of the service, such as hospice at home or day therapy had a clear structure for day to day management with service co-ordinators or unit managers leading teams. The management structures were supported by other roles such as senior nurses, clinical nurse specialists and a clinical governance nurse. Staff told us that the management structures supported their day to day work and personal development. They said they felt very well supported by all of the managers and again found them to be open and approachable. They told us they were kept up to date with organisational issues and improvements. The registered manager described how they had evaluated the effectiveness of team meetings within the in-patient unit as a vehicle for information sharing and found that improvements were needed. As a result they had developed a new initiative termed 'team huddles' which took place every week and proved to be more effective in ensuring all staff were kept well informed.

Staff told us there was good and supportive team work throughout each of the service areas. One person told us, "This is not like a job, it's like a rewarding hobby because it's so good working here." Other staff members shared comments with us such as, "It's a privilege to work here" and "Really enjoy working here." A member of staff told us how the provider's link nurse systems helped them to feel confident that they could call upon expert advice whenever there was a need and that they were up to date with current good practice and research initiatives.

Staff told us they were encouraged to share their ideas and views for service improvements through vehicles such as supervision sessions and surveys. They said they felt that their views and opinions were respected and they felt listened to. They also told us they were aware of the provider organisation's whistleblowing policy which supported them to report poor practice or any other concerns about the running of the service. They said they would not hesitate to use it if they needed to.

Staff, without exception, told us they would recommend St Barnabas Hospice as good employer. They said they were provided with the resources to do their jobs. One member of staff told us how they were encouraged to work within different areas of the service so that they were familiar with the options available to people in their care. They also told us they felt although the focus for the organisation was high quality care for people, staff welfare was important to them. The registered manager discussed with us the importance of ensuring staff were well supported and the organisations acknowledgement that working within palliative and end of life services can be emotional and stressful for staff. There were systems in place to provide this support such as counselling, bereavement support and debrief sessions. Staff also told us about the effectiveness of the provider's on-call system which operated outside normal working hours. They told us this helped them to feel confident that support and advice was available whenever they needed it.

The provider organisation maintained strong links with partner agencies and the local community. The registered manager and staff told us nursing and medical staff provided expertise to local general hospitals and NHS Trusts. An example of this was a specific nurse role within the local general hospital to support and educate their staff about providing good quality palliative and end of life care. We were made aware of other examples such as medical staff leading on the development of a county wide, integrated policy for resuscitation arrangements to ensure a more consistent approach was in place. The hospice palliative care co-ordination centre was developed in partnership with funding agencies such as the local authority and clinical commissioning groups to ensure a co-ordinated and responsive approach across Lincolnshire for people with a life limiting illness and palliative diagnosis. The registered manager told us how they were hosting events for the local community in May 2016 related to the national initiative 'Dying Matters' in order to raise the profile of palliative and end of life care issues and educating the public.

We saw that the services provided for people were based on current good practice and research within the field of palliative and end of life care. For example, the hospice team was leading on a county wide implementation of the five priorities for care of the dying person in line with national guidance set out by the Leadership Alliance for the Care of Dying People (LACDP). The provider organisation ensured staff had access to computer based forums to gather up to date practice information and were supported to attend national conferences. The registered manager also regularly attended a regional group meeting of hospice service providers in order to maintain knowledge and an overview of how people were supported across the region.

The representative of the provider organisation and the registered manager demonstrated a clear understanding of their roles and responsibilities within the organisation and within the terms of their registration with the Care Quality Commission. For example, the registered manager informed us in a timely manner of any occurrences with the service such as people passing away. They maintained systems to identify, assess and manage risks for people who used their services and they understood the need for continuous service improvements. They told us, for example, of their plans to improve the service provision for people who experienced learning disabilities or mental health needs. They had also begun work to improve services for people who experienced dementia related needs. They were able to do this because they maintained an oversight of national and local community population needs and closely monitored the needs of people using their services.

There were well-managed and effective systems in place to monitor and improve the quality of the services people received. People who used services were involved in the audit of care environments and volunteers were involved in gathering people's views about the quality of care they received. A programme of service audits was set out every year which covered topics such as infection control arrangements, accidents and incidents, medicines arrangements and the effectiveness of clinical supervision. The provider organisation held a regular clinical governance meeting where the outcomes of audits were reviewed. This meant they were able to monitor what improvements were needed and how they were implemented.

Records demonstrated that audits were carried out in line with the programme, the results were analysed and action plans produced for any shortfalls that were highlighted. We saw examples of this process within audits of general medicines and medicines which require special storage and recording arrangements. Another example was shown within infection control audits whereby issues had been highlighted that led to the provider's policy and guidance being updated. The registered manager and staff delivered the general audit programme, however senior managers from the provider organisation also visited service areas regularly for audit and monitoring purposes. The PIR showed us that eight of these visits had taken place and been reported upon within the previous 12 months. This enabled the provider organisation to have a comprehensive overview of the quality of the services provided.