

St. Mary's Hospice Limited

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Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place on 28 July 2016 and was unannounced. Further phone contact was made with people using the hospices community services, whose views we were unable to capture on the day of the inspection, on 2 August 2016.

St Mary's Hospice provides palliative and end of life care, advice and clinical support for adults with life limiting illness and their families. The hospice provides care to people from a multidisciplinary team of nurses, doctors, counsellors and other professionals including therapists. The hospice has a 16 bed in-patient unit that accepts admissions for end of life and palliative care, symptom control and respite care. At the time of our inspection there were 14 people receiving care and treatment in the inpatient unit. The day hospice service offered a range of care and treatment to people diagnosed with life limiting conditions. This included specialist clinical advice, educational courses and complimentary therapy sessions. The hospice community services supported people in their own homes through a hospice at home team and/or a clinical nurse specialist team. The hospice also provided patient transport services.

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

Staff were trained and knew how to recognise the signs of abuse and how to raise an alert if they had any concerns. The provider ensured that there were sufficient numbers of staff on duty at all times to meet people's needs effectively. Staffing levels were reviewed and adjusted according to people's changing needs. There were flexible working arrangements within the hospice to provide additional staff as was required. The recruitment process operated by the provider was effective in ensuring staff employed were suitable and safe to work with people who were cared for by the service. Assessments of potential risks were clear and included the measures to take to reduce the risks identified to make sure people were protected from harm. Accidents and incidents were effectively reported, analysed and shared to ensure that action was taken to minimise the risks of recurrence. Medicines were prescribed, recorded, administered and disposed of in safe and appropriate ways.

People were well supported by staff that were well trained. The provider supplied a range of learning opportunities for staff to enhance their knowledge and levels of skills. New staff were well equipped to undertake their role through effective induction. Staff received an annual appraisal and an appropriate level of supervision, with open access to the support they needed from peers and management. When complex situations occurred reflective learning sessions or debriefs were organised. People's consent was sought by staff before any support was provided. Records in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were completed to a high standard, with the person's knowledge, participation and agreement where possible. People were well supported to access the nutrition and hydration they needed and of their choice. The variety of health care professionals employed enabled people's health and

wellbeing to be responded to in a timely manner when their health needs changed.

People were supported by staff that were kind and caring. The hospice had a relaxed and homely feel with a sociable atmosphere but still had plenty of space for people to access quiet reflective time. People and their families had access to services which provided support and counselling with regards to their emotional, spiritual and religious needs. The hospice had a chaplaincy team and provided a rest room for people of all faiths, where a range of bibles were also accessible. People were communicated with effectively and provided with the information they needed. Staff involved people in all aspects of their care provision and ensured that family were also kept well informed. Staff supported people to access personal care respectfully and with the utmost discretion. Provision of education and equipment were just some of the ways that staff supported people to maintain their independence.

People received care and support that was tailored to their individual needs and improved their quality of life. People were involved in making decisions about their current and future care and planning their end of life care. A range of complementary therapies were available to help and support people's relaxation and general wellbeing. This had a strong emphasis on personalised care and that had a positive effect on people. Initial assessments had been undertaken to identify people's support needs and which team within the hospice was best placed to provide the support people needed at that time. The provider supported people to be more independent in planning their care and how and where they wanted it to be delivered. They were keen to reduce the stigma and break down the taboos about hospice care. We saw that communication was effective both in inpatient and community services so that access to the most appropriate care was made available when people's needs changed. People told us they felt confident and well informed about how to raise a complaint or any concerns.

Stakeholders were complimentary about the leadership and approachable nature of management. Staff displayed excellent team working and promoted clear communication throughout the service with an inclusive approach to care. Staff enjoyed their work and felt involved and valued by the provider. The provider promoted and encouraged an open and transparent but challenging culture. The provider actively sought to engage and access people to utilise the service through community groups and faith centres. The provider encouraged the involvement in the development of the service from staff at all levels. There was a comprehensive program of in-house regular audits of aspects of the service such as medicines, infection control, the environment, incidents and complaints. The hospice worked in partnership with other organisations that assisted them in the monitoring and development of the hospice service. The provider sought external reviews of its management performance and structure. The service was proactive in ensuring that stakeholders' feedback was regularly sought and used to develop the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Safeguarding procedures were well understood by staff and ensured people were kept safe.

Risk assessments reflected how care should be provided to each person to minimise any risks to them.

Medicines were prescribed, recorded, administered and disposed of in safe and appropriate ways.

Is the service effective?

Good ●

The service was effective.

People were supported and received the care that they needed from a staff team who were skilled and well trained.

Staff understood how to ensure people's rights and best interests were considered; they took the appropriate action when people did not have mental capacity to make decisions about their care and treatment.

People were supported to access the nutrition they needed and of their choice and staff had time to assist those people who needed help or encouragement to eat and drink.

Is the service caring?

Good ●

The service was caring.

People were supported by staff that were kind and caring.

People and their families had access to services which provided support and counselling with regards to their emotional, spiritual and religious needs.

People were communicated with effectively and provided with the information they needed.

Is the service responsive?

Good ●

The service was responsive.

People received care and support that was tailored to their individual needs and improved their quality of life.

A range of complementary therapies were available to help and support people's relaxation and general wellbeing.

People told us they felt confident and well informed about how to raise a complaint or any concerns.

Is the service well-led?

The service was well-led.

Staff displayed excellent team working and promoted clear communication throughout the service with an inclusive approach to care.

The provider encouraged the involvement in the development of the service from staff at all levels.

The provider operated a comprehensive and effective program of in-house audits and checks.

Good ●

St Mary's Hospice Limited

Detailed findings

Background to this inspection

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

This inspection took place on 28 July 2016 and was unannounced. Further phone contact was made with people using the hospices community services on 2 August 2016.

The inspection was carried out by one inspector, a member of the CQC medicines team, a specialist advisor and an expert by experience. The specialist advisor had the experience working as a nurse within the field of palliative care. The expert by experience is a person who has personal experience of caring for someone who has used this type of care service.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The registered manager had submitted the information as we requested.

We also reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We contacted the commissioners of local Clinical Commissioning Groups (CCGs) who had knowledge of the service to ask for their views on the service. CCGs are responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We spoke with ten people who used the services provided by the hospice, four relatives, four volunteers, one consultant and a doctor. We also spoke with a catering manager, the facilities manager, thirteen staff members, a student nurse, a social worker, two lead nurses, a pharmacy technician from the local hospital, the head of hospice at home, the registered manager, the head of human resources, the clinical education

lead and the chief executive officer.

We reviewed five people's care records, to see how their care and support was planned and delivered. We spent time observing staff interacting with people and their relatives. We looked at other records related to people's care and how the service operated, including four medicine records, three staff recruitment records, a range of meeting minutes, quality assurance documents, clinical and environmental audits and records of complaints.

Is the service safe?

Our findings

People using the service told us their support was provided in a way that made them feel safe. They said, "I feel very safe here I can press my call button and within five minutes a nurse will come to me", "They [staff] are brilliant a lovely team of people, they make me feel safe" and "I like having staff I am familiar with, that make me feel safe". Relatives we spoke with were satisfied that people were kept safe. A commissioner we contacted stated that they had confidence that the service was safe. They stated that the provider consistently had low levels of incidents and showed good scoring from internal audits relating to safety, for example medicines management and infection control.

Staff had received training and were aware of their responsibilities to protect people from avoidable harm and abuse. Staff told us, "We have training about how to protect people being taken advantage of; there is a safeguarding lead here who I have talked concerns through with before. It's about being observant, vigilant, sharing information and reporting your concerns", "The safeguarding policy is online and the forms to complete for referrals are really accessible" and "If I had concerns I would contact the local authority and speak to the duty social worker if I needed further advice or guidance". The hospice had a safeguarding lead that we spoke with; they were knowledgeable about the processes to follow and confident that staff knew who to report concerns to in their absence. They described their role saying, "If staff identify an issue or concern it is discussed. I support and empower staff to make referrals themselves, and of course I am available to help and I can go through the process with them". Records confirmed that the provider had effective safeguarding procedures in place and that staff had received appropriate training. Feedback and information regarding safeguarding outcomes were shared with staff at regular meetings and/or supervision. A staff member said, "We get feedback in meetings about safeguarding issues". This meant that people were kept safe by staff who could recognise signs of potential abuse and knew the processes to follow when they had concerns.

The provider operated clear processes and had a policy in relation to the reporting and learning from incidents. Staff we spoke with were clear about the processes for responding to and reporting incidents. They told us they were kept informed in meetings about the outcomes in relation to incidents they were involved in and those that occurred within the wider hospice. Statistics were collated in relation to all incidents and accidents that occurred and these were shared and discussed at the relevant governance committees and board meetings. Updates were given and actions taken or to be completed were also reviewed in these meetings. This demonstrated that the provider was keen to learn from incidents and maximise the safety of people using the service.

We met with the Head of Facilities who was able to demonstrate to us how environmental risks were managed. We reviewed the maintenance records and saw that for example, servicing of equipment, fire systems and boilers were effectively managed. Audits were undertaken to make sure all equipment was serviced and the environment was checked for safety as required. Feedback about any actions outstanding or completed in relation to health and safety was reported back to regular governance committees. Staff understood how they should respond to a range of different emergencies. They took part in regular fire drills which helped them to remember the procedures and there was appropriate signage about exits and fire

equipment throughout the hospice. The provider's insurers also conducted six monthly checks to assure the service was maintained safely.

Risks to people were considered and support was provided to them in line with their assessed needs. Staff told us, "We revisit the risk assessment at every visit, for example changes to people's level of physical ability tends to be the most notable change as people's condition deteriorates, so it's always good to check each time", "Right from the initial referral we are gathering information about any risks, for example anything that may be a risk in the environment" and "We assess people's individual moving and handling needs initially and then revisit this each time we see them, so that should needs change then we can see if they need support by more than one member of staff and plan for this accordingly". Staff we spoke with were able to describe people's individual risks and this reflected the information we saw in the person's care record. We observed people being supported appropriately by staff to use equipment that minimised their risk of falls, for example, walking frames. Records were reviewed regularly and/or updated when people's level of risk changed.

People using the inpatient wards told us there were ample amounts of staff to support them; those people using the community we spoke with told us of how they received consistency in the staff that visited them and that they had 24 hour availability to the advice and support they required. People said, "They [staff] are very quick in attending to me, I am very satisfied", "I can get the care and support I need day and night. I can also contact the on call if I need support" and "They come when I need them, they are my life line". Relatives said, "It's a small group of staff who come to us and we know them all" and "They never rushed anything, they [staff] spent the time they needed to". We observed that there were enough staff on duty to ensure people's needs were met in a timely manner, with call bells answered without delay. Staff were observed to anticipate people's needs and check on their well-being frequently.

The provider used a recognised dependency assessment tool to assess people's level of dependency in order to inform staffing levels. In addition discussions also took place in daily meetings to discuss each person's phase of illness and level of need, in order to ensure that enough staff were available to meet their changing needs. An internal bank of staff was used to cover any gaps in the staff rotas and we saw that there was flexible use of staff between inpatient and community services to cover changing needs and case load numbers. A staff member said, "Obviously the amount of people we care for can fluctuate day to day; if we get short there is internal movement of staff, we can call on the wards to help us and vice versa, staff are redeployed where there is a need if demand increases". The head of hospice at home said, "It is a challenge to manage a fluctuating caseload in terms of staffing but flexible working with the wards works really well". This meant that there were sufficient numbers of suitable staff to meet people's needs.

The provider had effective recruitment processes in place to ensure staff appointed were suitable and safe to work with people. The procedures included requesting references, validating professional registration, criminal records checks and checks on the prospective staff member's identity. Application forms included a full employment history. An explanation for any gaps in employment history was noted in the records.

People told us their medicines were always on time, anticipated and if required topped up without delay. They said, "I know what my medicines are for and I am very happy and get them on time" and "My pain is worse at night but whenever it is bad, they [staff] give me extra liquid I am prescribed". We checked the medicines prescribed on four prescription charts. We noted that there was clear recording of the prescribed medicines, which also included additional instructions for safe administration. One person was using a medicinal skin patch. The records showed where the patches were being applied to the body. However, the patches were not being applied and removed in line with the manufacturer's guidance, which could result in unnecessary side effects. We fed this back to the staff and were assured this would be dealt with and

rectified.

Medicines were checked when a person was admitted to the service by a nurse or a doctor to make sure they were accurate, current and suitable to use. Although there was a process to check that medicines were within their expiry date and suitable for use, we found three medicines in the fridge that had gone past the expiry date. These medicines were not being used but there was an increased risk that they could be accidentally given. We raised this and were told they would be disposed of as soon as possible. A clear system for managing the ordering and supply of medicines including controlled drugs was in place. The service used a local hospital trust for the supply of all medicines including out of hours. The service used a pharmacist and a pharmacy technician from the trust to provide clinical support, advice and medicines management services.

Medicines that people brought in to the service were used in addition to medicines prescribed by the hospice doctors. Arrangements were in place to enable people to look after and self-administer their own medicines following a risk assessment. These medicines were kept in people's rooms in a locked cabinet. Medicines kept by the hospice were stored securely in locked cupboards in a locked treatment room, with only authorised staff having access to this room. Staff had quick access to emergency medicines, for example those needed in the event of a severe allergic reaction. The hospice checked the competency of staff involved in medicine administration; however this was only completed when staff were involved in something that went wrong. This meant that some staff may not have had a competency check for some time. Medicine incidents were reported and arrangements were in place to ensure they were investigated and an action plan was completed. This meant that lessons were learnt and the risk of the incidents recurring was reduced.

Is the service effective?

Our findings

People spoke positively about the support they received from staff and were confident that they staff were well trained. One person said, "They [staff] are able to answer anything we ask". Relatives said, "It's like they were made for it [the job], they were so skilled and dedicated to what they do" and "Staff are very good and qualified. We have no problems, we are 100% happy". Staff we spoke with described a culture of learning and said the provider actively encouraged and supported them to develop their knowledge and skills. They told us, "The medical team do great teaching and we feel very involved", "Training is always granted" and "We are able to access training and are actively encouraged to do so". We saw that learning was also part of staff meetings with education sessions incorporated into the agenda. We spoke with the clinical education lead who was responsible for ensuring training was available for staff that enhanced their skills and was specific to the people they supported. They told us, "Training that staff identify that enhances or develops their role is mostly accepted and funded". A regular journal club was organised and was open to all staff. This enabled staff to discuss articles about research in the field of palliative care and how this could be integrated into the hospice. Records we reviewed showed that staff were up to date with their essential training and from our discussion with staff, it was clear that on-going learning opportunities were made available for them by the provider.

New staff were well equipped through effective induction to undertake their role. Staff told us their induction was comprehensive and tailored to ensure they had a good understanding of their role within the hospice. They said, "My induction was really good and comprehensive, I spent some time with the district nurses who hospice at home staff work closely with, to get to know how they work", "My induction was role specific and I was supernumerary for three weeks and had regular one to one meetings with my mentor as part of this; I was very well supported" and "Excellent induction, you get to meet everyone and see how they work. It includes a corporate induction so you get to know the hospice structure". We saw and were told by staff that they were well supported throughout their induction, including formal discussions about their progress to identify any areas they needed further exposure to as part of their learning. During induction all staff undertook mandatory training and read the relevant policies and procedures operated by the provider.

Staff received an annual appraisal and an appropriate level of supervision with open access to the support they needed from peers and management. They told us, "Appraisals are done every year and we also have access to supervision and one to one support", "Supervision includes reviewing our objectives, deciding how we are going to achieve them and discussing our well-being", "I have planned supervision but can get support whenever I need it, we support each other well" and "Supervision helps us to recognise training we need to do and any development needs are discussed". The Clinical Nurse Specialists from the community service received regular reflective practice sessions and group supervision from psychologists employed by Birmingham and Solihull Mental Health Trust. Staff told us that when complex situations occurred reflective learning sessions or debriefs were organised for them to attend. These included access to any psychological support they may need. A staff member told us, "A debrief was organised following the death of a person recently [they described the person's illness and death], a lot of staff were traumatised by this but I think being able to talk about it together helps". This demonstrated that the provider ensured staff had the support, knowledge and skills necessary to carry out

their roles and responsibilities effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS].

We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. People we spoke with told us their consent was sought by staff before any support was provided. A person said, "The staff always ask my consent and I am involved in decisions about my treatment" and a relative said, "They [staff] treat him so well, they always ask him everything first to make sure he is happy for them to help him". We saw that mental capacity assessments had been undertaken where necessary, appropriately recorded and were decision specific. Training for staff about DoLS and the MCA was mandatory for all clinical staff, with updates every three years including bespoke sessions for housekeeping staff. Staff revisited and reviewed people's level of capacity with frequency, as medicines and their condition could affect their reasoning, level of confusion and ability to make informed decisions. One person who was subject to a DoLS authorisation was receiving one to one nursing care due to their high level of falls risk; we saw that their family had been fully involved in this decision.

The provider's computer based care records included a prompt for staff if they typed the words 'capacity' or 'best interests', which asked if they wanted to complete a mental capacity assessment. A staff member commented about the prompt saying, "This is for everyone to complete and not exclusive to the medical staff; there is a template which is easy to follow and takes the mystery out of it." Another staff member told us about the timing of any application for a DoLS referral to the supervisory body [in most cases the local authority], they said, "If we are to deprive someone of their liberty and if someone is safer to be here and needs care here, but may not recognise this need due to their level of mental capacity". At the time of our inspection six people were subject to a DoLS authorisation. This meant that care was provided to people with the appropriate consent having been sought directly from the person and/or in line with legislation and guidance.

We saw that the necessary documentation in relation to people's decisions about resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation [DNACPR] was in place. A relative said, "I have never had to worry about anything, like future decisions about resuscitation, it has been discussed with [person's name] and sorted". Records we viewed were completed to a high standard and had been completed with the persons knowledge, participation and agreement where possible, or alternatively their representative. A staff member said, "We make sure that sensitive subjects such as resuscitation decisions are done in advance and with sensitivity".

People were well supported to access the nutrition and hydration they needed and of their choice. They told us, "The food is so good, it's freshly cooked and we have lots of choice including a cooked breakfast and lunch with delicious homemade soups if you want them" and "My favourite was the chicken pie with lovely pastry yesterday. They [kitchen staff] make a good crumble pudding and also light evening meals; you have a good choice". We observed that lunchtime was a relaxed affair and pleasant interactions were seen between staff and people. Menus were made available to people to enable them to make choices and offered a variety of options including vegetarian and gluten free meals. Lunchtime was unhurried and

staff were seen offering each person a choice. One person requested a meal but didn't want it when it arrived, so staff suggested they put the meal to one side for them for when they may want it. We saw that people's daily food and fluid intake was recorded directly onto the computer system alongside the appropriate care plan. The catering manager personally met with every person about what they liked to eat when they arrived at the hospice. They said, "We use 'red trays' to help identify those people that need assistance to eat and we make sure we follow up that they [the person] received the support they needed". They went on to say that they use meals that have been most in demand to design the menus but were working on consulting more with people in the future in relation to menu planning. Information about specific dietary requirements including any cultural needs were clearly identified and recorded on the catering food notice board for all the kitchen staff to refer to when preparing food and drinks. Events in the various religious calendars were celebrated with the appropriate food, for example Diwali (Indian festival). Staff demonstrated they knew those people who needed additional support and monitoring to ensure their nutritional needs were met. We observed that staff had time to help and encourage people to eat and drink effectively.

We saw evidence of people having access to the healthcare and on-going support they needed. One person told us, "My pain [control] is very good, better than when I came in. The doctor comes to see me every day and I get round the clock care". A staff member said, "If people's needs change we liaise with all the involved professionals including district nurses to ensure everyone is aware and the treatment people need is made available to them". The hospice employed a range of healthcare professionals including a team of doctors who worked across all services provided within the hospice; including people in the in-patient unit, the hospice day service, at home and in out-patient clinics. The variety of health care professionals employed enabled people's health and wellbeing to be responded to in a timely manner when their health needs changed. Records we reviewed showed that people were seen by a variety of staff to meet their holistic needs, for example the chaplain, a social worker, physiotherapists and occupational therapists who were all employed by the provider. External referrals to other healthcare professionals were made as necessary. This meant that people were supported appropriately to maintain their health through access to a range of healthcare support from a range of professionals available to them.

Is the service caring?

Our findings

People were complimentary about the approach and caring nature of staff. They said, "I am always impressed with all the staff the way they care for me. They use your Christian name and treat you like family" and "Everybody from the person who cleans the floor to the person that does my hair is kind, caring and compassionate. I am so privileged to be here, I am so lucky". Relatives we spoke with also had high regard for the care shown by staff. Their comments included, "This hospice is where I want to come when my time comes; the care here has been second to none, they [staff] are absolutely excellent" and "They [staff] stayed longer than they should, particularly when [relative] was in discomfort. I don't know how they choose them, they were so giving of themselves". A volunteer we spoke with described the hospice as, "A caring place, where people can relax emotionally and physically". A commissioner we contacted stated they had 'every confidence' that the staff were caring.

The hospice had a relaxed and homely feel and we observed people chatting with each other and this gave it a sociable atmosphere, with plenty of space and respect given to people wanting to have quiet reflective time. People told us, "I can't do much at the moment but I love the quietness of this place and garden to look at", "They [staff] listen to you and try to help us where they can. We have had lots of problems with our family and they have been brilliant, they have time for you" and "I have been able to enjoy the therapies here, including the Jacuzzi, it's a very calming environment and they can't do enough to help you". Relatives told us, "They [staff] have given my [relative] lots of tender loving care and [relative] has improved here, they couldn't be anywhere better" and "It's a perfect pattern of love and comfort, it's all enveloping. It's all about the person wherever possible, they are put first". During our time at the hospice we observed many interactions between staff and people that were warm and compassionate. For example, we overheard staff talking to one person, kneeling down to be on their level and being engaging and empathic in their responses. It was clear that the staff member was listening carefully to the person.

People and their families had access to services which provided support and counselling with regards to their emotional, spiritual and religious needs, which included bereavement support before, during and after death. A person told us, "I have Christian readings every week, [staff members name] speaks to me, she is very good". A relative said, "I was offered bereavement counselling and I have chosen to have some". The hospice had a chaplaincy team and provided a reflective room for people of all faiths, where a range of bibles were also accessible. Translation services were readily available if required and some of the staff were also able to speak some languages other than English. Staff told us, "We are mindful of people's beliefs and cultures, we had one person who wanted only male staff to support them and we managed to fulfil this for them" and "We do meet people's cultural and spiritual needs, they are identified and assessed, it's about what's important to the person". This meant that people's needs in respect of their religious and spiritual needs were assessed, understood by staff and met.

People we spoke with told us that they were fully involved in all decisions about their care. They told us that they were more than happy with how the staff communicated with them and were provided with the information they needed. People said, "They [staff] speak and explain things in plain English", "They [staff] chatted and made us feel comfortable straight away, explaining everything, they were really good", "The

staff talk to us on our level "and "I have a voice here at the hospice, the way they [staff] communicate with me is good". Relatives also felt involved and informed telling us, "We got all the information we needed and if they [staff] didn't know they would find out for us", "[Staff members name] has been in to all [relatives] children to support and prepare them, they got the information they needed" and "We have all the contact numbers we need and know what to do if we have a problem". We observed staff involving people in all aspects of their care provision where possible and ensured that family were also kept well informed. For example, we observed a staff member making a telephone call to a relative, as their family member had been moved to a different room and wanted to advise them of this before they visited. This showed consideration of everyone's emotional well-being as staff did not want to cause any distress to the relative if they arrived for visiting to find an empty bed. Care plans we reviewed were individualised and clearly demonstrated that people and their families had been involved in their development.

People told us and we observed that staff respected their privacy and dignity. One person said, "The care is dignified, very much so, they [staff] helped me with my water works discreetly and kept my dignity; it was difficult for me and they understood". Relatives told us, "I couldn't have managed without them they were fantastic, [person's name] died with total dignity because of them [staff]", "They [staff] helped sort out equipment, like a bath chair and this helped [relative] with their pride", "[Person's name] was very private, so you could always hear the staff chatting to her when they washed her, reassuring her all the time even though she couldn't communicate with them at that stage. Honestly they [staff] couldn't have been any better, it was what she would have wanted" and "When they help [relative] with care they shut the door, they [staff] allow him privacy when they come in and out. [Person's name] likes certain items around them; they make sure it's all put in place and nearby". Staff we spoke with were clear about how to maintain people's dignity and the importance of showing them respect. They said, "I make sure I talk to people, make sure the room is not overlooked, pull the curtains, ask them throughout if they are okay, cover them using a small and large towel in-between personal care, to keep them warm and preserve their dignity" and "We re-establish dignity for many people; we facilitate what's needed, to get things in order for them, including symptom control and supporting their family". We observed staff supporting people to access personal care or to use the toilet. Help was always offered respectfully and with the utmost discretion.

People were actively encouraged to remain as independent as possible through staff provision of education about their condition to supporting them to access the equipment they needed. People using the day hospice service spoke of how they were helped to make their lives more independent by educational tips, exercise training and therapies to enable them to become more mobile. They told us they enjoyed the educational talks and tips to stay healthy given by the staff. We observed a physiotherapist demonstrating to people in the day hospice exercises to help keep them energised. Staff were mindful of the importance of people being in control and maintaining the skills they had. They said, "I always promote people to be independent when they can, but you have to talk to people. I see how well they are when I visit and change approach accordingly. People's preferences are recorded so we can always refer to them too" and "We try to empower and encourage people to live well. We educate them about their illness and they can learn how to manage their anxiety". This meant that the staff promoted people's independence through supporting them in a way that they wanted or to their level of ability.

Is the service responsive?

Our findings

People told us that the care and service provided by the hospice staff was tailored to their individual needs and had improved their quality of life. They said, "I have been here over two weeks and I was so ill when I came in, I wanted to die. Now I want to live forever", "They [staff] sorted out my tablets, their help was excellent" and "I feel like a VIP here. When I came here I was seen by my GP in the morning and was admitted here about three hours later and everyone was here to greet me including a doctor. They [staff] have done so much for me". Relatives said, "We were at crisis point and suddenly they stepped in, and sorted everything out, it was amazing" and "We had an issue and [relative] became increasingly agitated. They [staff], came to see them and sorted their medicines which were made available that day. [Relative] was so much more settled afterwards". Commissioners we contacted stated they received statistics relating to both routine and urgent admissions and they had confidence that people were admitted in a timely manner.

People and their families told us they were involved in making decisions about future care provision and that their preferred place of death was respected. People told us, "I am fully involved in planning my care needs and treatment", "I have chosen to die at home, but know I can change my mind at any time and the staff will support me" and "I have been supported to make advance decisions about my care". A relative said, "We are fully involved. They [staff] told us everything". Staff demonstrated knowledge and understanding about these important but sensitive discussions. We saw that decisions were recorded in order that all staff were aware of the person's preferred place of care and/or place of death. Staff told us, "We have handovers with all staff involved have access to all the information and updates on how people are progressing. There is lots of communication to keep me informed" and "We involve people in all decisions about how their support needs may be changing, for example if someone's condition is deteriorating they may need continence wear to be introduced. It's important these conversations are done with sensitivity". A commissioner we contacted told us the provider had recently started reporting the percentage of patients who die in their preferred place of death. They went on to state that "obviously this can be difficult for the hospice to achieve as the person's decision can change closer to death, however the hospice do consistently achieve good scores on this". Records we reviewed contained the necessary plans that clearly outlined people's wishes for end of life care.

Staff were keen to support people to meet all of their desired wishes at the end of their life. Staff were asked about how they approached advanced care planning with people. They told us, "We gauge the situation when we meet the person. These conversations are never planned, you work up to it over time with some people, less so with others. You have to respect that", "It's about unpicking the issues and finding out what's important to the person" and "It's about picking up on the little things and asking the person to elaborate and get them talking and thinking about what they want". We saw that one person was supported to write letters they wished to give to each of their relatives after their death that they found too difficult to write on their own. Another person who wanted to go to a festival was supported by staff to achieve this through liaison with external health care professionals so that should the person have needed support when they were there this was made accessible to them. Clinical Nurse Specialists working for the hospice in the community provided training to the district nurses and hospital staff in relation to advance care planning

and communication skills. This evidenced that people were supported to develop advance personalised care plans which detailed their end of life care wishes.

People shared examples with us which demonstrated that the focus of the care being provided to them was personalised to their needs. They said, "I am supported at the day centre with educational tips and equipment for the home plus personal one to one personal care help. I use the Jacuzzi, have massage and it's all very calming. Also my family benefit, it all helps me to cope better", "I have help from the Occupational therapist and the Physiotherapist had provided pain aids and they even managed to find a stick for me as I left it at home and I get support from the family carers support team [FACT]" and "There was an issue with my benefits, they were stopped. [Staff member's name] got some help for me and they sorted it out, which was a relief, I was very grateful". All of the people we spoke with had access to the complementary therapies, social, occupational and practical support they needed. We saw that a range of complementary therapies was available to help and support people's relaxation and general wellbeing. A staff member from the day service said, "We structure people's day to suit them. Today we have a physiotherapist leading a session on managing fatigue and a pet therapy session and we've just had a quiz. People can take part in the activities that they prefer".

Initial assessments had been undertaken to identify people's support needs and care plans had been developed outlining how these needs were to be met. There was a strong emphasis for people to receive care that was personalised and meaningful to them, which had a positive effect on people. We observed the staff provided people's care in this way. For example, staff spent time with people discussing management plans for their symptoms; including their emotional and spiritual needs and identifying their preferences and choices. Care plans we reviewed were individualised and written for each person as their condition dictated. These were updated on a daily basis. It was evident that the content of care plans had been developed and discussed with people and their family.

The provider had established ways to ensure that people were given options to receive the care and support they needed where they preferred. The provider had recently set up 'satellite clinics' in two localities in Birmingham. This was to make it easier for people to access the service for specialist support in their own locality, should they so wish. Clinical nurse specialists told us, "It allows people to be seen where they want. A lot would prefer to be seen nearer their home and the clinics allow us to be more accessible" and "It allows us to see more people, promotes people's independence in deciding where they receive support and can alter any preconceived ideas of hospice care". GP surgeries were used for convenience and consistency of staffing was optimised in order to support people appropriately by staff they knew and were comfortable with. This meant that the provider supported people to be more independent in planning their care and how and where it was delivered. This was in an attempt to reduce the stigma and break down the taboos about hospice care.

People told us that staff provided the care they needed when they needed it. People said, "I have had round the clock care, I am so lucky", "The staff noticed I was looking unwell at the Day Care session, so they escorted me home and helped me settle in, made me safe and sent a doctor to check on me" and "The doctor comes to see me every day". Relatives told us, "They [staff] worked in great ways with the district nurses and ensured [relative] was pain free" and "The duty of care from the staff has been excellent including making sure [relative] is not discharged home yet as his home is unsuitable for his illness and condition". We saw that communication was effective both in inpatient and community services. Any changes were recorded using both written and computerised records to ensure good access for all staff to a clear and up to date picture of people's needs. Staff were asked how they shared information. They told us, "We have daily meetings and discuss each person and their individual needs and changing level of needs" and "There are multi-disciplinary meetings and I feel I can contribute to these, any changes or concerns are

shared here".

People were supported to access the care most appropriate to their needs when their needs changed. They told us, "When I was in a lot of pain in the early days of my illness, the doctor organised a short stay in the hospice for me and sorted out pain relief for me. It was a positive experience" and "When I was more unwell, [staff members' name] comes in more often to see me. I have been into the hospice for respite which really helped me". We saw that a triage nurse was allocated to take all new referrals as they came into the hospice and they looked at people's individual needs and which team was best placed to support them. This demonstrated that changes were identified quickly and, where required, people had rapid access to the support they needed.

People told us they felt confident and well informed about how to raise a complaint or any concerns. People said, "Staff listened to us and followed up our issues promptly and made things happen" and "I can't imagine what anyone could complain about but I do know how to complain if I ever needed to". Other people told us they were happy that they could talk to staff about anything that concerned them even if it was a delicate matter.

The complaints procedure was accessible for people to refer to and leaflets were also made available to people. There were arrangements for recording, acknowledging, investigating and responding to complaints and any actions taken or changes made as a result. Records showed outcomes from complaints were clearly documented and were communicated to staff. The provider was keen to improve the service people received by learning from complaints and routinely used complaints as a learning exercise. For example, a complaint which identified issues with the referral process resulted in the recruitment of a triage nurse dedicated to supporting effective partnership working and stream lining the process of referral into the hospice. Another complaint had resulted in training being developed specifically for reception staff. Complaints received and outcomes of subsequent investigations undertaken were shared at regular clinical governance meetings and board meetings. This meant that the provider effectively listened, responded to and learnt from people's concerns and complaints.

Is the service well-led?

Our findings

People and staff were complimentary about their experience of using or working at the service and how it was managed. They told us, "Those people [staff] are wonderful, they help me a heck of a lot. I don't know how I would get through it without them", "This place is beautiful, better than any hotel, it's perfect", "My care here is 100%, actually 110%, nothing is missed", "The volunteers and staff here are marvellous, they are like friends" and "I can't tell you how good it is, it's excellent". Relatives were equally as complimentary saying, "I have been visiting for five weeks now and the quality of care is fantastic, there is always someone here to help", "The staff made [relative] ending just perfect". Commissioners we contacted stated the information they received showed a high level of positive feedback about the care provided. In addition they had undertaken several visits to the hospice and spoken to people and their families and the feedback had been very positive. Staff were asked what it was like working for the provider. They told us, "It's a wonderful place to work", "I left and came back and appreciate now what a great place it is to work" and "I am enabled to do what I came into nursing to do".

The registered manager knew their responsibilities for notifying the Care Quality Commission of any significant events that affected people or the service. We requested information in the form of a Provider Information Return [PIR]; this was fully completed and returned to us within the given timeframe. Staff described the service as 'organised' and senior managers and medical staff as 'supportive and understanding'. Other staff members we spoke with said, "It's the most supportive place I have ever worked" and "Managers are really approachable, you always have access to the support you need". Commissioners we contacted stated they had confidence that the service was well-led. They described the Chief Executive Officer (CEO) as a good leader, who was very knowledgeable and they said she had developed a good relationship with members of their Clinical Commissioning Group. Another commissioner shared with us that they found the hospice had always been a responsive service which appeared to be well led. One staff member said, "The CEO knew my name when I first started, which surprised me. Everyone in management is really approachable".

During the inspection, we observed excellent team working and clear, transparent communication throughout the service with an inclusive approach to care. We saw that the provider used regular department meetings in order to update and cascade important information to staff about the wider organisation. Staff told us, "We have staff meetings and an open agenda is displayed for people to add on items they wish to discuss" and "One to ones, updates and meetings all make us feel valued and involved". Staff overwhelmingly told us they enjoyed their work and felt involved and valued by the provider. Comments received included, "I do feel valued and a sense of worth about what we do. I feel we make a difference through good practices", "Everyone is committed top to bottom" and "There is a good team effort and we help one another. We have transparency here and are informed appropriately". Staff were informed and consulted about plans for development of the service by the provider using a variety of communication methods to keep them up to date and able to give their comments and opinions about the hospice's future. Methods included updates through emails, newsletters and surveys, for example 'Butterfly buzz' newsletter was regularly sent out to staff and volunteers to keep them informed of developments within the wider organisation. This meant that the provider promoted and encouraged an open and transparent but

challenging culture. Staff told us they understood the concept of whistleblowing and would feel supported if they needed to raise a concern.

The provider was keen to develop strong links with the local community and ensure that the services being provided were inclusive for all. For example a community liaison worker post had been created and a person had recently been recruited into the role. The aim of the role was to engage and promote the hospice by accessing people through community groups and faith centres to encourage people in areas of Birmingham which had been identified as having a low rate of engagement. The head of hospice at home told us, "The community engagement officer's role is to engage with more diverse communities through community groups and leaders, to target those locations where we get fewer referrals".

The hospice four year strategy had been developed by the business development team, with the aim of creating new ways of working that were sustainable. The provider had put on engagement events both internally and externally to share and get feedback from all stakeholders regarding the plans and to increase people's and staff involvement in the development of the service. We saw that the two internal sessions to introduce the strategy and translate this into how they care for people day to day, were attended by 97% of staff. A staff member said, "We know who's who at the senior management level, we are always invited to be involved in future developments, such as the four year plan". This meant that the provider encouraged involvement in the development of the service from staff at all levels.

We found the provider operated an effective system to regularly check and monitor the quality of the service. There was a comprehensive program of in-house regular audits such as medicines, infection control, environment, incidents and complaints. The findings and action plans where improvements were needed were fed into meetings for consideration and scrutiny. These included meetings held by the trustees and senior managers to oversee the governance arrangements in the hospice. Organisational risks were also reported and reviewed at these meetings. The hospice Board was made up of twelve Trustees and one Chair who met up four times per year. Staff told us, "We do a lot of audits here" and "We are allocated audits to complete for our own department. It helps us to understand where improvement is needed".

We found that the hospice worked in partnership with other organisations which assisted in the monitoring and development of the hospice service. The service had established links with local universities and attended a number of regional palliative care focussed groups; this enabled them to share good practice and assess their own performance against other local and national providers. The provider also sought external reviews of its management performance and structure, including observed meetings and interviews undertaken with the heads of departments. Findings were discussed and potential improvements planned in summit meetings that were organised. This demonstrated that the provider was keen to measure and review their performance against current guidance and adopt recognised best practice.

The service was proactive in ensuring that stakeholder's feedback was regularly sought and used to develop the service. This included questionnaires, face to face discussions, external events and the use of social media sites. Feedback forms were supplied to people and their families using both community and inpatients services within a few days of receiving the service. Changes to practice were evident as a result of listening to feedback, for example one person raised concerns that mail received from the hospice was identifiable from the franked post mark put on by the mail machine. As a result the provider removed this for all outgoing mail in order to address this issue. The provider's computerised records prompted staff that people were due to receive a satisfaction survey and volunteers provided support to ensure forms were distributed and completed. We saw from the analysis undertaken by the provider of stakeholder's feedback that people experienced a high level of satisfaction.

