

## St Peter's Hospice

# St Peter's Hospice

### Inspection report

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Date of inspection visit:  
16 March 2016  
17 March 2016

Date of publication:  
06 June 2016

### 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

St Peter's Hospice is located in Bristol. The service provides care to adults with life limiting illnesses, and their families. As well as caring for people as inpatients, the hospice provides a service to people in their own homes, a day hospice and a support and advice service by telephone. The hospice inpatient unit can care for up to 18 adults who require symptom control or end of life care. The average length of stay is two weeks. At our last inspection in August 2014, no concerns were found.

This inspection was carried out on 16 and 17 March 2016 by two inspectors. One of the inspectors had specialist knowledge around end of life care services. We gave the service 48 hours' notice of our visit. This was because we wanted people and their families to be able to be prepared in good time to speak with us.

There was a registered manager for the service. 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 protect people from the risk of abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

Risk assessments were written in a way that was centred on the needs of each individual. Each assessment included clear actions to take to reduce identified risks.

Staff had a good knowledge about each person and about how to meet their specific care and support needs. The staff team all tried hard to go 'the extra mile' to ensure people's needs were met in a person centred way. This included support for people's partners, their family and friends.

People's feedback was actively sought and acted on. People and relatives were overwhelmingly positive in their views of the service that they were receiving. They told us they were very satisfied about the staff approach. People also praised how their care and treatment was being planned and delivered.

There was enough staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. Medical staff were available at any time of the day or night to provide medical support when needed.

There were recruitment procedures in place that helped to ensure only suitable staff were employed. These included checking previous conduct as well as suitability from previous employers. This was to ensure staff were suitable to work with vulnerable people at the hospice.

Staff were very kind and compassionate to people. Relatives told us, "The care was exceptional the staff were all so kind and spent so much time with me and asked how I was ." People's feedback about the caring

approach of the service was overwhelmingly positive and they described it as "Exceptional" and "Wonderful." Staff communicated effectively with people. They responded to their needs attentively and treated them with kindness and positive regard.

People were involved in all aspects of how their care and time at the hospice was planned. People praised the medical staff who they said supported them to make their own decisions about their care and treatment.

The environment was well utilised for the comfort of people. It was welcoming, well maintained and suited people's needs. The grounds had been well maintained and were accessible for people to enjoy.

Staff went on a range of training based on best practice and research around end of life. They were booked in for regular update courses. Staff were given a wide range of opportunities for further learning specific to the needs of the people they supported on their end of life care journey. The team received regular one to one and group supervision sessions and an annual appraisal. There was also a free to use counselling support line to offer further emotional support to the staff. This ensured they were supported to work to the expected standards.

The Mental Capacity Act 2005 is a legal framework to ensure decisions are made in the best interests of adults who do not have the mental capacity to make decisions themselves. There was guidance available about the Deprivation of Liberty Safeguards (DoLS). This information helped staff if needed to ensure safeguards were put in place to protect people in the least restrictive way. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered in relation to the requirements of the Mental Capacity Act 2005.

Meals were in sufficient quantity and met people's needs and choices. People praised the food they received. Staff knew and understood people's dietary preferences. This included restrictions on what people could eat and reduced appetite.

The registered manager was open and transparent in their approach. Staff told us they felt valued and supported by them. They described the registered manager as friendly and caring. People also said that they were someone who people could talk with easily. Relative's comments about the management of the service were extremely complimentary. A comment made was that the management support was "Wonderful."

Audits and quality checks were carried out about the way the service was run. This was to identify ways that it could improve. When improvements were needed action was taken to improve the quality of the service and care. The service worked in partnership with other organisations to drive improvements for the benefit of people who at 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.

People told us they felt safe at the hospice. There was enough staff to provide people with safe care and treatment.

Staff were recruited only when the checks necessary to show they were suitable to work with people had been completed.

Staff understood safeguarding procedures. They knew what to do to alert the relevant people if there were safeguarding concerns.

### Is the service effective?

Good 

The service was effective

Staff ensured people's needs were met in a personalised way. This included support for people's family friends and other loved ones.

Staff had been trained to understand the principles of the MCA and DoLS and understood about the requirements of this legislation. This meant staff knew how to protect people's legal rights if they did not have the capacity to make informed decisions about care and treatment.

People were provided with food and drink in an individualised way depending on their particular needs.

People were referred to healthcare professionals promptly when needed. Staff worked closely with health professionals to ensure people received a well-planned service.

### Is the service caring?

Good 

The service was very caring.

People, their relatives, friends, advocates and other people who had contact with the service, were very positive about the way staff treated them.

Care was planned in a way that was individual to each person. People received care and support from staff who knew and valued their history, likes, preferences, needs, hopes and goals

When people were approaching the end of their life they received compassionate and supportive care. They and the people who mattered to them contributed fully to their plan of care so that staff know their wishes. This was to ensure the person had dignity, comfort and respect at this time.

### **Is the service responsive?**

**Good** ●

The service was responsive

The care people received was very flexible and staff knew how to respond quickly to people's changing needs or wishes.

People, families, friends and health professionals were able to gain support at any time. People received personalised care from staff with skills and knowledge to meet their needs.

People's care and support was planned and reviewed in partnership with them, to reflect their individual wishes and what was important to them.

The service had a wide range of ways to involve people and their families, stimulate their engagement and provide support.

The service took an active role in the local community. People, their families and friends were actively encouraged, enabled and supported to engage with events outside of the service.

### **Is the service well-led?**

**Good** ●

The service was well led.

The organisation and the registered manager provided compassionate leadership and support. This showed that the needs of people who used the service were central to how it was run.

People and staff were actively involved in developing the service and their views were used to improve the way the hospice was run.

The service had clear visions and values that included involvement, compassion and respect. Staff understood these values and embedded them into their work.

Governance and quality assurance systems were effective at driving up improvement in the service. There was a culture of openness that encouraged people and staff to question practice.

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# St Peter's Hospice

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. At our last inspection in August 2014, no concerns were found.

This inspection was carried out on 16 and 17 March 2016 and was announced. The inspection team consisted of one inspector and an inspector with specialist knowledge of palliative care.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. The registered manager sent us 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. This document is also used to inform our inspection and give us specific areas to focus on.

We looked at the premises, spent time in the inpatient unit, the clinics and went out on visits with the community nurse specialists and a Hospice at Home nurse. We looked at seven sets of records that related to people's care. We looked at the systems in place for managing medicines, spoke to staff involved in the administration of medicines, and examined ten people's medicines charts. We looked at six people's assessments of needs and care plans. We viewed documentation related to staff management as well as four staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and the activities programme. We checked the administration of medicines and looked at a sample of policies and procedures.

We spoke with seven people who were receiving care in the inpatient unit and four of their relatives. We also met six people using the day care service. We spoke by telephone with four people receiving care from the Hospice at Home service and one person's relative.

We spoke with the registered manager who is the head of patient care, two ward clerks, two doctors, an occupational therapist, the catering manager, a member of the 'spiritual' team, the inpatient unit manager,

two seniors nurses, three staff from the day care services, and seven care staff.



## Is the service safe?

### Our findings

People told us they felt safe staying at the hospice. One person said, "This is the best option for me. Another comment was "Of course I feel safe here." People said that there was always someone to talk to at any time of the day or night and they were always listened to.

People were supported by staff who knew how to keep them safe from abuse. The staff knew about the service's procedure for safeguarding people from abuse. They told us they were given their own copy of the procedure so that it was available to them in the event of an allegation of abuse being made.

We saw a copy of a procedure and other relevant information to guide and help staff to know how to keep people safe from abuse. Information in training records showed staff had been on training courses to learn more about the subject of safeguarding people from abuse. The staff knew about whistleblowing at work. They knew it meant reporting dishonest or abusive activities at work to relevant authorities. The whistleblowing procedure was up to date with contact details for the organisations people would use if they needed to report concerns.

People were protected because risks from possible harm were well managed. Risk assessments had been carried out to identify and manage people's individual risk. These also incorporated people's views with regard to their needs and wishes at the end of their life. For example one person had been able to bring and then use their mobility scooter in the grounds. Another person was supported to go home when they wanted to be with their family.

The service had an online care planning system. This included risk assessments such as falls, dietary and mobility and tissue viability. For example, care plans showed how people were to be mobilised safely and how to minimise falls. Appropriate equipment and prevention methods were followed for people at risk of skin damage from pressure. Staff handover records documented in detail people's risks and staff were aware of the risks for each person.

Safe recruitment procedures were followed to ensure that suitable staff were employed at the service. Criminal checks had been carried out through the Disclosure and Barring Service (DBS). Staff had not started working at the hospice until it had been confirmed they were suitable to work with people. Staff from overseas provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work. References had been obtained before staff were appointed and these were when possible from their most recent employer. This helped to ensure people were supported by staff and volunteers who were of good character and suitable to carry out their duties safely.

There was enough staff on duty to meet people's needs. We saw that it was always easy to locate a member of staff, staff were very visible and approachable. We heard call bells being always answered swiftly. One visitor said, "There is always enough staff on duty and lots of volunteers too." Staff spoken with also confirmed there were enough of them on duty. People and their loved ones were supported by sufficient care staff in the inpatient unit, the day services and in the community. The team of doctors worked across all

services and visited people in the inpatient unit, at home, care homes, in out-patient clinics or in hospitals. One of the doctors was always on call at weekends and overnight for advice with a consultant in palliative medicine consistently available for further advice if needed.

We saw, and people and staff told us how the team worked closely with the consultant and medical team in palliative care medicine. Staff rotas indicated there were sufficient staff. Staff told us there were enough staff to meet people's needs, including at times they preferred. Staff were available to help people at various times on the In-patient Unit (IPU) depending on their wishes. We found that there was a sense of calmness so that people did not feel rushed. The team were supported by ward clerks and a co-ordinated trained team of volunteers.

Medicines were managed safely. The security of medicines being used in the hospice was robust. The medicines room could only be accessed by staff responsible for administering medicines using a swipe system. Keys to medicines cupboards were held securely in a key safe which was accessed via a key code. Staff responsible for administering medicines were protected from interruptions because other staff had clear instructions not to disturb them. We observed that staff followed the guidance and respected their colleagues during the medicines calculation and dispensing procedures.

Records in relation to strong pain relieving medicines were up to date and had been checked. The medicines log book had been completed in full and there were no gaps seen. Staff recorded maximum and minimum temperatures for medicines in fridges and these were stored safely. There were medicines to reverse the effects of sedation in an emergency available. There was also a protocol for safe dispensing of medicines for people to take home with them for discharge and leave. This meant medicines were managed in a safe and flexible way for the benefit of people who were inpatients and those who were leaving the service.

Staff training in medicines management and assessment of competence was robust. We looked at the medication workbook that new staff followed as part of their induction programme. This contained medication information, medication calculations, conversions and evidence of meetings with an allocated mentor before staff were signed off as competent to administer medicines. One staff member said, "The meds training I received during my induction was brilliant. The amount of controlled drugs can be overwhelming but I was never rushed to get signed off and felt really well supported." The workbook was also being considered by staff as being suitable for use for revalidation with the Nursing Midwifery Council. Revalidation is a process whereby all registered nurses need to provide evidence of their learning in order to remain on the register to practise as a nurse. When patients brought their own medicines to the hospice, these were checked in by two members of staff and then secured within a sealed bag in a locked cupboard. The integrity of the seal on the bag was checked daily. Stock controlled medicines were also checked daily to ensure that stock balance levels were accurate.

Some patients were receiving medicines via transdermal (skin) patches. The service had recently introduced a checking process in relation to ensuring the patch was still in situ. The patches delivered analgesia (pain relief) and it was therefore important that they stayed on the skin where they had been applied. The new process showed that that patch positions had been checked twice a day which meant the service could be assured that this aspect of people's pain relief was being delivered as prescribed.

Medicines were disposed of safely and in accordance with legislation. Again, we saw the service had implemented changes to processes in order to improve. For example, the bin bag colour in the medicines room was a different colour from other bags. This meant that if any medicine was thrown away in error, the bag could be easily identified and searched.

Medication errors were reported and analysed for trends. Staff said there was an open culture in relation to reporting errors and that any incidents were shared and discussed with the team in order to prevent a recurrence. We saw that practise improvement was a key theme; for example the documentation in relation to one medication incident had been anonymised and was being used for staff training. There was evidence that incidents were discussed at team meetings, and staff said they were asked for their input into how errors could be minimised.

Medication audits had been undertaken, including reconciliation audits and controlled medicines audits. However audit tools were not always being used effectively. The controlled medicines audit of 22/10/2015, had no dates and timescales associated with any of the identified actions and the audit did not specify how many people's medicines or drug administration charts were looked at. For example, in the section of the audit titled "Patient Medicines Administration Chart", comments from the auditor in relation whether the charts had been completed in full, did not refer to the chart(s) in question. This meant that although the audit identified areas for improvement and action, it was not clear how wide spread the issues were or if they were in relation to only one chart. The comments "not consistent" and "not always" had also been written in sections of the audit relating to signatures of staff in the controlled drugs register and to the quality of prescriptions and "further work needed" regarding how some medicines of different strengths were stored. We discussed the audit with the registered manager who said they had already identified the issues we had noted. They said they had recently completed the CQC self-assessment tool and intended to use this as a benchmark for areas of required improvement. This showed how the service was run in a way that was transparent and aimed to drive up standards and outcomes for people.

The fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. Maintenance issues were dealt with promptly and we saw maintenance staff carrying out their duties on the days we visited. This meant people lived in an environment where risks to their health and safety were minimised.

## Is the service effective?

### Our findings

People said the staff gave them the care they needed and had the knowledge and skills to carry out their roles to a very high standard. Every single person felt the service and care was outstanding. One person said, "I should say it was exceptional." Another comment was "They have been absolutely marvellous." People praised the clinical team, one person in the IPU said, "They have talked through all the options with me and helped me to make up my own mind about things."

People who attended the day services unit attended regular support sessions. These sessions covered areas that included food choices, anxiety and fears, sleep management and pain management. People in the day unit told us how much sharing and support they gave each other.

People in the community said they were relieved and felt very supported when the community staff visited. One relative said, "They are a life line for both of us." Another person told us that the community staff were "quite simply amazing." Every person told us they could not manage to keep going each day without the support from the community based staff.

Assessments of people's needs were centred on their preferred wishes for care and support. These were devised by the multi-disciplinary team of staff who were trained in palliative care. The hospice had care planning systems in place to ensure care was planned and delivered to meet people's needs, as well as of those close to them, at every stage of their care.

People's nutritional and hydration needs were assessed on admission. There was a record of peoples preferred portion sizes and dietary needs. For example diabetic or vegetarian and any specific needs such as the use of thickeners or pureed diets. Likes and dislikes were also noted. However, the care plans did not always provide the same level of detail. For example, staff had documented in one person's nutritional plan that they had a poor appetite and a "variable swallow." The plan informed staff to "Trial thickened fluids to soup consistency." It did not specify precisely how much thickener should be added to the person's drinks. The daily notes reflected the lack of detail. On 14/03/2016 staff had documented "Will accept thickener as long as not too thick" and "Continues to decline thick and easy." On 15/03/2016, staff had documented "Drinking minimal fluids, sometimes causes him to cough" and on 16/03/2016 "Drinking oral fluids." It was not clear how much thick and easy staff should add to the person's drinks in order to prevent coughing or choking whilst also ensuring the drink was palatable to the person.

People praised the food that was served and comments included, "Food has been excellent, just like being at home", and "The chef will make me whatever I feel like." A copy of the flexible menu was given to people when they were first admitted. A member of the catering team visited people regularly to take their food orders and find out what they liked. People were regularly asked about their likes and dislikes and how they preferred their food to be prepared.

Visitors were able to have meals with their loved ones as well at any time. They said the food was "Lovely" and "Just enough even though I don't always feel like eating." When food was served to people staff wore

protective aprons and the food was covered as it was transported to people's rooms. It smelt appetising, and we heard staff offering people a choice of main meal. We overheard one person asking the chef to consider buying some vegetarian sausages. They told the chef they were hoping to be discharged home the following day and the chef commented, "That's not a problem at all, I'm happy to get some in for you. You should have asked earlier in the week and I could have got some sooner."

There was a training programme run by the hospice academy and put on by the education team. The hospice academy programme offered internal and external courses on a range of topics such as how to talk with someone who is dying, palliative care, dementia awareness, symptom control, syringe pumps and end of life.

Every staff member told us how the whole team supported each other. Staff told us there was no status or hierarchy in this. They said that they supported the Doctors and vice versa. Staff also said they could phone a support line if they wanted extra emotional support. The staff also attended regular group supervision sessions. These meetings were used to discuss care and treatment matters. They were also used as time to support each other and share feelings after a patient had died. Supervision records showed how well staff were supported and guided in their work. The staff confirmed that they met with their supervisor regularly to talk about work matters and review their performance. Training needs and performance related issues were also brought up at each meeting.

Staff demonstrated a good understanding of the processes to follow in relation to the Mental Capacity Act 2005 (MCA). Staff were trained in the principles of the MCA and the Deprivation of Liberty Safeguards and these were applied in practice. When people had been assessed as being unable to make relevant and specific decisions, applications for the authorisation to restrict their freedom in their best interest had been submitted to the DoLS office. DoLS' applications were completed by the senior medical staff caring for the patient in collaboration with the multidisciplinary team.

Records were made of how appropriate meetings had been held to discuss people's best interests and make a decision on their behalf, in accordance with the requirements of the MCA. For example, we heard how a situation was being managed in a discrete and respectful way. A best interest meeting with the multidisciplinary team had been held with the person's loved ones to discuss their care and treatment.

People were referred to healthcare professionals when necessary. For example, before a person had returned home, the service's occupational therapist had visited their home to assess what equipment and adaptations may be required and ensure this was provided. Staff worked in close partnership with people's GPs when they supported people in the community. The service's clinical nurse specialists worked closely with GP practices and attended regular meetings with them. All organisations providing end of life care are expected to adopt a co-ordinated process such as the Gold Standards Framework. This is an evidence-based approach, developed to improve care for people with a life-limiting illness.

There were facilities for beds to be moved outside, along with discrete seating areas for more ambulant patients near to the wards. We heard how people had benefitted from accessing the outdoors. There were ramps from the terrace that allowed safe movement away from the immediate ward area to other parts of the grounds.

## Is the service caring?

### Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively valued the service that was provided, and the manner in which it was delivered. . One person told us "They are absolutely wonderful every single one of them." Other comments included "The staff here are all absolutely marvellous", "My doctor has talked through all the options and let me come to my own decisions" , " The care from all of the staff is second to none every single one of them cares so much about what they do."

We looked at people's testimonies on the iWantGreatCare website. This is a national website which services can sign up to collect online feedback. The hospice had achieved a five star rating. This meant people felt that the care they had received was of a very high standard. People's testimonies included, "The staff are compassionate and they really do care, they talk to me as an individual and respect how I feel", "When you come in it's very frightening but it's been so calm and relaxed they put you at your ease immediately", and "The staff are like angels and "I was made to feel that I had a life of love ." A relative said, "The service we have received had been totally overwhelming I feel as if I am not alone with all my worries and I feel such a sense of relief". Another relative told us "To be honest the staff here are all amazing if you find yourself in my situation then I would not hesitate to recommend this service to anyone."

Other comments included "So far everything has been good can't think of anything which needs to be improved", "Counselling was really good with the hospice. I was struggling after looking and I sought help and it was the best thing I ever did. The counsellor made me feel at ease and was able to discuss my fears and problems. I think this is a great service to offer patients and loved ones and I recommend it to anyone." "I have home visits from one of the community nurses and the care and attention I have received since referral has been superb."

Staff were also positive about the care they were supported to provide. A staff member said, "The patients want for nothing." Staff comments included, "The work is really rewarding and I would not want to work anywhere else", "I love my work and you really feel like you are making a difference the team are lovely and we support each other, we always have time to spend with the patients" and "It's a wonderful place to work I love it here" Staff all spoke about how it was a wonderful place to work. Comments were, "It's the best job I've had and it's is not like a normal job" and "I I've worked in plenty of other places and I would never want to be anywhere else."

Visitors were welcome at any time. We were also told that if close relatives had been called in and were required to stay at the hospice there was a bed, partners could stay and when possible, beds could be moved together. Visitors were able to stay with their loved ones anytime during their time at the hospice. Meals were also prepared for them free of charge. We met people staying with their loved one at the service. People told us that this was an immense relief for them at such a difficult time. Staff and the spiritual team told us that they all saw a key part of their role as being to support family and people who mattered to the patients. We saw staff spend plenty of time supporting visitors in a discrete and sensitive way.

There was a homely feel to the service in the inpatient unit. There was a social atmosphere where people were encouraged to chat if they wished and were listened to. Staff were smiling and attentive in manner. Staff stopped to listen to people and responded to them with genuine interest and always with plenty of time for them. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they had conversations with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names.

There was a full time spiritual coordinator, and four volunteers supporting them who worked part time. They were available for spiritual care of any denomination or belief. Hospice staff were looking at further ways to capture people's spiritual, cultural and religious beliefs.

There was a sanctuary room used for spiritual reflection. The room was calm and inviting area and was tailored for all faiths. Candles were available to light and people were invited to write prayer requests onto small heart shaped paper. There were many other examples showing how caring the hospice staff were in helping to provide care and positive memories for people. One person was served Irish food as they were from Ireland and we had visited on St. Patrick's Day. They told us how lunch they liked this gesture.

There was bereavement support for staff and families. Staff were in turn supported by the management team if they experienced emotional difficulties due to the nature of their work and were also able to receive counselling. Staff felt part of a team as their views and opinions were listened to. The staff team had regular meetings. A meeting was arranged for example with a specific agenda focusing on improving communication with people. Then there was consideration of how to put into practise the team's ideas and make an action plan for implementation and evaluation.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. There was a comprehensive information booklet that included the service's mission statement, the range and nature of services available, the structure of the medical team; Out-patient clinics, how to complain, and a list of information leaflets were available. The service had an updated website that contained clear, comprehensive information and that was user-friendly.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment. People were encouraged to think about 'advance care plans'. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they wished to be their legal representative. These advance decisions were recorded, effectively communicated to staff and respected.

When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. People and their relatives were included in the discussions about the way the risks were managed to ensure people's preferences were considered.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. Each person in the inpatient unit had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered.

All staff knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request. We saw that staff checked regularly in a discrete way on people's wellbeing. Care plans included instructions for staff to follow to keep dignity when helping people with eating, drinking, and with their personal needs. People all told us they were assisted with their personal care needs in a way that respected their dignity.

During our visit a person died. We saw their family were with them. After the person died the family were supported by staff and given plenty of time to talk in a private space that was available. The staff told us they were able to signpost people to appropriate local community services. The hospice bereavement service provided pre-bereavement support and a range of one to one and group support for after a loss. This was through hospice staff, trained volunteers and counsellors



## Is the service responsive?

### Our findings

People and their relatives told us that the way staff responded to their needs was, "Fantastic", "So easy" and "Priceless." They felt the Hospice services were easy to access and a lifeline for people and their families. People all told us they could not believe they were able to access such good care and felt very appreciative of the care and support.

One person said, "I get exceptional care from all the staff, they take time to talk to me and listen to what I decide." Another person said, "The chef knows what I eat and he comes to see me most days." A relative said, "They know me and they greet me and always ask how I am and take the time to find out." Another relative told us "I'm in an awful situation but they have made the burden feel far less I know I'm not alone with this now."

There were numerous testimonies and positive feedback from people, friends and relatives who expressed how responsive the staff had been to people's needs. All were extremely positive and thanked the staff. For example, "Staff were so kind to both of us thank you." Recent comments on the national review website were all universally positive praising the staff and the care. People also praised how flexibly and sensitively loved ones had been supported at the end of their life

People could be referred to the service by a member of the St Peter's community specialist team, GP, district nurse, care home manager or members of the out of hours healthcare teams. Referrals could be taken 24 hours a day, 7 days a week. The service aimed to respond to urgent referrals within 24 hours. All requests for routine admissions were considered at a daily admissions meeting. One person said that a recent visit had identified they would be better off at the hospice. They said this had been well planned with them and their family.

The service was clear about their local demographic and what the needs of the local community were and followed national guidelines such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice. Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, major difficulties in adjusting to a terminal illness, or the need for in-patient end of life care. Many people wished to be cared for in their own home.

The service aimed to prevent unwanted hospital or hospice admission and worked closely with NHS staff to facilitate rapid discharge to a preferred place of care for people at end of life. There was a clear referral criteria for all areas of the service and the inpatient unit and hospice at home service provided 24 hour care. We heard examples from people who had been able to go home for end of life care as they wished. Other people told us of how prompt symptom control had helped them to be prepared for a peaceful death in the place they wished to be.

The service worked flexibly to meet people's needs. For example, visitors including children were welcome at any time and stayed with their loved ones. People could keep the hours that suited them during the day and night. Also some people chose to keep very late hours and sleep during the day staff supported people

to do this.

The registered manager told us and so did people we spoke with that the hospice staff worked closely with local health professionals. This included GPs to district nurse teams and domiciliary and care home providers. They had built up a responsive relationship to ensure that gaps in care could be filled.

There was effective communication on a multidisciplinary level. The computer system contained information that was able to be accessed by all staff so they could follow a person's journey from diagnosis to being provided care from hospice services. They were able to identify any issues with people attending and were able to offer support to people. This meant the service had a range of options to offer people that they may not have thought about. The system was reviewed and changes made to alert people to changing needs. This was to help to ensure people's care needs were known by all the staff they saw and they did not have to keep repeating their medical history to different professionals.

The electronic system was used alongside paper care plans on the inpatient unit. This was to enable staff to document care needs more efficiently. These were reviewed every day or more frequently as required. When people remained in the inpatient unit for a short period to have their symptoms managed, there were effective transition arrangements to ensure they received continuity of support at home. People told us how the staff who they saw in the community had helped them to plan their stay at the hospice. They said this had also helped them to feel more prepared and less fearful. The staff told us this also ensured they were fully informed of any changes in people's health, medicines or treatment when people moved from one service to another.

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the inpatient unit, and when people received support from the community staff sat with people, enabling them to spend as much time as they needed.

People told us staff had encouraged them to ask questions, discuss their options and reflect upon them. People felt valued and understood because people and staff worked as a team to ensure each support plan was unique and responded to specific needs.

Staff were aware of people's care plans and were fully aware of people's likes, dislikes and preferences. Staff knew when a person preferred a late breakfast, a shower in the morning, or that they preferred to sleep on top of their chair at certain times, but staff continued to ask people's preferences as they provided care. For example, one care plan detailed how a person's needs were fluctuating and care was tailored to how they felt throughout the day.

Admission assessments to the inpatient unit ensured that people received a management plan of their symptoms, emotional and spiritual support, pain relief and specialist care. People were discussed daily in a multi-disciplinary team meeting each morning. The hospice was not a long term placement. If someone was stable enough to be moved they would be. These discussions would be held with the person and their families. We heard about one person who had an infection. The doctors had discussed with the person what sort of treatment they wanted and what the likely outcomes would be of the various options. The person was able to take time to consider if they wanted intravenous antibiotics or not. Staff said, "We try to do whatever it takes [to respond to people's needs]." We were told that, a dentist could be brought in to assess people's teeth and provide treatment.

People were involved in the planning of activities that responded to their individual needs. The hospice inpatient unit cared for people for short periods in an acute setting. This meant that generally people were

not well enough in the inpatient unit to be able to participate in organised activities. Therefore, activities were more based on how each person was feeling. One to one time was given that was tailored to people's individual social and psychological needs.

A range of therapies were offered such as massage, aromatherapy, relaxation techniques and mindfulness based stress management for patients, carers and bereaved relatives. The therapies were adapted to suit the needs of each individual. The team of therapists, which included paid staff and volunteers, worked across the whole service, the inpatient unit, and outpatients, in the community and in outreach centres.

The service took a role in the local community and was actively involved in building further links. The hospice maintained a high profile in the community and was regularly prominent in the local press through fundraising events. Links with the community were actively sought and encouraged by the leadership team. Volunteers and staff contributed to the planning of events. For example fun runs were regularly held .

Annual satisfaction surveys were carried out and responsive action was taken to address shortfalls that were identified as a result. For example, staff shift patterns were being reviewed to see if this was of benefit for people and the team who cared for them.

The record of complaints showed that complaints were dealt with properly. One recent complaint about staff communication with a person's family had been investigated by the registered manager. They had addressed the matter in an open and transparent way. The staff concerned were provided with extra training to improve the way they communicated with people and families.

The people and visitors we spoke with said if they were to have a complaint they could easily raise the matter with the staff and the registered manager. One person said, "I would speak to any of the staff ". Another person told us "I would see the nurse in charge."

People were given a copy of the information brochure about the hospice. This included a copy of the complaints procedure about the service. This was set out in an easy to understand format. It clearly explained how people could make complaints if they had them. Each person was given a copy of the service user guide. This contained information about the organisation and their visions and values, useful phone numbers, and safeguarding contact details.

## Is the service well-led?

### Our findings

There was an open and positive culture which focused on people. This was reflective of the leadership and management of the service. People received care and support by staff who upheld strong values about person-centred care. Staff were encouraged to build positive connections with patients and their loved ones. These were promoted to enhance their experience of the service. The staff told us the registered manager and the board members were actively involved in the day to day care at the IPU. Staff spoke highly of the positive approach of the senior leadership board. They said there was no sense of hierarchy status from the leadership team. For example care staff said they often supported Doctors who had been affected by a person's death. Staff also said this approach was part of the open culture of the service.

The registered manager led by placing emphasis on continuous learning and development of the hospice. People's feedback about the way the service was led said, "I cannot fault the management, they are all so caring and supportive." Relatives told us, "There are no improvements to be made." This was also a theme repeated in the comments on the [Iwantgreatcare](#) website.

The registered manager was open and transparent. They notified the Care Quality Commission of any significant events that affected people or the service. This showed the registered manager understood their legal responsibilities and worked in partnership with other relevant organisations. All the staff we spoke with told us they had confidence in the way the service was run. Staff praised the provider and the leadership team for their approach and support. They said they could come to the registered manager or any of the directors for advice or help. All of the staff we spoke with told us they felt valued working in the service, and felt motivated to maintain high standards. The registered manager worked closely with staff on the inpatient unit. The registered manager took an active part in monitoring standards of practice. The staff told us they were motivated by the registered manager's style and positive caring approach towards people.

Staff reported that the registered manager was good at their job and supportive. Comments included, "I love it here", "I never want to work anywhere else it's a great place and "It is a privilege to work in a team like this where we all care for each other."

Staff commented on how well they felt listened to and supported by management. There was a culture of collective responsibility between teams and services, which was evidenced at the handover meetings. Staff stated they were able to raise concerns including whistle blowing through a range of channels. We saw how this was taken seriously and how a recent whistleblowing challenge resulted in an investigation and recommendations which were acted upon.

The staff were all aware of what the organisations visions and values were. They included involvement, care and compassion independence, respect and promoting equality. Staff gave us example of how they embedded this into practise when they supported people. For example ensuring people had privacy to be with their partners, and helping people to reflect on their spiritual beliefs.

There was an effective leadership team that oversaw the running of the service, that included a registered

manager who was the director of patient care, and other department and clinical directors. They had particular experience and expertise in leadership, nursing and palliative care.

The registered manager who was also director of patient care met with clinical directors regularly looking at wider quality and service developments in end of life care. There was a programme of clinical audits to check that quality of care and best practice were maintained. Where appropriate, audits were discussed with the clinical management team, a clinical governance committee and the board of trustees.

Accidents and incidents were recorded and logged onto the services electronic patient record. This was to identify how the risks of recurrence could be minimised. There were records showing external clinical incidents, internal and incidents relating to drugs, pressure sores or falls. All incidents were reported to the quality team who analysed the findings and ensured appropriate actions were taken. The quality team also completed notifications required by CQC.

Audits of incidents were discussed at clinical governance committee meetings to explore how risks could be further managed. We saw the St Peter's hospice annual audit programme. This included co-ordination of care, audits of treatment, bereavement support and access to external health professionals.

The hospice used a benchmarking system which was a review of information such as pressure sore occurrence and falls in comparison with other hospices. Some audits were carried out regularly to ensure compliance with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care that defines clinical best practice. NICE provides specific quality statements and measures to provide service providers with definitions of high-quality care. Such audits to measure how the service performed were completed either monthly or quarterly, were documented and used effectively to monitor the quality of the care provided. They included how skin integrity was managed which had improved.

The service worked in partnership with other organisations to ensure they provided a high quality service. For example, clinical commissioning groups, local surgeries, hospitals and external health care professionals and agencies.

There were a number of ways that people could comment on the care provided other than online. There were feedback forms for people to leave comments for the inpatient team, day service and community team. An on-going survey was offered to people on site, by post and at reception.

Satisfaction surveys and complaints were looked at closely and used to identify whether people's experience of the service could be improved. There were examples of how this happened in practice effectively. For example, comments around meals and how they were served had been acted upon.

Records that were related to the running and management of the service were organised and were reviewed and updated. All records were kept securely and confidentially. Policies were detailed and they set out how care was delivered in the service. Staff knew of policies and knew where to locate them for guidance.

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