

St Peter's Hospice Ltd

St. Peter's Hospice

Quality Report

Charlton Road
Brentry
Bristol
BS10 6NL

Tel: 0117 915 9400

Website: www.stpetershospice.org

Date of inspection visit: 6 May 2014

Date of publication: 27 August 2014

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask about services and what we found	3
What people who use the service and those that matter to them say	5

Detailed findings from this inspection

Background to this inspection	6
Action we have told the provider to take	0

Summary of findings

Overall summary

St. Peter's Hospice provides care for adults with life limiting illnesses. They provide physical, psychological and spiritual care for patients in their own homes as well as at the hospice. At the time of our inspection they provided care for approximately 700 people living in Bristol, South Gloucestershire, North Somerset and part of Bath and North East Somerset.

They provide a range of services which include hospice at home, services in the community, a day hospice, a 24hr helpline, a spiritual care coordinator and an in-patient unit. As well as the work they do with patients and families they have an education centre with trainers who work with those who advise and care for patients away from St Peter's Hospice such as GPs and care home workers.

When we visited 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 and shares the legal responsibility for meeting the requirements of the law with the provider.

The people who used the service and their relatives were full of praise for the highly considerate and personalised and professional approach of staff. Patients felt they were listened to and that their needs and requests were acted upon in a way that made them feel they mattered.

Staff we spoke with and observed were sensitive to the emotional needs of patients and offered appropriate and effective support as needed.

In consultation with patients the inpatient unit of nurses and a consultant led team of doctors worked together in the care planning process to provide specialist, intensive symptom control for patients. Depending on the specific risks and needs of the patient the care planning process was updated regularly, in many cases daily. The information was documented and communicated to the team. This ensured the staff had the most up-to-date information relevant to the individual.

There were also various non-medical approaches to pain and symptom control. Staff explained these were not an alternative to medical care but an enhancement of care

whereby complementary therapies worked alongside medical treatments. These included emotional and spiritual support, developing coping strategies, relaxation and distraction techniques.

In some cases it was agreed by the patient that advance care planning would be appropriate. This process involved discussions between a patient and their health care professionals about future needs. The discussions established the patient's priorities regarding their end of life care and enabled them to plan their future and prepare for their death whilst maintaining control over their wishes and preferences.

Staff we spoke with felt well supported in their role by the registered manager. There was an emphasis on support and an open dialogue was encouraged.

The service placed a strong emphasis on education of its staff and to other health professionals who cared for dying people in other settings, such as the community. The Education Department is an established centre for the provision of palliative care (management of pain and other aspects of long term illness) education. They provide education that is aimed at developing clinical practice and to improve care.

We identified that there were robust support arrangements in place which monitored and reviewed members of staff involved in delivering care, treatment and support in end of life care.

We found the service worked with key organisations, including the local authority and the national charity, Help the Hospices, to support local and national hospice care provision and service development.

Where people did not have the mental capacity to make their own decisions there was a process to be followed in considering a patient's best interests. Staff we spoke with told us they practised best interest's decisions for those people who did not have capacity. All clinical staff had received training in the Mental Capacity Act 2005.

We found the service was currently meeting the requirements of the Deprivation of Liberty Safeguards.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. The patients we spoke with felt safe because their rights and dignity were respected as the hospice provided a regular opportunity for the review of medicines, pain management and changing care needs. People were safe as there was an effective system in place to manage accidents and incidents and learn from them. Staff we spoke with demonstrated an understanding of the Mental Capacity Act 2005 and how to apply the principles of the Act. The Act protects the rights of people who are not able to make decisions about their care or treatment. There were robust systems in place with regards to ordering, receiving, administration, storage and disposal of medicines.

Are services effective?

The service was effective as people's views are taken into account regarding the assessment of their needs and the planning of their service. Staff we spoke with demonstrated a clear understanding of the person's clinical and emotional needs and, where appropriate, involved family members in the care planning process. Skilled nurses and a consultant led team of doctors worked together with the patient in the care planning process to provide specialist, intensive pain symptom control. People's needs and preferences were respected when planning their end of life care.

Are services caring?

We observed that the service was caring because staff were sensitive to the emotional needs of the patients and were attentive to their care needs. People who used the service were given emotional and physical support and their wishes were respected. Patients told us they felt their privacy and dignity was respected at all times by all members of staff. We saw that advance care planning discussions were held between a patient and the healthcare professional about future needs. This enabled the patient to establish their priorities in end of life care and helped them plan their future and prepare for death, allowing them to maintain control over their wishes.

Are services responsive to people's needs?

People receive personalised care that was responsive to their needs. Detailed assessments were conducted by the hospice team and involved the patient. This enabled staff to ensure that pain and symptom control was personalised and effective and specific to the

Summary of findings

individual's needs. This aspect of their care was constantly under review and monitored. There were also various non-medical approaches to pain and symptom control adopted by the service. This included emotional and spiritual support, developing coping strategies, relaxation and distraction techniques and complementary therapies. Patients described the service as providing an integrated approach to their care, with staff being very helpful in reviewing and coordinating their treatment. End of life discussions were documented about the patient's understanding of the severity of the disease and the likely course of the patient's medical condition, preferences for future care and treatment, and what to do in a crisis.

Are services well-led?

The leadership of the organisation assured the delivery of high quality personalised care and supported learning and innovation. Staff we spoke with felt well supported in their role. The service worked with key organisations, including the local authority and the national charity, Help the Hospices, to support hospice care provision and service development. There were robust support arrangements such as clinical supervisions in place which monitored and reviewed members of staff involved in delivering care, treatment and support. To ensure patients were protected against risks of inappropriate or unsafe care the management team regularly assessed the quality of services provided.

Summary of findings

What people who use the service and those that matter to them say

We spoke with three patients and eight family members. Staff nurtured a sense of security and this was commented on by several of the people we spoke with. They told us this included a warm welcome on arrival, respectful communication, and a real understanding of individual concerns and routines.

The relative of a patient described the staff as “incredibly caring” and the sense of safety that they felt on their arrival to the hospice. They described the importance of “continuity”, “the hand-overs being very detailed” and how important it was to them and their family that the staff “get to know people”.

The day hospice was regarded as important by patients as it allowed for weekly treatment reviews with additional consultations arranged as needed. One patient stated “there’s been a solution to everything I have been worried about” and referred to “outstanding communication” and “reliable” staff, including both hospice and community staff.

Patients told us they were listened to and their needs and requests were acted upon. One family member described how perceptive and helpful a member of staff was when they were having “a bad day” and feeling “very angry”. They told us “they recognise the priorities in terms of what a family needs at a time of crisis” and they “recognise what is needed at that moment.” One relative of a patient described how “little things make such a

difference” and the care received by their relative and the whole family is “second to none”. They said that “as a Bristolian I am very proud of this place.” Another patient told us: “The doctor actually cares, actually listens to you. I cannot emphasise enough how wonderful this place is. It’s the first time I have felt confident that people actually talk to each other and care.”

Staff presented a sense of familiarity with patient and their relatives, smiling and using names on greeting, while maintaining a high level of professionalism and respect. We saw that the atmosphere around the hospice was calm whilst being active and purposeful. One patient commented “it is as light-hearted as it can be.”

The service conducted an annual Patient and Carer Outcome measure questionnaire. Two hundred and eighty completed questionnaires were received between August 2012 and March 2013. A number of positive results included that 100% of respondents felt they were always treated with respect and dignity and they always had confidence in those caring for their relative/friend. When respondents were asked how to improve the service two patients mentioned food on the in-patient unit could be more appetising and one mentioned the lack of facilities to heat up food for relatives. Owing to the comments made the service will be examining these issues at their User Involvement Forum to be held in the next year.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We inspected the service on the 6 May 2014. We were told the service supported up to 700 people at the hospice and in the community. The service was last inspected on 8 September 2013. There were no concerns found at this inspection.

Before our inspection we reviewed the relevant background documentation and other information held by CQC. This included reviewing safeguarding and statutory notification records.

The inspection team consisted of a lead inspector, a second inspector and an Expert by Experience who had experience of hospice services.

We visited the whole site and spoke with patients and staff during the day. We observed staff providing care to help us to understand the experience of people who used the service.

We viewed the care records of six people who used the service. We examined the policies and procedures of the service and the audits undertaken to review their service provision. We spoke with three patients, eight relatives, seven members of staff, the registered manager and six members of the senior management team.

Are services safe?

Our findings

People we spoke with and their relatives told us they felt safe at the hospice.

We observed the care provided by staff nurtured a sense of security and safety. The people we spoke with were full of praise for the highly considerate, personalised and professional approach of staff. This applied to staff in all roles and levels of responsibility at the hospice. This included a warm welcome on arrival, respectful communication and a real understanding of individual concerns and routines. A relative of an in-patient told us of the sense of safety they felt on arrival at the hospice. To ensure their relative's safety they felt the hospice provided "continuity" and "the handovers are very detailed".

One family member described how their relative had decided that the hospice was the setting where they would choose to be at the end of their life. This was in preference to their own home due to the particular sense of safety and reassurance that they immediately felt when admitted to the hospice.

We were told by patients and family members that their rights and dignity were respected as the hospice provided a regular opportunity for the review of medicines, pain management and changing care needs. Following the reviews we saw that new measures were put in place promptly, as needed such as changes in medication. A relative told us they felt the reviews were valuable and the risks were being effectively managed, particularly as their relative's care needs were becoming increasingly complex. Another family member told us they felt well informed when their relative's pain management had been reviewed and were made aware of the medicine's effects.

Causes of pain were attributed to both the physical and non-physical factors. In consultation with the patient and to ensure their safety and well-being a full assessment was completed by the health professionals for each patient. This included descriptions of what the pain was like, what was the cause of pain, specific types of pain and factors such as psychological, social and spiritual distress. People were safe because there were detailed plans around their pain relief and clear instructions of how to deal with their symptoms.

People were safe as there was an effective system in place to manage accidents and incidents and learn from them.

We viewed incident and near miss forms for recording and analysing individual incidents such as falls, pressure ulcers and medicines incidents. When necessary, action had been taken to reduce the likelihood of them happening again. An example of an incident we saw included where one patient had received "as required" medicines overnight to a level that should have been referred to a doctor) but they were not informed. This meant there was no review of the person's medicines until the next day. A clinical incident form was completed by the doctor involved. As a direct result of this incident there had been a review of all the hospice guidance given to on-call doctors and to the nursing staff regarding out-of-hours support. Nursing staff had been instructed to seek advice from the on-call doctors in such situations. Such an action protected patients' future welfare and safety when requiring "as required" (additional) medicines out-of-hours. Staff also completed a reflective practice record form, which is used as a means of reflecting on an incident and improving self-awareness and practice. The form used was for staff member's own personal use. Staff were provided with an option to use it to discuss any training needs with their manager.

We found that staff consistently managed medicines in a safe way. The six records we viewed identified there was a doctor's signature completed for each medicine entry as required; allergies were documented; the frequency of use of "as required" medicines were correctly completed, discontinued medicines were correctly crossed through and initialled/dated; dose changes were clearly written/initialled and the old dose crossed out; and the nurse administration of medicines were all signed for or coded. These actions minimised the risks of unsafe or inappropriate medicines being given to patients.

We spoke with a newly employed nurse who had recently completed their induction training. They told us their induction around managing medicines safely and pain and symptom control was "very good" and they felt "effectively supported". There was a mentorship programme and they felt this had helped them to feel confident and suitably equipped to fulfil their roles and responsibilities. Educational sessions in medicines had included looking at and understanding policies and procedures, practical sessions such as setting up and monitoring equipment and various scenarios to help them understand the dosage of medicines and why they were being used. They told us there were "very safe systems in place and that all staff accepted equal responsibility."

Are services safe?

We saw in the staff training records that all clinical staff had received training in the Mental Capacity Act 2005. There was a multi-disciplinary approach to making best interests decisions with regards to pain and symptom control. We were told that families, significant others or Independent Mental Capacity Advocates would be involved throughout the process to ensure that choices were respected and that treatment was effective and meaningful. If people did not have the mental capacity to make their own decisions the principles of the Mental Capacity Act 2005 would be followed and people's human rights would be properly recognised, respected and promoted.

All the patients we spoke with felt they were fully consulted about their care planning and reviews and had given consent to the provisions held in the care plan. We looked at six care plans that detailed that the patients had the mental capacity to make their own decisions. Where people did not have the mental capacity to make their own decision there was a process to be followed in considering a patient's best interests. Staff we spoke with told us they practised best interest's decisions for those people who did not have capacity.

The staff training database we saw documented that all relevant staff had received safeguarding training. Staff we spoke with confirmed this. They all demonstrated a good understanding of what constituted abuse and the reporting mechanisms in place. The numbers of relevant agencies to call in the event of needing to report an issue of concern were well publicised in the service. The policies and procedures in place meant that people were at a reduced risk of harm because staff had full information if they had any safeguarding concerns.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). While no applications had needed to be submitted, proper policies and procedures were in place. Relevant staff had been trained to understand when an application should be made, and how to submit one. There were no undue restrictions on people's movements within the hospice.

Are services effective?

(for example, treatment is effective)

Our findings

The service was effectively meeting the needs of the people who used the service.

We saw that patient's needs were assessed before they entered the in-patient service and during the first three days of admission to the service. We saw that care plans were developed from these assessments to ensure that the identified needs were met. People's views were taken into account regarding the assessment of their needs and the planning of the service. Care plans showed that patients who lived at the hospice, or their representatives had been formally involved in the assessment of their needs. Patient's or their relatives were consistently supported to have their views taken into account.

From the conversations we held with patients and our observations it was clear they felt they were listened to and their needs and requests were acted upon in a way that made them feel they mattered. One patient stated: "The doctor actually cares, actually listens to you. I cannot emphasise enough how wonderful this place is. It's the first time I have felt confident that people actually talk to each other and care".

The care planning process took into consideration the clinical assessment of the person's needs, the patient's expectations and concerns, social interests, psychological information, spiritual issues, personal background and the family's understanding of the person's diagnosis and prognosis. Staff we spoke with demonstrated a clear understanding of the person's clinical and emotional needs and, where appropriate, involved family members in the process. One care plan viewed identified that the patient was struggling with their loss of independence and was wary about being in a hospice and having to fit into the hospice routine. The staff member told us they had tried to incorporate the patient's routine into their care such as administering medicines at the times they had requested, rather than on the routine hospice medicine round.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. The hospice supported a holistic approach to pain and symptom control. During the care planning process staff

took take into consideration and documented the physical, psychological and spiritual facets of pain experienced by people. People's views and concerns were included in the care plans.

Detailed assessments enabled staff to ensure that pain and symptom control were personalised and effective to the individual. We found that pain and symptom control was constantly under review and being monitored. Staff used a "pain scale" tool to determine the level and severity of pain. They recorded this hourly over each 24 hour period alongside any interventions that took place. This ensured any risks to the person's health, safety and well-being was assessed and recorded and communicated within the team.

Within the in-patient unit skilled nurses and a consultant led team of doctors worked together to plan and provide specialist, intensive, symptom control for patients. Depending on the specific risks and needs of the patient we found that the care plans were updated regularly, in many cases daily. The staff members we spoke with told us that the information was documented and communicated to the team in staff handovers. This ensured the staff had the most up-to-date information relevant to the individual and they were supported to meet their needs.

Staff told us about how emotions such as anxiety, fear and depression would have an effect on patient's pain thresholds. During the planning process significant life changes were taken into consideration. This was because life changes could have a significant impact on how people coped with and perceived pain. The care plans viewed included issues of low self-esteem, altered body image, financial security and concerns about their family in the future. There were plans in place to support patient's and their relatives. One relative we spoke with said that it was important to them and their family that the staff "get to know people".

Staff we spoke with and observed were sensitive to the emotional needs of patients and offered appropriate and effective support as needed. All patients we spoke with were full of praise for the regular contact they had with health care professionals at the hospice. They knew who to speak to if they needed anything and felt their requests were always responded to effectively.

Admissions requests from the community nurse specialists, GPs or hospital colleagues were discussed every morning

Are services effective?

(for example, treatment is effective)

at a meeting on the in-patient unit, and planned for based on the urgency and complexity of patient's needs. On the day of the inspection we were invited to observe the meeting. The process ensured that people's needs were understood and could be catered for on admission. One patient we spoke with had encountered a range of health services prior to being an in-patient at the hospice. They stated that the hospice provided "exactly what I want". This included reference to the communication between different settings in which they had received care and the hospice. They felt that it was only after starting to use the hospice that the "system was working".

Patients cited the day hospice in particular as providing an improved, integrated, approach to their care. Staff were described as being very helpful reviewing and coordinating their treatment and support from a range of services. The patients we spoke with felt that the transition from using the day hospice to being an in-patient went smoothly.

The relative of a patient supported in the community described the very smooth transition of their relative's

admission to the hospice for a one week stay. This was organised by the hospice team in consultation with the patient's out-of-hours GP. By adopting a multi-disciplinary approach people told us that they experienced well planned and effective arrangements when moving between care services.

As part of the care planning process end of life planning was considered. We found that, where people did not feel ready to discuss this particular aspect of their planning, this decision was documented and respected. Discussions were documented about the patient's understanding of the severity of the disease and likely prognosis, preferences for future care and treatment, and what to do in a crisis. The basic premise of the discussion was "what would you like to happen or not to happen?." The person's wishes and choices were communicated to the relevant hospital team, GP, community team and support services, as appropriate. Advanced decisions were recorded so that everyone knew what to do without delay, such as resuscitation decisions.

Are services caring?

Our findings

During the inspection the patient's who used the service were given emotional and physical support and their wishes were respected.

We spent the day talking to patients who used the service and their relatives. A family member spoke about the young children of a patient being made to feel at home on the regular and sometimes long visits to their relative, each child being made to feel special and being issued with their own security card for entry to the unit. A relative of an in-patient described the staff as "incredibly caring".

We observed a relative of an in-patient being shown around the hospice? On the day of their admission. The member of staff was providing a high level of detail and care that was reassuring. They also gave the person practical information: security card for out-of-hours admission, use of the coffee machine and encouragement to use the common areas and facilities. There was very much a "make yourself at home" approach.

Staff were sensitive to the emotional needs of patient's and could offer appropriate and effective support as needed. A member of staff described the efforts made to support a patient's feeling of autonomy over their medicines administration after admission, so that times of when a patient was used to taking their medicines at home were, as much as possible, kept the same rather than conforming to the times of the "rounds".

Patients told us felt they were listened to and their needs and request were acted upon in a way that made them feel they mattered. This was not just in terms of major adjustments to treatment or care, but by the seemingly small gestures and details that made a huge difference to comfort and morale. Examples given were; the immediate response to a comment from a patient that they were uncomfortable in bed so that they were given an adjustable bed and a longer mattress more suitable for their height; another patient saying they were moved to tears when greeted like "an old friend" by staff when they returned to the hospice after a weekend at home; all efforts to provide meals that patients felt like eating, and on several occasions when family members were offered food and children visiting were given ice cream. One relative of an

in-patient described how "little things make such a difference" and the care received by their relative and the whole family is "second to none." They stated that "as a Bristolian I am very proud of this place."

We saw that interactions between staff and with other people were positive. Staff presented a sense of familiarity with individuals, smiling and using names on greeting, while maintaining a high level of professionalism and respect. We saw that the atmosphere around the hospice was calm whilst active and purposeful. One patient commented "it is as light-hearted as it can be".

All patients we spoke with, including those in the community, felt well supported by staff at the hospice. This included emotional support offered by staff on the unit as well as the sessions delivered in the day hospice, by the spiritual care coordinator and the music therapist.

Systems were in place to support patients to have a dignified death. We found that advance care planning discussions were held between an individual and the healthcare professional about future needs. This enabled the patient to establish their priorities in end of life care and help them plan their future and prepare for death, allowing them to maintain control over their wishes. Their preferences were documented and communicated to all professionals involved. The plans we reviewed also encouraged the patient to include family members in their discussions. The documentation held deeply sensitive information about the person's and family member's thoughts and views about their end of life care and preferences. The patient's permission was sought for recording discussion and sharing the information with healthcare teams and their family. Where people did not feel ready to discuss their end of life care this decision was respected and documented. The process helped to ensure that staff knew the person's wishes and could respond to them in their end of life care.

During the previous financial year (1 April 2013 – 31 March 2014) the service received over two hundred and fifty compliments in the form of cards and letters. Comments included: "Thank you very much for all you did for x during the last period of his life. I know x was appreciative of your excellent care and kindness you showed towards him. I would also like to thank you for the care and kindness you gave us. It made the experience of being with x when he

Are services caring?

died, one of calmness and dignity. We cannot ever thank you enough” and “may the magnificent work of caring for loved ones at the end of their lives by St. Peter’s Hospice long continue”.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We observed that people received personalised care that was responsive to their needs. We found that the detailed assessments conducted by the hospice team enabled staff to ensure that pain and symptom control was personalised and appropriate for each patient because it was regularly under review and monitored.

Care and treatment were available that enabled patients to receive personalised care that met their needs. With respect to pain and symptom control there were options of pain killers that were administered in various ways. This was dependent on where the pain was, the severity and at what stage patient's were with their illness.

There were also various non-medical approaches available to patients to help pain and symptom control. Staff explained these were not an alternative to medical care but an enhancement of care whereby other therapies worked alongside those that were medical. This included emotional and spiritual support, developing coping strategies, relaxation and distraction techniques and complementary therapies (CT). To receive these therapies people were referred from another member of the hospice team such as a doctor or community nurse specialist.

We met with a member of staff who provided CT to people. Therapies were planned with the individual and options were discussed and how the therapy worked. This was to ensure the CT was effective and meaningful to each individual. CTs included massage, aromatherapy, head and neck massage and reflexology. CTs helped to relax people, improve mood and sleep, relieve tension, anxiety or stress and promote a sense of general well-being. We spoke with a person who had just received a CT and they were "very pleased" with the therapy and told us how it helped them to feel "relaxed and ready for the day ahead".

In addition to CTs people were able to take part in art and music therapy. We spoke with the music therapist. It was evident that the benefit of music therapy was different for each person. Each style of therapy helped people in different ways and it was tailored to individual choice.

The music therapist told us that, for some patient's, "music stopped or alleviated the gateway to pain". We joined in session of musical therapy to understand how it worked for

people. This particularly related to ways of self-expression and releasing anger, frustrations and fear. One patient described the therapies as "allowing you to step outside of yourself".

Patient's receiving end of life care were often worried about their families "when they were gone" and this gave them immense emotional pain. One person had recorded themselves singing songs that they used to sing to their children. They wanted their future grandchildren to be able to hear them singing these songs to them. Other people wrote songs or poems to express how they felt. There was an array of musical instruments in a dedicated music room. We were told that some people would simply want to bang hard on a drum to relieve or express their anger whilst others would play gentle musical scales on an instrument in order to relax and find inner peace.

The staff listened to family members in order to support the person appropriately. One family member described when they were having "a bad day" and feeling "very angry" and how perceptive a member of staff was to how they were feeling and how helpful the member of staff was. The music therapist was also praised by the family member for the support they gave. The person told us "they recognise the priorities in terms of what a family needs at a time of crisis" and they "recognise what is needed at that moment".

We found that that the day hospice provided a supportive environment, enabling people to have an increased sense of confidence and empowerment to support people living with their illness. It was run by a small team of experienced nurses and a doctor. Individualised care was provided with access to specialised skills such as physiotherapists, social workers and the CT team. They also ran a six week course to enable patients to manage fatigue and breathlessness more effectively and regain a sense of control.

We observed staff being sensitive to the specific needs of individuals and offering a highly personalised approach that was effective and well-received. In terms of diversity one patient in their thirties commented on their attendance at the day hospice. They said they were by far the youngest but that did not matter and they felt as included and involved as everyone else. When there was an activity they did not want to be involved in they were able to find something they preferred to do, such as attending a complementary therapy session instead.

Are services responsive to people's needs?

(for example, to feedback?)

The role of the day hospice was regarded with the utmost importance by the people who use it. It provided a weekly treatment review with additional consultations arranged as needed. It also provided a welcome coordination and overview of the care received in different settings. One person we spoke with told us “there’s been a solution to everything I have been worried about” and referred to the “outstanding communication” and “reliable staff”, including both hospice and community staff. One relative of a patient commented that the day hospice was very helpful in picking up and dealing with any new problems as they arose.

The Community Nurse Specialist (CNS) Team offer community support to all patients referred and accepted to the hospice services for community intervention. The CNS teams provide on-going support for patients. They offer symptom control, psychological support, family support and liaise closely with GP’s and District Nurses. To ensure that all levels of hospice service are used appropriately to meet the patient’s needs they meet one of the hospice consultant’s to talk through their patients’ needs and identify further input that may be helpful.

We found that the CNS Team enabled people to speak about what is important to them and the team provided access to relevant services. The relatives of two patients in the community described having access to support and facilities offered by the hospice. The relative of one patient said how helpful it was to be in touch with the hospice spiritual care coordinator. This had been organised by the community nurse and initially involved telephone conversations with the spiritual care coordinator and a visit to the hospice had been arranged. Another patient received a monthly home visit from the music therapist who was praised for the support they provided and their communication skills. The relative told us “x seems more at ease when the therapist has gone – they know how to put things”.

The care plans viewed highlighted that a full assessment of the person's needs had been undertaken by the service.

This meant that staff had the information and knowledge about the person regarding how to meet their care needs. As part of the process a patient’s capacity was considered under the Mental Capacity Act 2005. People and those that mattered to them were formally encouraged to make their views known about their care, treatment and support. Each care plan identified the patient’s views regarding their condition, their thoughts and expectations of the service. We found there was an in-depth review of the person’s views about their condition, what was important to them, their spiritual beliefs, family views and fears. The care plans were amended regularly to reflect changing conditions, needs and the person’s views. A summary of resuscitation discussions were held with the patient and their relative. Their views on this matter were also held on file and their requirements were understood and respected by staff members.

We reviewed the systems in place for assessing and monitoring the quality of the service. The service conducted an annual Patient and Carer Outcome measure questionnaire. Two hundred and eighty completed questionnaires were received between August 2012 and March 2013. A number of positive results included that 100% of respondents felt they were always treated with respect and dignity and they always had confidence in those caring for their relative/friend. When respondents were asked how to improve service two patients mentioned food on the in-patient unit could be more appetising and one mentioned the lack of facilities to heat up food for relatives. Owing to the comments made we were told that the service will be examining these issues at their next impending User Involvement Forum.

Patients and family members we spoke with were clear on who they would speak to if they had any concerns or complaints. They were confident that if any concerns arose they would be dealt with promptly and successfully. No one we spoke with had needed to raise any concerns with the service.

Are services well-led?

Our findings

The leadership of the organisation assured the delivery of high quality personalised care and supported learning and innovation.

At the time of our inspection there was a registered manager in post. Staff we spoke with felt well supported in their role. We were told that regular staff meetings were held across the hospice teams, and a number of diverse issues were discussed. We viewed the minutes of recently held staff meetings. Issues discussed included patient reviews, reflective practice, medicines policy, clinical audits and team building days. This ensured that the staff and the registered manager were kept fully informed of any issues arising regarding people's needs and the running of the service.

Interactions of discussions were observed between a senior manager and members of staff at all levels of responsibility, and between a middle manager and members of her team. In all cases, there was a very positive and professional rapport. We observed that there was a high regard for mutual team support and support amongst staff member was integrated into the daily routine as needed.

The staff we spoke with presented a clear understanding of what to do if they had any concerns about the practices adopted by the service. Staff were supported to question practice and they told us that they would approach the registered manager in the first instance. If they did not feel that the registered manager responded in the appropriate manner they were all aware of the reporting mechanisms in place and would contact the relevant external authorities, such as the local authority or the Care Quality Commission.

The service placed a strong emphasis on education of its own staff and to those caring for dying people in other settings, such as in a person's home. The Education Department has an established centre for the provision of palliative care (comfort care and symptom management) education. Examples of this included offering certificated courses aimed at increasing skills and knowledge in relation to end of life care. Courses also included ethics and end of life care which was aimed at registered practitioners who require more information about working and providing care for patients who were at the end of their life.

We found the staff worked with key organisations, including the local authority and the national charity, Help the Hospices, to support hospice care provision. The service has begun work on a major new partnership with Bristol Community Health that is to coordinate end of life care across Bristol as commissioned by the Bristol Clinical Commissioning Group. The Group are a clinically led membership groups of GP practices that plan, commission and manage a range of local health services. Staff are involved with reviewing quality issues relating to patient safety and benchmarking and comparing data with other hospices to review differences/similarities in practice. This will enable them to draw on trends and share methods of best practice. They are working together with these organisations with the objective of improving end of life care throughout the UK and within their own service.

During the previous financial year (1 April 2013 – 31 March 2014) we found that 21 complaints had been received. All the complaints had been examined in detail and an investigation was undertaken by a person nominated by the Director of Patient Care and were dealt with in accordance with the complaints policy. Complaints were examined by the management team and the trustees. This led to new initiatives being incorporated by the service such as improved access to clinical supervision and a new method of peer review in clinical practice. This ensured that the improvements had been made where concerns had been substantiated.

The Director of Patient Care enabled and encouraged open communication with staff members and patients. We viewed the report of the Director's general hospice spot check visit made on February 2014. This involved talking to patients of the day hospice, carers of in-patients, and staff members crossing all levels of responsibility and establishing their views. Patients, carers and staff alike were, without exception, overwhelmingly positive about their experience of the service. The staff interviewed were proud to work for the service and used the term "privilege" in relation to their work. They were positive about the leadership and being accessible particularly when "walking the floor." This position was reflected in the conversations we held with staff and patients. One of the issues identified by the Director regarding the conversations held was that day patients felt a real loss of the social networks established when they have reached the end of their twelve week programme provided by the day hospice. This posed the question to the Director of whether the service could be

Are services well-led?

more proactive in supporting the social networks that emerged from the twelve week programmes. The proactive level of communication encouraged by the service ensured questions are raised on how to continuously improve. This area for improvement is currently being examined by the Director of Patient Care.

There was an effective system in place to manage accidents and incidents and learn from them. There was a process for recording any clinical or non-clinical adverse events that had resulted in actual or possible personal injury. The information was collated and analysed in order to establish where improvements could be made. When necessary, we found that action had been taken to reduce the likelihood of them happening again, such as medicines errors. The system in place allowed the management team to identify, analyse and review adverse events. In the case of a specific medicines error the service introduced regular clinical supervisions for junior doctors by their allocated consultant to review performance and provide training support, if required.

On the day of our inspection we examined the staffing rota for a four week period for the day services and the current week of the in-patient unit. There were sufficient numbers of staff on duty to meet people's needs. We found the staffing levels were maintained to the planned level as determined by the provider's dependency tool. This determined the current staffing levels in place based on the patient's needs. If unexpected absences occurred we found there was a protocol in place to ensure the absence was filled. The management team either called on existing staff or bank staff to work. This meant they had a robust system to respond to unexpected changing circumstances in the service such as covering sickness, vacancies and absences. We observed that staff were available for people throughout the day and they were attentive to people's needs and they did not rush people. Staff, patient's and relatives we spoke with felt there were enough staff to assist with patient's needs.

We identified that there were robust support arrangements in place which monitored and reviewed members of staff involved in delivering care, treatment and support. Regular staff supervisory review arrangements and performance reviews were in place which supported the professional development of staff. Staff members we spoke with told us that the process encouraged open discussion and reflection on practice and performance. This support reviewed their effectiveness when delivering care and support. Without exception the patients spoke very highly of the staff and their abilities.

To ensure patients were protected against risks of inappropriate or unsafe care the management team regularly assessed the quality of services provided. A recent example of this included an audit of the transfer of patients to nursing homes from the hospice in-patient unit. The audit identified that there were good levels of communication with patients, families and staff. However, it was identified that there was poor recording of these communication activities on their planning checklist which was designed for this purpose. As a direct consequence of this audit they reviewed the suitability of their electronic and paper records to ensure this area of their practice improved.

Owing to the organisation being a registered charity the board of trustees have overall responsibility for the management and administration of the service. We found that regular reports were produced for the board of trustees regarding the overall performance of the service. To ensure they have a reasonable overview over each area of the organisation a number of sub-committees had been set up. The sub-committees covered such issues as investments, resources, clinical services and governance. The reporting mechanism in place enabled the trustees to regularly assess and monitor the quality of the services provided. This assisted them in their decision making to scope future projects such as extending their work with outside bodies such as Help the Hospices alongside assessing the continuing work of the service.