

Hospice of St. Mary of Furness

# Hospice of St. Mary of Furness

## Inspection report

Ford Park  
Ulverston  
Cumbria  
LA12 7JP

Tel: 01229580305

Website: [www.stmaryshospice.org](http://www.stmaryshospice.org)

Date of inspection visit:  
02 June 2016

Date of publication:  
09 August 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

The inspection took place on 31 May and 2 June 2016 and was unannounced. At our last inspection the registered provider was meeting all the regulations that were assessed.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The Hospice of St Mary of Furness is registered to provide specialist palliative care, advice and clinical support for adults with palliative care needs, life limiting illness and also their families. The hospice delivers physical, emotional, spiritual and social holistic care through teams of nurses, doctors, counsellors, a chaplaincy/ spiritual care team and complimentary therapists. The hospice worked with the palliative care consultant for the local NHS Trust to try to make sure the team provided seamless holistic care. The service provides care for people through an In-Patient Unit, a Day Service, and Hospice at Home. The hospice also offered a 24 hour telephone advice line for people and their carers to request help if there was a need for it.

The inpatient facility accommodated up to nine people and they were all within individual rooms. At the time of the inspection there were seven people using this service. The hospice at home service provided specialist advice with regards to symptom control and worked in partnership with health and social care professionals to ensure that people and carers received the best possible support whilst the person remained at home.

The Hospice of St Mary of Furness is located in a residential area of the market town of Ulverston. It is an older detached stone building with modern extensions to accommodate patients in individual rooms. The hospice has undergone substantial external and internal refurbishment to extend and improve facilities. The addition of an orangery has provided a place where patients and their carers and family can spend time together; staff can also use the orangery as a place to relax. Although built on a hillside, the hospice has level access for those with impaired mobility. The internal refurbishment has provided improved assisted bathing and showering facilities for patients and facilities for carers and family have also been improved.

People told us they felt safe while receiving services from the staff team and that "I have total confidence in the staff; they're all highly skilled and know their jobs". We found during the inspection that the people using the hospice services were placed at its centre and were treated very much as individuals and with respect and compassion. People and their relatives told us that staff understood their specific needs. A person who had used the service told us "I certainly felt well rested after my stay and would recommend the Hospice to anyone". We were also told "I am so at ease here" and how coming into the hospice was like "Being amongst friends".

Care plans in regard to all aspects of people's medical, emotional and spiritual needs were personalised and

written in partnership with people so their preferences were made clear. Staff delivered support to people respecting these wishes and preferences about their care and life choices. The catering team spent time with people to make sure the food and drink provided to people was of a high standard and that people could choose what to eat and drink whenever they wished to. We were told, "The food is absolutely excellent, better than a five star hotel and beautifully presented".

We saw staffing numbers and skills mix were planned to respond to changing needs and provide a high standard of care and to keep people safe. There were experienced palliative care nurses, health care assistants and nurse practitioners working on the inpatient unit to provide appropriate palliative and end of life care and support to people. There was a high level of expertise in the way people's symptoms were managed and clinical care was delivered. People told us that their pain was well managed and also that they received the support and understanding to deal with the emotional impact of their illness. We saw people who used the service were protected by the provider's thorough recruitment policy and practices.

A wide range of educational development programmes, meetings and educational support was provided to staff and management at the hospice and to external organisations to help develop their end of life care. All staff had access to person and professional development and training courses relevant to their different roles. Training and education programme was also available to all managers and those in leadership roles working in the hospice. We were told that the focus the training programmes for the coming year was upon developing and maintaining a positive culture and promoting leadership in services in order to "shine a light on forward progression". The overall goal for the year being of having an "outstanding place of work as well as an outstanding place of care".

The management and staff team undertook work in the local community to raise awareness and understanding of end of life care and to encourage health awareness. Strong relationships had been developed with local healthcare services and community groups so people received any specialist or individual support they required. This included care and treatment planning to make sure it was inclusive to meet the diverse and changing care needs of the local population. This also helped people to receive seamless care and treatment through shared working and knowledge.

Great emphasis was placed on promoting and ensuring dignity, respect and supporting the aspirations and wishes of the person who was receiving care. Staff and volunteers working for the hospice had been trained in how to protect people from 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 centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm.

A pharmacist inspector looked at the way medicines were prescribed and managed at the hospice. We found that patients were protected from the risks associated with medicines because medicines were used safely and were thoroughly monitored for safe use and effectiveness. The governance arrangements around the management of medicines including controlled drugs was thorough and consistently good..

The registered manager and staff we spoke with understood and were clear about their responsibilities to people around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were dedicated in their approach to supporting people to make informed decisions about their care. Where people were unable to make complex decisions for themselves the service had considered the person's capacity under the MCA and had taken action to arrange meetings to make sure any decisions taken were in their best interests.

The management team were highly visible and demonstrated strong shared values and a desire to learn about, develop and implement best practice throughout the service. There was a strong organisational and governance structure and all the people we spoke with who worked for or volunteered in the hospice were clear about their roles and their responsibilities toward the people using the service.

Feedback from people using the service, health and social care professionals and visitors was entirely positive. Staff took pride in their work, job satisfaction was high and continuous learning and development for all staff was addressed comprehensively by the registered provider, leading to positive outcomes for people using 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 using the hospice services were protected from the risks associated with medicines because medicines were being managed safely. Appropriate arrangements were in place for the recording, administration, storage, disposal and monitoring of medication systems.

People were safe and protected from harm. Staff knew what action to take if they suspected abuse was taking place and risks to people had been identified and risk assessments were centred on the needs of the individuals.

Staff levels were kept under continuous review to help ensure there was a high staff to patient ratio to ensure that people had their needs met promptly and safely. The service followed safe recruitment practices when employing new staff.

### Is the service effective?

Good 

The service was very effective.

There was a comprehensive training programme in place, that was subject to evaluation, to provide continuous staff and management development and to keep staff skills up to date. All staff had supervision, psychological support and appraisals and they told us they felt very well supported and valued by the hospice management team and trustees.

The staff and managers understood and applied the requirements of the Mental Capacity Act 2005 (MCA) 2005 and the Deprivation of Liberty Safeguards (DOLs) and were clear about their responsibilities under this legislation to promote people's rights and choice.

Staff worked in close collaboration with local community groups, other healthcare professionals and specialist palliative care teams, service commissioners and social services to make sure that appropriate support, advice and treatment was accessed safely and in a timely way suited to the individual

People were fully involved in deciding on the meals they wanted and were offered a wide range of homemade nutritious food and drink suited to their needs and preferences.

### **Is the service caring?**

**Good** ●

The service was caring.

People's views and preferences were central to the care and spiritual support being provided. This support that was being offered was individually tailored to meet people's beliefs and faiths and that took full account of the needs of family and close friends involved in people's support and care.

The service was very flexible and responded quickly to people's changing needs or wishes.

People were encouraged and supported to make decisions about their care and given time to make their own choices and this included about their end of life care.

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

**Good** ●

The service was responsive.

Staff showed that people mattered as individuals and they went the 'extra mile' to provide person centred and compassionate care. There was a strong sense of commitment shown by all staff to working together to providing the right care and treatment from the right professionals.

People and their families were being fully involved in assessing and reviewing their needs, making their own decisions and planning how their care should be provided including their stated wishes and priorities regarding their care and support at the end of their lives.

The service provided person-centred care based on evidence based best practice that focussed on continuous improvement and service development. This was to make sure staff understood and could respond effectively to people`s different needs which enhanced the quality of life and the care people received.

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

**Good** ●

The service was being well led.

The management team and The Board of Trustees gave strong and effective leadership that was proactive and had a clear strategy for the long term development and continuous improvement of the service.

Staff felt supported and valued in their roles and were proud to work at the hospice as they told us people were being placed at the heart of all their care and treatment.

The service promoted a positive and open culture. There was a strong commitment to and focus upon continuous assessment and improvement to ensure the services offered remained led by the needs of the people who used it and were inclusive to all people with life limiting illnesses.

# Hospice of St. Mary of Furness

## 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.

The inspection took place on 31 May and 2 June 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit. It was carried out by an adult social care inspector and a pharmacy inspector. The last inspection for this service had been in February 2014 and there had been no concerns.

We spent time during the two days speaking with people who used the services, their relatives and the staff in various parts of the hospice service. We spoke with four people using the hospice in patient services, one using the hospice at home and three relatives. We looked in detail at the care records and plans for four people. We looked in detail at the medication management and administration records and the risk assessments in place to see how care was being planned with people and delivered. We looked at records relating to the ordering, management, use and storage of medicines. We looked at the staff rotas, recruitment files, staff training and supervision records and records relating to the maintenance and the management of the premises and the equipment in use. We looked at records that related to how the home was being managed and how service quality and effectiveness was being monitored. We attended an inpatient unit staff meeting and also the clinical leads meeting that was focusing on risk registers.

On the days we inspected we spoke with four members of nursing staff, the inpatient/hospice at home sister, the hospice at home coordinator, four health care assistants, a nurse practitioner, the hospice chaplain, the Deputy Chairperson of the Trustees who was a retired senior nurse, the senior speciality doctor and the Head of Clinical Services (who was the accountable officer) and the Head of Administration and Finance. The accountable officer is the person who has a legal responsibility to ensure that controlled drugs



(drugs liable to misuse) are properly managed. During the inspection we contacted external health care professionals by email to seek their views on the care and service received. We also received email comments from three people who had used or come into contact with the hospice services who wanted to share their views and experiences with CQC.

Before the inspection, the provider returned a Provider Information Return (PIR). This form asks the provider to give us key information about the service, what the service does well and any improvements they planned. The registered manager had completed this in considerable detail.

We reviewed information we held about the service including statutory notifications sent by the registered manager about incidents and events that the service must send to us by law. No concerns about the service had been raised with CQC. We used this information to decide which areas to focus on and to help plan the inspection.

## Is the service safe?

### Our findings

Everyone we spoke with who used the hospice services and their relatives spoke in positive terms of the care and support they received from the staff and volunteers. A relative told us "I know that here [relative] is in safe hands, the staff are worth their weight in gold and I know they will do everything possible to keep [relative] safe and comfortable".

We observed that here was a high level of expertise in the way clinical care was delivered. The pharmacist inspector looked at the way medicines were prescribed and managed at the hospice and found that people who used the service were protected from the risks associated with medicines because medicines were being used safely. We watched a nurse and health care assistant give medicines to one person and saw that a safe procedure was followed. The patient told us that they were "receiving excellent care". They said "It is better than private health care" and that their family were "elated" because they "Know I feel safe". We were also told "Staffing levels are very good, even overnight".

People and relatives told us that they were able to talk openly about anything that concerned them and that staff were "honest and open". The management and staff promoted an open culture to help people to feel safe and to be comfortable sharing any concerns in relation to their comfort and welfare. There was a high ratio of suitably experienced and skilled staff to people using the service to keep people safe and meet their needs and expectations. Staff we spoke with told us that they felt that they had the time they needed to give people person centred and individual attention.

Staff levels were kept under continuous review and a recognised dependency tool was used to help assess the staff and skills required to support people's different needs. On the day of the inspection the dependency tool had been evaluated for the day to reflect people's needs and unit activity. Using this a limit was put on the number of admissions to ensure staff still had adequate time to spend with people.

We spoke with the staff about safeguarding adults and the action they would take if they witnessed or suspected abuse. The nursing and care staff we spoke with could tell us what might constitute abuse and how they would report it. Everyone we spoke with told us they would have no hesitation in reporting any safeguarding concerns and were confident that any concerns they might raise would be followed up by the management team and that prompt action would be taken to make sure people were kept safe. There were whistle blowing procedures in place for staff to use to raise concerns and so they knew who to seek advice from.

The service had clear policies, procedures and effective systems in place to help to make sure new staff were only employed if they were suitable and safe to work in a hospice care environment. We looked at the recruitment records of new staff and some volunteers and spoke with the new staff on duty. We saw that all the checks and information required by law had been obtained before all staff were offered employment in the hospice. Checks had been made to ensure that the nurses and doctors working in the home were registered with their professional body and fit to practice and these were checked at regular intervals.

Staff we spoke with described their recruitment process and the checks done and their induction. Induction had included spending time in other departments in the hospice to get an overview, meet people and orientate themselves. They told us they had seen it as "A gentle breaking in period. New nursing staff took part in a 'preceptor programme' where appropriate and received support and mentoring from a senior member of nursing staff. Preceptorship is a period of transition for the newly qualified nurses during which time they are supported by a preceptor, to develop their confidence as an autonomous professional. Staff we spoke with told us that they "always" had the time they needed to give people person centred and individual attention.

We looked at four people's medicine charts and saw that doctors followed national prescribing guidelines and nurses administered medicines in the right way. When patients were discharged they were given detailed, written information about their medicines. There were clear, detailed policies and procedures covering the different aspects of medicine management. The link pharmacist did a three monthly controlled drug audit and the hospice's local pharmacy provider worked with the hospice's pharmacy link nurse to do a monthly audit. These checks helped to identify any issues in order to improve patients' safety and prevent mishandling or misuse. It also helped to make sure that high professional standards and guidance were being followed in relation to medicines management.

Controlled drugs were handled safely and nurses checked the stocks twice a week. We checked a sample of five controlled drugs and found no discrepancies. The Head of Clinical Services was the accountable officer. The accountable officer is the person who has a legal responsibility to ensure that controlled drugs (drugs liable to misuse) are properly managed. They participated in local meetings and submitted reports to the controlled drugs local intelligence network. There was a system in place for responding to national drug safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Arrangements were in place to ensure that medicines incidents were recorded and fully investigated and analysed under the clinical governance systems.

Some hospice staff visited patients in their homes (hospice at home service). They liaised closely with district nurses when arranging visits and would sometimes administer medicines or request and collect prescriptions for the patient. Patients had a record and medicine chart in their home which the GP, district nurses and hospice at home staff all used to ensure good communication, for example about times doses of medicine had been given. Electronic records were also shared, with the patient's consent to make sure information was up to date.

Staff were able to describe in detail the action needed to support the people they were caring for and what action was needed to manage their different needs. Care records showed that people had their needs and risks fully assessed and regularly reviewed throughout the day using accepted measuring and monitoring tools. This helped to make sure that people received the support they needed to live the lives they wanted and to stay safe. People's care plans included risk assessments for swallowing problems, skin and pressure area care, falls, moving and handling, mobility and nutrition and risks specific to their conditions. This helped to make sure that people received the support they needed to live the lives they wanted and to stay safe.

Emergency contingency plans were in place for foreseeable emergencies and there were on-call managers covering 24 hours. Records indicated that the hospice complied with Health and Safety regulations and had a programme of buildings and equipment checks and maintenance. There were procedures and guidelines about managing infection control. There was a designated link nurse for infection control who took the lead role.

## Is the service effective?

### Our findings

Our observations demonstrated, and training records confirmed, that nursing, medical and care staff had the knowledge, expertise and communication skills to provide people with a high standard of holistic care and treatment. People using the service were entirely positive about the staff and care provided. We were told "I have total confidence in the staff; they're all highly skilled and know their jobs". Another person told us "I would never be anxious about coming back here when I need to. They have worked wonders with me". We were told "I am so at ease here, when I come in it's like staying with friends". One person using the service told us "This really is an amazing place, nothing we ask is ever too much. When I have had problems they talk with me and are always ready to listen and talk things through and then get on with doing something about it".

A relative told us "You just don't realise how important and what a difference it makes to us all until you have experienced this kind of care and attention. They have never kept anything from us, we can discuss anything". We were told "The nurses are kindly, fast, efficient and caring, every request I have made has dealt with promptly and efficiently". One person told us "They [staff] really put themselves out for you and are very concerned about looking after my family as well". Other comments made to us included "The food is brilliant, can't do enough for me, they tempt and coax me with whatever I fancy, I only have to say and it's here. Nicely presented too".

Staff told us how important it was that they offered people choices, favourite foods and high calorie snacks if their appetite had reduced. They said they could offer people high calorie drinks or snacks if people felt they were unable to eat a full meal. The cook visited people on the inpatient unit daily to find out what people enjoyed and about particular preferences or dietary needs. Survey comments also praised the food, for example, "The food was first rate, tasty, appetising, with a good choice of menu". Another person told us "The food is absolutely excellent, better than a five star hotel and beautifully presented. I have eaten in some good restaurants and this would be among them" and also "There's a good menu but the cook will do you anything you want".

Nutrition risk assessments were carried out with people and used to identify specific risks associated and these were subject to continuous review. This identified people's dietary needs, if they needed assistance to eat or drink and what type of food they had to have soft, pureed or normal diet. If people found it difficult to eat or swallow advice had been sought from the dietician or the speech and language therapist (SALT). There were clear management plans and checks for staff if nutrition had to be provided via a percutaneous endoscopic gastrostomy (PEG). This is a system by which people that are unable to take food or fluid by mouth receive supplements via a tube directly into their stomach.

Survey results we looked at were also very positive, including "The medical staff were well qualified, compassionate and professional and "My pain was really well managed". Health and social care professionals who were involved in people's care and treatment we spoke with told us that the staff worked collaboratively. They told us staff made changes to people's care and support, following consultation, when it had been needed.

The hospice philosophy and values were understood by all the staff we spoke with and they confirmed that had been developed through collaboration with them, the volunteers and trustees. Internal newsletters, staff briefings and visible internal communication had been part of establishing this shared understanding and the practical implementation.

The hospice took a strategic approach to training and development. The hospice management team and staff placed great importance on developing and supporting staff. This was to make sure people using the hospice received a high standard of effective care from nursing and care staff that had the knowledge and skills they needed to carry out their roles and responsibilities. The hospice was using regional development funds with the University of Cumbria to help some nurses top up their qualifications from diploma to degree level and allow them to further develop their knowledge base and skills as practitioners. Funding had also been accessed for the training and development of an assistant practitioner. This supported and promoted the development of health care assistants in the team. In this way all members of the team were encouraged and supported to develop different skills and contribute to the effectiveness of the team as a whole.

The hospice management placed great emphasis upon preparing staff to take on new roles and challenges to develop themselves and the services they could provide to people needing palliative care. For example the two nurse practitioner roles were to enhance service provision as they assessed people's needs and diagnosed health challenges. Their enhanced clinical skills made them knowledgeable about a wide range of medical conditions and they provided emotional support to patients and family members facing devastating diagnoses. Their skills were also used to raise awareness through training and engagement with the local community. For example work had been done alongside a local football team to raise awareness of men's health issues in the community.

A training and education programme was also available to all managers and those in leadership roles working in the hospice and this programme was continuing. The registered manager told us in the PIR that the focus of this programme for the coming year was upon developing and maintaining a positive culture and promoting leadership in services in order to "shine a light on forward progression". The overall goal for the year being of having an "outstanding place of work as well as an outstanding place of care".

A new permanent clinical development nurse role had been implemented in order to provide support in the further development the clinical education and audit activity to strengthen the hospice's evidence base. The role was one of quality assurance, promotion of evidence-based practice and clinical staff development. The role also supported the development of assessment documentation and care-plan templates on electronic records, undertakes evaluation of service provision and action planning and supported the development of clinical mandatory training and its delivery. This extensive role also co-ordinated the student learning experience and mentorship programme.

Regional development funds had also supported the roll out of emotional resilience training for all groups of staff across the hospice. The management team had recognised that hospice services were changing and were under pressure to be ever more efficient. The aim of resilience training was to keep employees healthy, happy and effective even in times of such change. The hospice had set the goal of making sure all staff had the opportunity to participate in this training to at least level one to promote their own resilience and wellbeing. Also access to mindfulness and relaxation was being put in place for staff to use.

Research and current best practice (NHS Health and Wellbeing: Final report. Department of Health; 2009) in palliative care has indicated that the nature of the work with patients who are dying can lead to staff experiencing a sense of chronic anticipatory grief and loss. It also highlighted that the quality of care dips if staff are not well or happy at work. Therefore the hospice team had taken a proactive approach in

recognising resilience as a vital ingredient for all working within palliative and end of life care to maintain staff wellbeing and high standards of care.

All staff and volunteers had induction and training tailored to the roles they would fulfil and any specific needs. There was a clinical mandatory training schedule for nursing and, where appropriate, care staff working in the hospice, some scheduled annually and others at two and three year intervals. Mandatory training was concerned with minimising risk, adhering to safe procedures and policies and was monitored at performance and development reviews (PDR). This schedule included moving and handling, symptom management, end of life care, blood transfusions, nutrition and hydration, wound management, skin care, assessment and prevention of falls, incident reporting, the Mental Capacity Act (MCA), safeguarding, conflict resolution and de-escalation, lymphedema management and the use of equipment required by the nursing role, such as syringe drivers.

In addition staff with link roles had training and development focussed on service needs for example pain and symptom management, communication and leadership and management. Two senior nurses were undertaking the Advanced Nurse Practitioner MSc in order for them to work as clinical leaders within and outside the hospice. We spoke with a staff member doing this who confirmed the support and encouragement that had received in taking on this level of study. They were being supported to develop into their enhanced role in a very structured way working with the nursing and medical staff. They told us that the implementation of their role "felt safe and paced" and policies and procedures had been reviewed to encompass their role in prescribing.

A member of staff told us "I get a lot of opportunities to attend training, I can top up my degree with a palliative specialism and I get a lot of support from the sister and junior sister. They don't try to overload me but keep me interested and motivated. I am taking on extra training for my new link role. It's good". We saw records of all staff having had regular supervision and annual appraisal and staff told us they could speak with managers "at any time" if they needed to.

We found that the approach being taken to staff training, support and professional development was one that was continuously looking for ways to help the staff continue to improve their skills and progress professionally in a safe and structured way. We could see that time and resources were made available for mentoring and supervision to help make sure what staff learnt was being put into practice safely with the aim of putting the experiences of the people they cared for at the centre of the service.

The records in people's care files we looked at showed that consent to care and treatment was being sought from people in line with legislation and guidance. The service had clear procedures for assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests. The Hospice Head of Clinical Services was a trained Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing. They actively supported work to enable information sharing where it was appropriate to share and advised on options for lawful and ethical processing of information.

The hospice had a clear policy on administration of medicines covertly [without a person's knowledge] that set clear boundaries and instructions around its use to safeguard people. Such medicines were only to be given following an assessment where it was shown that the person was not able to make an informed choice and understand what the consequences could be of not taking their prescribed medicines.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that people were assisted to make informed decisions about their care and treatment options. Records showed their care wishes were explored with people and recorded and included the use of deciding rights principles. Management and staff we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005 and how to put this into practice.

## Is the service caring?

### Our findings

Everyone we spoke with who had used the hospice services and their loved ones told us that they had always been treated with dignity, respect and compassion. They praised the staff and volunteers highly for their thoughtfulness "attention to detail" and their caring nature. We were told "It's outstanding, it really is fantastic place, so professional but at the same time so caring" and also "The staff here must be handpicked, they are so kind and caring".

People using the hospice expressed to us how much they valued what the service did for them. One person shared with us how it had really made a difference to how they felt both physically and emotionally and told us "I'm feeling pretty good now but if you had seen me when I first came here you would not have recognised me. They [hospice team] have helped me so much on every level and I feel I can cope better now. If I have a problem now I am not afraid to ask for help; they have shown me the way." Comments made to us included "I feel that I am in charge and they [staff] listen to me, it helps me stay positive" and "It's so good they never rush me, I have my own space and they don't intrude unless I want them to". We were told "What has been so vital is their huge capacity for emotional and psychological support that I so needed although I didn't know it at the time". Staff we spoke with felt they had the time and resources to give people the care they wanted and needed. A staff member told us "Here I feel I really can take the time people often need and give my patients and their families the right care and level of support for them as individuals".

One person told us "My privacy is respected and it's so very peaceful here, not solemn because we have lots of laughs and fun, no grumpy faces here" and another said "They are always so cheerful, even in the middle of the night". Another comment was "I certainly felt well rested after my stay and would recommend the hospice to anyone". Staff told us how they worked in a way that protected people's privacy and dignity. For example, the importance of making sure people were happy with them coming into their room, knocking on their doors and asking permission to come in before opening the door. We saw that doors were closed and curtains drawn while any care, consultations or treatment was in progress. One person told us "I can discuss anything, they are all very discreet".

We saw that the way care was organised focused on the individual and their stories, views and life choices. This information promoted a holistic and person centred approach as staff had the information to support people in a way that met their wishes, beliefs and preferences. Records showed that staff worked with people supporting and giving them information so they were empowered to make their own decisions about their care and treatment. One person told us about the care they received in the following way, "They [hospice staff] make things really special for you, at Easter an egg was left on my bed, at Christmas a present. It's really lovely because we really do matter to them".

We saw people had been able to discuss with staff their spiritual and cultural beliefs and how they wanted these to be met and respected. There was a voluntary chaplaincy service to offer pastoral and spiritual support whatever a person's individual beliefs. Volunteers and staff from the Family Support Service offered counselling and a support bereavement service that could remain in contact with relatives for as long as they felt it was useful to them. The chaplain had also been involved in providing training for those working in



the hospice environment and worked with the bereavement team to support them in their work. The hospice has linked with 'Cancer Care' to facilitate access to their adult and young person's counselling services. This was to give families access to a more structured service than previously. 'Cancer Care' also had a qualified Children's therapist who could also offer supervision to hospice volunteers who occasionally worked with younger family members. (Cancer Care is an independent charity in North Lancashire & South Lakeland for families affected by cancer and other life limiting conditions).

The chaplain told us about the cooperation between local churches to provide network of contacts from other world religions who could offer support and comfort. For example the hospice is close to a Buddhist community and they had worked to meet a person's wishes in relation to have daily visits from a Buddhist monk. The hospice also provided a place where the monk could support the person spiritually and guide them to a peaceful death through chanting and meditation, as the person wanted.

The hospice held events within the community to help families and friends remember their loved ones and to help alleviate a family's pain. These included the 'Light up a Life' and annual remembrance ceremonies to offer families the opportunity to come together to reflect upon their loss.

We saw in care planning records that advanced care planning assessment and end of life care plans were done with people. This allowed people to be clear about their expectations regarding their end of life care and their wishes at this important time. This helped to ensure that people's final wishes could be met. Records indicated that people's wishes were treated with the same respect in death as in life.

We found the hospice environment to be calm and informal and the unit was open to relatives and visitors to visit and stay day and night if they needed to. Places were available for people to use as they wished including for prayer or reflection, 'The Orangery Café and terrace, the reception area, the gardens and a quiet family room for care and privacy after death. We could see, and relatives told us, that staff "went the extra mile" and invested their own time in helping people live full lives, make their own choices, and be part of the local community. We found staff and management to be passionate about and dedicated to their work

## Is the service responsive?

### Our findings

People who used the service told us that the staff teams consistently responded to their individual needs. Without exception people we spoke with and their relatives told us they were "grateful" and "very happy" with how staff had provided treatment and cared for them and the support given to their families. We were told "They go that extra mile and more, they are always interested and move fast when they have needed to for me". Other people told us "The standard of care here is exemplary" and "They [staff] make it so easy for you to do as you want; they asked me what my goals are and then help me make it happen".

A relative told us "They organised all the care we needed, it's unbelievable what they can do so quickly" and "It was all sorted by lunchtime so [relative] could come home as both [relative] and I wanted that. I could not believe all the planning and support they put in to do that for us". The hospice's own surveys showed that people valued the services provided. Including the comment "I cannot speak too highly of the Hospice. The care there was excellent throughout". The hospice used its established liaison roles with the local hospital to offer hospice at home as a fast discharge route when needed for people who wished to be cared for and die at home. The hospice staff worked jointly with community nursing team to care for people at home and the hospice nurses could use core end of life or 'just in case' medication to support a symptom free death.

Staff, management team and volunteers worked together to be responsive to the needs expressed by families in developing the services. We saw this demonstrated in the planning that had gone into developing and improving the services. For example the in-patient unit always had one bed allocated for respite care that was always occupied. A trial was underway to expand this to two respite beds and include emergency respite to the non-cancer patients. The hospice at home service had recognised an increased need for support at home and had accessed additional funding to allow them to increase staffing to offer support to more people at home. By having availability of both in-patient beds and Hospice at Home care the hospice could respond and support choice for people in place of treatment and death.

There was a strong multi-professional approach to responding to people's different needs. The hospice had a weekly palliative care multidisciplinary team meeting and a bi-monthly neurological multidisciplinary team meeting. These meetings encouraged good communication across professional boundaries and the establishment of a practical network with partner agencies. This approach had led to collaboration in service provision and to establishing a more seamless and effective care and development of services people could use. The hospice was part of a South Cumbria multidisciplinary dementia working group, which aims to promote collaborative service provision and the development of Dementia Communities. This development was aimed at making palliative care services more responsive to the needs of people at the end of their lives or with life limiting conditions that were also living with dementia. The Hospice of St Mary of Furness had drafted criteria explaining the use of hospice services with regard to people living with dementia and had initiated a closer working with the community psychiatric nursing team. This had helped in the development of collaborative local services for end of life care for people living with dementia. Also as part of this initiative hospice staff had been delivering education to GPs and primary care staff.

A range of ways to communicate with and care for patients with particular needs such as dementia was

used. For example through pictorial formats, the use of 'Talking Boards, reminiscence boxes and 'Tweedle Muffs' (these provide simple stimulation for active hands, while promoting increased flexibility and brain stimulation) for people living with dementia. The hospice had begun offering 'community neighbours' and dementia support to people using the hospice services and living with dementia. This was subject to a review to make sure the help provided was being effective for the person using it. Community Neighbours provided companionship and free practical help to any individual or families living with life-shortening conditions and to compliment the clinical and pastoral work of the Hospice in the local community. It helped people with practical aspects of life that were becoming more difficult to do such as, walking the dog, doing some gardening, light household tasks and generally give a helping hand.

We found that the hospice continuously looked for ways to better understand and respond to people's experiences and to work with academic institutions to develop knowledge in the field of palliative care. An example of this was in the joint work that had been initiated by the hospice with the University of Cumbria on 'Narrative Research' to identify aspects of care the service could develop or use to improve the experiences of people with end of life care needs improve. This is a relatively new research area with people at the end of life and has an analytical focus on the naturalistic storytelling of people and their and informal carers. This approach can throw a new light on individuals' perceived illness states and symptoms, their care-related needs, behaviours, and individual wishes and desires This collaborative work was started to promote a deeper understanding of people's experiences and keep a focus upon the lives of individuals as told by them through their own stories. The hospice planned to continue to develop the project to include people's families and work with academic colleagues to analyse the stories gathered to identify key themes and areas of significance to people. This should allow people the opportunity to explore their individual experiences and help uncover areas of risk and need at the end of life.

We saw that during the initial assessment process that relevant information was gathered from people and their families. This was so that staff could get to know as much as possible about the person, their needs, preferences and lives and what care and support they would require. There was close working with other professionals to make sure the hospice staff were prepared and able to meet that person's needs. Nursing staff explained how the care plans for people were developed and maintained and how they were stored securely on EMIS. This is an electronic patient record system that connects patient information across healthcare settings. We saw that written records were also kept as 'back up'.

A person centred approach had been used for one admission where the person had very complex individual needs. The pre admission and care records showed that planning for the admission had started months before and had been done with the full involvement of family and with the formulation of a continuously evolving plan to facilitate the admission. This advance planning involved the palliative care consultant, the MacMillan nurses involved and the staff supporting the person in their original care setting. We saw that the complex care being provided was in line with the appropriate guidance from the Royal College of Physicians and palliative care guidelines. The comments made to us and records we saw showed that the staff and management were meeting people's expectations of a person centred care service.

At the end of each working day there was a unit meeting that staff said they called 'The Hoot'. It was a team discussion about where they were up to as a team that day, what needed addressing, what had changed and if anything additional was required. Staff told us this "tied everything together" and allowed for planning ahead to make sure people's needs and preferences were known and understood by all staff so people's needs were met as agreed with them. Staff we spoke with displayed a clear shared sense of purpose around making sure any issues were followed up promptly.

There was a complaints procedure given to people on referral to the service and information leaflets on

raising concerns. There had not been any complaints made in the last 12 months. We saw that comments made were addressed no matter how small there were. Debrief sessions with staff following challenging or complex care situations and were also being used to highlight any concerns, learn lessons and change practice. A relative we spoke with told us "If there was anything we weren't totally happy with they followed it up right away and did what needed doing".  
to uncover issues of importance in care management.

## Is the service well-led?

### Our findings

Feedback collected from relatives was very positive and this had been recorded by the service. The themes running through the letters, cards and general feedback given to the hospice included the dedication of staff, and the competence of staff and the compassion and sensitivity shown to people and their families. We were told that all the staff and the volunteers whatever their different roles were "cheerful, kind and supportive" and were "unflappable". Our observations supported that staff across all areas within the service were highly motivated and committed to the continuous development of a high quality service to people and their families within and outside the hospice in the community.

People using the service, their relatives and staff said that the managers were approachable and supportive and they could speak to them whenever they wanted to "about anything". Feedback was being sought from people verbally on a daily basis and more formally by using surveys and relatives and professionals were also asked to provide regular feedback. There were also suggestion boxes within the hospice so people could make a comment or say what they thought at any time and also for anyone visiting the service to give their views.

There was a clear management structure at the hospice. The staff we spoke with were aware of the roles of the management team and trustees and told us they were approachable and had a regular presence within the hospice. During the inspection we saw that the management team were very visible in the hospice and we saw they related well to staff and staff said they felt confident to question practice or to raise any matters with senior staff. Senior management on call support was available out of hours and at weekends to support staff and come in if necessary.

Good communication was promoted throughout the service. There were weekly multidisciplinary patient reviews, twice weekly liaison visits to the local hospital to work with them regarding discharge planning and to give advice. The hospice clinical leads met at monthly intervals and there was a standing agenda item on clinical governance. The senior managers had regular meetings with the Board of Trustees and reported back on quality assurance and progress against the business plan and agreed annual objectives. Records showed that the service's accounts were filed with Companies House and the charities commission for audit and scrutiny. We saw that notes were circulated after board meetings and team meetings to keep all staff informed.

There were regular staff meetings and we attended one of these during the inspection. Staff had the opportunity to raise topics and there was a high level of engagement from staff. There were staff briefings and forums that focused upon staff related issues and an e-newsletter. The forums were held quarterly with staff representation across all the different hospice departments with the aim of getting staff to engage and feedback. The hospice trustees were part of this process and there had been positive outcomes as a result. For example, the implementation of the emotional resilience training for staff.

We found quality monitoring systems and processes to be thorough and consistent. There were established systems for gathering, recording and evaluating information about the quality, effectiveness and safety of

care. The management and senior nursing had a programme of clinical audits and safety checks across the year and also for the evaluation of projects. For example an audit of the EMIS patient records to measure record keeping performance against professional standards and guidance.

Clinical audits included three monthly controlled drug management audits, twice yearly infection control, nutrition and hydration and medicine administration audits. Controlled drug prescribing was subject to annual audit also medicines administration, medicinal gases, blood transfusions, falls prevention and pressure sore prevention. The pressure ulcer audit completed in April 2016 was based in NICE guidelines and against CQC's key question areas. The resulting action plan was used to inform improvements in practice, staff training and development. For example a review of the assessment tool being used, a laminated information sheet for people using the hospice, outlining the importance of pressure relief in their care and well being and CQC regulations and requirement to be included in mandatory training and staff induction.

The management team analysed and logged all significant Incidents using the '5 Whys' root cause analysis tool and reviewed all accidents in order to try to learn from these and apply that learning practically. This is a recognized technique used in the Analyse phase of the Six Sigma DMAIC (Define, Measure, Analyse, Improve, and Control) methodology. It is a tool that is easily applied without statistical analysis to help identify the root cause of a problem and so promote prompt analysis and action to prevent a reoccurrence.

The management team looked for ways to keep up to date with what was happening locally and nationally in the care sector and attended monthly pharmacy meetings, local network meetings and provider forums in order to achieve this. We could see managers had gathered information and researched what was available to help them progress and develop the hospice services. A 'ratings optimiser tool' had been used to support the staff and management in working to achieve and evidence each of the Key Lines of Enquiry (KLOE) used by CQC. The aim being that management and staff could assess and identify any areas of weakness against the lines of enquiry and where attention might need to be focused to improve.

Using a benchmarking toolkit the management have developed an action plan from identified areas for further improvement in relation to the CQC key lines of enquiry. Benchmarking provided the hospice with a mechanism to compare performance across a range of activities and against similar organisations as part of continuous quality improvement and an on going review of their practices. As part of this initiative a new post had been implemented across the five Cumbrian Hospices to lead on developing shared coding and improving patient record keeping in the EMIS system. The post was for 18 months against agreed performance indicators to verify its effectiveness.

The hospice planned to introduce palliative care outcomes with the Outcome Assessment and Complexity Collaborative (OACC) through a stepped approach during 2016 into early 2017. The measures were tools to measure patients' physical symptoms, psychological, emotional and spiritual, and information and support needs. They are validated instruments that can be used in clinical care, audit, research and training. The stated hospice aims for these measures was to help them enhance team working, be a driver of quality improvement, deliver evidence on the impact of services, inform commissioning and, most importantly, achieve better results for patients and families.