

# Rennie Grove Hospice Care Grove House

## Inspection report

Waverley Road  
St Albans  
Hertfordshire  
AL3 5QX

Tel: 01727731000

Date of inspection visit:  
20 April 2016  
21 April 2016

Date of publication:  
31 May 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

This inspection took place on 20 April 2016 and was unannounced. We contacted people and their relatives for feedback about the service on 21 April 2016.

Grove House is registered to provide specialist palliative care, advice and support for adults with life limiting illness and their families in their own homes. They deliver physical, emotional and holistic care through teams of nurses, doctors, counsellors and other professionals including therapists. The hospice also operated a Day Service however the only service which involved an activity the provider was registered for with the Care Quality Commission was the hospice at home service.

At the time of the inspection there were 55 people using this service. The service provided specialist advice with regards to symptom control and worked in partnership with health care professionals to ensure that people received the best possible support in their own homes. There was a counselling, pre- bereavement and bereavement support offered to families and relatives.

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

Staff were trained 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. Staff assessed the risks involved in delivering a service in people`s own homes. Staff communicated any risks to people`s health and well-being to health and social care professionals. They followed up and reviewed risks regularly to ensure these were appropriately managed and mitigated.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. Plans in regard to all aspects of their medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people respecting their wishes and preferences.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. Staff reported any concerns so that these could be reviewed and discussed to identify if lessons could be learnt to reduce the likelihood of reoccurrence.

Recruitment procedures were robust and ensured that staff working at the service were qualified and skilled to meet people`s complex needs. There were sufficient numbers of staff to ensure people received support when they needed it.

The service operated a 24 hour service and on-call system to ensure people received the same support and

advice during the day as during the night. This gave people great confidence and comfort. People told us they valued this service and they felt reassured to know they could talk to a member of staff any time during day and night.

People who used the Day Service told us that this service enabled them to meet the staff and form relationships before their condition progressed to a stage when they will use Hospice at Home service. They appreciated the opportunity to meet with people in similar circumstances and was a welcome part of the community support.

People told us that staff understood their individual care needs and were compassionate and understanding and that their cheerful and friendly approach gave them reassurance and made them feel safe. Staff told us they undertook training which enabled them to provide good quality care to people in their own homes.

People's medicines were administered by trained and qualified staff who had their competency assessed regularly by their manager. Any changes in people's medication were discussed with health care professionals to manage and support people's symptoms and pain management. Medicines were regularly reviewed and audited to ensure they met people's needs.

The registered manager and staff were clear about their responsibilities 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.

People and relatives were very positive about the caring and compassionate attitude of the staff delivering the service. They told us they were completely satisfied with their care and thought highly about staff and management. Staff were very motivated and demonstrated a commitment to providing the best quality end of life care in a compassionate way. People's wishes for their final days were respected.

The management structure showed clear lines of responsibility and authority for decision making and leadership in the operation and direction of the hospice and its services. The registered manager was committed to improve and broaden the services the hospice offered.

The service actively encouraged and provided a range of opportunities for people who used the service and their relatives to provide feedback and comment upon the service in order to continue to drive improvement.

There was a comprehensive auditing programme for all the services the hospice provided carried out by the management team. Action plans were comprehensive in detailing actions taken, time frames and the responsible person for the actions.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

Staff knew how to recognise and respond to any actual or potential abuse.

Potential risks to people were assessed and measures put in place to reduce risks. Where accidents or incidents occurred these were analysed and learning was shared amongst staff to prevent reoccurrence.

There were sufficient numbers of staff with the appropriate skills and knowledge to meet people`s needs at all times.

People received their medicines from staff who were trained and qualified in safe administration of medicines and the use of specialist equipment to ensure people received their medicines in time and safely.

Good 

### Is the service effective?

The service was effective.

People received support and care from a staff team who were well trained and used their knowledge and skills to meet people`s needs effectively.

Staff felt supported in their role by managers. They were encouraged to develop their knowledge and skills, follow best practice in regular meetings, one to one supervision sessions and yearly appraisals.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making decisions about all aspects of their treatment and care.

People were given advice on how to maintain a healthy balanced diet.

People's health needs were carefully monitored by nursing staff and if people`s health required, appropriate referrals were made to other professionals.

Good 

**Is the service caring?**

The service was caring.

People and relatives told us that staff were kind and empathetic and they provided excellent care and emotional support which was responsive to their needs.

Staff demonstrated compassion and understanding when talking about people.

Staff supported the emotional wellbeing of people and their relatives with end of life care being provided with sensitivity and compassion.

Staff made every effort to ensure people experienced a comfortable, dignified and pain-free death and they were cared for where they wished to be.

People`s right to privacy and dignity was promoted and respected in life and in death.

People were consulted about and fully involved in their care and treatment. The service was very flexible and responded quickly to people's changing needs or wishes.

**Is the service responsive?**

The service was responsive.

People and their families were fully involved in assessing and reviewing their needs and planning how their care should be provided, which included their wishes and priorities regarding their end of life care and preferred place of death.

The service provided person-centred care based on best practice and focussed on continuous improvement. Staff understood and anticipated people`s needs which enhanced the quality of the care people received.

The service encouraged people with life limiting conditions and their families' early involvement in the hospice by organising diverse activity groups part of the Day Service and complimentary therapies.

People's families were offered bereavement support and counselling as long as they needed it.

The provider had a positive approach to using complaints and

concerns to improve the quality of the service and this was closely monitored by the management team.

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

The service was well-led.

The service promoted a positive and open culture and provided a range of opportunities for people who used the service, their relatives and people from the wider community to comment and influence the quality of service provided.

The management team was pro-active in introducing new ways to meet the needs of people in the wider community and promote good practice.

The registered manager worked with other healthcare professionals and other providers of similar services to share best practice and have a positive influence on the care people received.

There were robust auditing systems in place to ensure the quality of the service was constantly monitored and actions were in place to constantly drive improvement.

**Good** 

# Grove House

## Detailed findings

### Background to this inspection

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

This inspection took place on 20 and 21 April 2016 and was unannounced.

The inspection was carried out by one inspector, a pharmacy inspector, a specialist advisor and an expert by experience. The specialist advisor had the experience working as a nurse within the community and within the field of palliative care. The expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We also reviewed information that the provider had sent to us which included notifications of significant events that affect the health and safety of people who used the service.

We spoke with five people who used the service, four relatives, two volunteers, four nursing staff, two care staff, two service managers, the clinical audit lead and the director of nursing and clinical services who was also the registered manager for Grove House.

We reviewed five people's care plans to see how their support was planned and delivered. We looked at a selection of medication records to check medicines were managed safely. We looked at a range of policies and procedures, quality assurance and clinical audits and meeting minutes for different departments.

# Is the service safe?

## Our findings

People and their relatives were happy with the service they received, they told us they felt safe and well looked after by staff who were knowledgeable and met their needs. One person told us, "I feel very safe knowing that any time I need them [staff], they will come and help." Another person told us, "They [staff] are my salvation. I feel reassured and safe because they [staff] are coming in time and help me to cope." One relative told us, "I cannot say anything but praise every single staff who comes to [relative]. They make my [relative] feel comfortable, safe and we know they [staff] are always at the end of the phone to help if we need them."

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. They described how they would refer people to the appropriate organisation if they had concerns to ensure people were protected from potential abuse. One staff member told us, "We are well trained in recognising any possible abuse. We have an on-call manager for safeguarding issues day and night. We can ask for advice and report any concerns we have."

Staff told us and we saw that they had safeguarding training and regular updates to ensure they were knowledgeable in safeguarding vulnerable people from abuse. We found several examples where staff reported incidents they saw or witnessed when visiting people in their own homes to management and social care professionals. For example when staff attended to a person they were told by the family carer that they were exhausted and tired and they could not look after their loved one safely. Staff reported this to the registered manager and a social care professional. They increased their support until arrangements were made for other agencies to offer additional support for the person and relieve the family carer to be able to rest. This meant that staff recognised the risk of potential harm to the person by not getting appropriate level of care and support and they took appropriate action to protect the person under the safeguarding procedure.

People had individual risk assessments which were reviewed every time they received support from the service. We found that an initial risk assessment was done for each person on their first day ` assessment day ` using the service and this was reviewed and developed further by nurses depending on the needs of the person. The risk assessment considered environmental risks for the person as well as risks to their health and well-being. For example we saw for one person the risk assessment considered the environmental risks like smoking and pets but also risks of their skin breaking down and potentially developing pressure ulcers. Staff involved the district nurse team in ordering a special bed and mattress to ensure the risk was mitigated. This meant that there was a multi-agency approach in managing risks and this helped to ensure better outcomes for people ` s health and welfare.

Risk assessments were reviewed daily by nurses and were updated appropriately. Staff were aware of the risks that related to each person and we saw evidence throughout care plans of people's involvement and preferences when measures were put in place to mitigate risks. For example staff recorded that they observed whilst offering support to a person that they were losing their mobility. Staff established there was a high risk of falls because of the person ` s poor mobility and the fact they had to climb stairs to get to their

bedroom. They discussed the risks with the person. The person wanted to stay in their own home so staff ordered a specialist bed for them to use downstairs in their home to mitigate the risks of falls. This meant that risk assessments were centred on the needs of the person and took account of people`s wishes and decisions.

Incidents and accidents were monitored by the registered manager and the quality manager. Staff told us they were encouraged to report any incidents or near misses which occurred. These were categorised by the management team to ensure relevant actions could be taken to prevent re-occurrence. Each type of incident had different actions and learning points which were shared with the relevant staff in meetings and handovers so lessons could be learned. We saw that one incident involved a piece of equipment which was in place to relieve the anxiety and pain symptoms for a person nearing the end of their life. The equipment stopped working shortly before the hospice staff arrived to the person`s home where they discovered and re-placed the faulty equipment. This was then sent to a specialist in medical equipment to establish the cause and the incident was also reported to all relevant partner agencies. This meant that learning and awareness was shared amongst the agencies involved in delivering care to people who received end of life care. This practice improved the quality of care people received and aimed to ensure people were comfortable and pain free.

People and their relatives told us staff were always in time and spent as much time with the person as needed. One person told us, "They [staff] come and visit me regularly. If I have a problem or I don't feel well I can ring them [staff]. They [staff] always ring back and give me advice or they come and visit. I don't know what I would do without them [staff]." One relative told us, "The nurses visit regularly and they always come when they say they will. Sometimes they [nurses] come with other staff who help with the care. They [staff] are reliable and wonderful."

The registered manager told us the demand for the services offered by the hospice increased significantly in the past year and they had to review the staff teams and increased the numbers of staff to be able to meet the needs of the people in the area they covered. Planned visits were only carried out during the day, however there was a night staff team on –call and they carried out visits to people who used the service in case of an emergency. Staff rota`s were planned for four weeks in advance and ensured there was a good skill mix within the teams. For example each team who carried out visits to people in their geographical area had a clinical nurse, senior staff nurse, junior nurses and health care assistants to ensure they had the skills and expertise to meet people`s needs. Staff leave and absence was managed and covered by the hospice bank staff group. This meant that there was enough staff with the right skills and experience to deliver safe and effective care to people who used the service.

Safe recruitment processes were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the hospice until it had been established that they were suitable to work with people. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and were obtained from their most recent employer.

People and relatives told us people had their medicine when they needed it and staff were quick to respond to any need they had. One person told us, "They [staff] are very good to ensure my medicines are available. They [staff] collect my prescriptions and talk to my GP to suggest any changes in my medication."

Medicines were obtained from people`s own GPs and community pharmacies for hospice at home staff to administer to people in their own homes. This included medicines administered through syringe pumps (medicines that are mixed together in a syringe and given through the skin). Staff had good relationships

with local GPs and pharmacies to ensure that people got their medicines when they needed them.

There was a current medicines policy in place and staff had access to procedures and guidelines to allow them to make decisions about the safe and correct use of medicines. Staff involved in medicines administration had undergone annual medicine training and competency checks. One staff member told us, "We have regular training and guidance about medicines. If we are unsure we always talk to a consultant from a similar service we work very close with. They have on-call consultant who can advise us."

We saw evidence that medicine incidents were being reported and reviewed appropriately. For example, we saw an incident report where a member of the hospice team discovered a discrepancy in the numbers for a medicine used for a person. They reported to the relevant authorities to ensure an investigation could take place. All the medicines were accounted for by the authorities. Staff monitored and regularly audited the medicines they administered to people using the service.

## Is the service effective?

### Our findings

People and their relatives told us they received excellent care from skilled staff. One person said, "Staff are wonderful. Every advice they gave me made a difference and made me feel better." Another person said, "They [staff] look after me and they are kind and peaceful. Sometimes I feel ill and they [staff] look after me and make me feel better." One relative told us, "Their [staff] advice is very good. The staff is very knowledgeable in my [relative`s] condition. They were very ill and had no quality of life. The nurses talked to the GP and suggested a combination of medication which dramatically improved [relative`s] quality of life. They are now enjoying the time they have left."

People were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and to the specific care needs of individuals. One staff member told us they received training and qualified to undertake verification of death which meant that people's families had not had to wait for a doctor to confirm death. Staff told us they received all the training that was required to work effectively and to provide the best quality of care. One staff member told us, "The training is excellent and it keeps us up to date with latest studies and information about palliative and end of life care."

Staff had access to training essential for their role and they were supported to maintain their professional registrations. Training was delivered by a variety of methods which included e-learning, classroom based and external trainers. There was specific clinical practice training such as medication, resuscitation and pressure ulcer training for relevant clinical staff. Other training provided included palliative care competency, motivational interviewing skills and root cause analysis training which were undertaken by relevant staff according to their roles and responsibilities.

There was also specialist training in areas such as advance care planning, spiritual care for all the staff employed throughout the hospice. There were regular nurse revalidation workshops for the nursing staff registered with the National Midwifery Council to ensure they kept their registration and were kept up to date with recommended care practices. One nurse told us, "We have re-validation workshops and we learn how to write reflective accounts and gather the evidence we need to keep our registration."

Staff told us they had regular supervision meetings with their manager where they discussed their training needs and performance. Staff said they met their manager often, usually monthly, and felt managers listened to their views. One staff member told us, "We have regular supervisions and yearly appraisal. The team is very supportive and help each other. Managers are always available if we need support." This support enabled the provider to be confident that the care being given was provided by staff who were supported and valued and had the opportunity to reflect on their work and practices to drive improvement.

New staff completed a comprehensive induction programme which included topics related to health and safety and infection control, incident reporting and communications skills and also training on sensitive subjects surrounding death. They worked alongside a more experienced staff member until they felt confident in delivering care to people without close supervision. One staff member told us, "I had full training and I have done shadowing (worked with another staff) and I was introduced to every person I had

to care for." They continued to say, "The team didn't push me to be ready, the decision was mine when I felt confident working alone." This practice helped to ensure that the care people received was consistent and staff were competent and skilled to meet people's needs effectively.

People told us and we saw that they were asked for their consent to the care and the services they received from the hospice. One person told us, "They [staff] always asks me if it is okay to do something for me. They are brilliant and I really feel listened too." One staff member told us, "Regardless if a person has or hasn't got capacity, I will always talk to them and ask for their consent before I care for them."

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 make their own decisions. 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.

We checked whether the service was working within the principles of the MCA. People were enabled to make informed choices and decisions regarding their treatment. Staff understood the role of the MCA and the need to act in a person's best interests if the person they cared for had difficulty making a decision about their treatment or their wishes as they approached the end of life. For example staff reported that a person developed a pressure ulcer. They discussed with the person the use of a specialist bed and mattress, however the person refused. The staff assessed the person as having capacity and discussed alternative treatment like the use of a cream and regular turns. This was agreed by the person and staff ensured they attended to the person's home and ensured regular change of their position. This meant that staff respected people's choices and supported them through their decisions.

Staff described how they assessed the person's mental capacity and they reported to relevant practitioners if they felt decisions had to be made in the person's best interest. Staff told us if a person was assessed to lack capacity to make their own decisions best interest decisions were taken following a process which involved a meeting with nursing staff, GP, district nurses and the person's rightful representative.

People who used the hospice at home service and one day a week used the day service told us the food served at the day service was very good and met their needs. People's physical and nutritional state and appetite was reviewed on each visit to the day hospice by staff. One person said, "The food is excellent here – we have a drink before, we can even have a glass of sherry and then the main lunch and it is very enjoyable."

The chef discussed people's nutritional needs with staff. Menu choices were chosen by the people using the service and these were different each time they visited. People told us they were able to have any particular food they desired on the day. We found that people's particular dietary needs and preferences were recorded and staff were knowledgeable about these. People's feedback was encouraged and recorded anonymously to ensure quality could be improved if needed.

People who used only the hospice at home service had regular conversations about their nutritional needs and staff monitored their appetite. In case people needed nutritional supplements and drinks staff contacted local GP's for these to be prescribed. The staff developed a good working relationship with the dietician in the adjoining hospital should they need specialist advice regarding people's diets.

Staff liaised with the community nurses and GP surgeries regarding people's health. Various complimentary therapy sessions were available at the hospice where people had on-going support from a physiotherapist,

a specialist nurse and other complementary therapy specialists. The aim of these clinics was to provide support to people with regards to symptoms and managing their life limiting condition. It was an important aspect of supporting people to maintain their health and receive on-going support. People told us attending these clinics and the day service was an opportunity for them to meet with others who had similar symptoms and it helped them learn about their condition and how to effectively manage these. One person told us, "The hospital said I have [time] to live. I can talk to anyone here, I know all the people, everyone understands."

The staff had access to medical advice offered by a consultant from another hospice they worked in partnership. Staff told us their first point of call for medical advice was people`s own GP however for more specialist advice or out of hours they turned to the consultant from the partner hospice who was able to give the advice and even carry out visits to people if it was needed. This meant that people using the service had access to professional help and advice over a 24 hour period. This gave people reassurance and advice on pain and symptom management and helped people to cope with their condition.

## Is the service caring?

### Our findings

People and relatives were very positive about the care provided by the hospice at home staff. They told us staff were friendly, approachable and showed empathy towards people. One person said, "I am so glad I can share how grateful I am for being cared for by the staff from the hospice. They are kind, caring, funny and they make me feel normal." Other people said, "They [staff] really care about us. "I have the greatest confidence in all the staff.", "They [staff] are all lovely, and make me feel so peaceful." One relative told us, "I am delighted with the care they [staff] give to [relative], I am very thankful for everything they do. They [staff] are kind and compassionate."

People told us staff respected their privacy and dignity. One person told us, "They make me feel a proper adult person, an individual and not a dying ill person. They show respect and they are very mindful of my privacy and dignity." One staff member told us, "It is so important to ensure the room is warm before we offer personal care. We close the curtains and we give people choices, where they would like us to offer support." This meant that people were treated as individuals and staff was knowledgeable and understood how to promote privacy and dignity for people in very vulnerable position.

People we spoke with told us that they had made decisions about their care, which included advanced decisions with regards to future treatment. People told us that each week they saw a nurse for an assessment and a discussion about their care. This was confirmed by the nurses we spoke with, each week every person they supported had one to one time with a nurse to revisit and review their care. One person told us, "We can tell them [nurses] whatever we want to and they will support us and if I ask a question I know they will answer me." Another person said, "I don't want to make any decisions myself, it's all too much. They [nurses] will talk to me whenever I want."

We saw that staff used a computerised system to assess and review people`s needs. Issues like people`s preferred place of death and care (advance care planning) and discussions about Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were mandatory fields they had to discuss and complete with each person. These issues were discussed at the initial assessment however if a person refused to talk about it then this was recorded and was re-visited at each review they had. One person said, "I feel involved in everything." One relative told us, "The planning of care for [person] started with an open discussion about what we need to think about and what we can expect. There was no doubt on how it is going to happen and what is going to happen."

This meant that people were involved and informed about the care they received. Staff having discussions with people about the future when they started using the service enabled people to prepare and make informed decisions about what was important for them and make the most of their remaining time. One staff member said, "It is such a privilege to be able to support people the way they want to be supported. We [staff] are part of something very special and everything we do is about the person not us."

People had access to information about the services provided by Grove House, which was given to them when they started using the service. The information leaflets provided covered a range of topics, which

included practical support, information about advocacy services, and information of other organisations that provided support. Information booklets about specific health related conditions were used by staff in the hospice and given to people to help them understand their health needs and how to manage them. People using the day service told us they felt reassured that when their health will prevent them attending the day service the hospice at home staff will look after them in their own homes. One person said, "The hospice at home nurses will be really good for me when I'm ill." Another person said, "They [staff] told me the hospice at home nurses will be good and I can have them when I am ill, that makes me feel better." This meant that staff supported people throughout their journey between services and this gave continuity to the care and support people received.

Staff developed very positive working relationships with people. We observed staff attending and approaching people who came in the day service. From the discussions they had with people it was obvious they were knowledgeable about their needs and how to support them. All staff we observed had a gentle and calm approach. They created a sense of peace and comfort for people. For example we observed a person feeling unwell in the day service; a member of staff quietly stayed with them, whilst someone else went to get help. One staff member remained with them for the next hour until they started feeling better. This meant that people were supported in a caring way by staff who valued and respected them as individuals.

## Is the service responsive?

### Our findings

People told us staff and the service staff delivered was very responsive to their needs. Relatives we talked to appreciated that staff reviewed people's needs and kept all the agencies involved in their relatives care up to date with any changes in their condition. One relative told us, "[Person] was in dreadful pain and felt miserable, we were desperate. They [staff] came and talked to us and the hospital and [person] was taken in for a short while. They rang me back to check if I am alright and to find out how [person] was." They continued, "I would be lost without them [staff], they keep everything together." One person said, "They prepare me for the future and any new symptom I have they will discuss and help me manage. I am so grateful for this."

The nurses delivered a range of services to help people live with changes that had been brought about by their illness from the point of a life limiting diagnosis. For example there were regular breast clinic, breathing clinic, younger persons (40+) day hospice day, family carers support group and three days a week day service where people could socialise and join in activities. One person said, "I get lonely at home, I like it here. We have word games that keep my brain ticking over." Another person said, "I'm on [treatment], they [staff] said if I liked I could just come for a short time but they've got a ukulele group coming this afternoon so I'd like to stay even though I feel a bit rough. They [staff] are happy for us to do as we want." This meant that people were supported by staff to enjoy time together with other people with similar symptoms to help them cope with their condition.

People using the service had an assessment and review of their health and care weekly carried out by the nurses. They discussed symptoms and priorities, matters which were important to them and any goals they had, as well as any concerns people had. This gave people an opportunity to develop a plan of action collaboratively with the staff team. One person said, "We discuss everything, what is important for me and any worries I have. They [nurses] suggest things and they talk to my GP if needed. They are brilliant."

The Day Hospice team introduced a Drop in Session to enable patients, family carers and friends to drop in and find out about the services offered by the hospice. The staff team ran regular Health and Wellbeing Clinic, Scar Treatment Therapy, Tai Chi and Yoga classes. These were well attended by people from the community who were in early stages of their life limiting illness and people who used the hospice at home service. People told us this was a good opportunity for them to socialise with other people with similar conditions.

When people were referred to the hospice initial assessments had been undertaken to identify people's support needs and care plans had been developed outlining how these needs were to be met. There was a strong emphasis for people to receive person-centred care and support and this had a positive effect on people. For example, one person told us when they started using the hospice at home service their pain was not controlled and they lost their mobility and were confined to bed all the time. They had additional support from a care agency in addition to the support they received from the hospice at home service. Staff worked with them and with their GP to control the person's pain and their condition improved. They told us, "They were wonderful. They helped me get better and I don't need the care agency anymore. My mobility

improved and I can enjoy doing things." Their relative told us, "We are forever grateful for what they [staff] did. My [relative] quality of life is so much better."

Staff were able to demonstrate their understanding of how to give people personalised care. People had detailed individualised care plans which described their needs, personal circumstances, preferences and choices. People told us staff followed the care described in their care plan which was as they preferred.

People`s constantly changing needs were recorded and discussed by staff on a daily basis or more frequently in order to address them appropriately. Staff attended thorough handover meetings at the beginning of their shift. Each person was discussed in depth including care needs, changes to treatment and care plans and medication requirements. Staff contacted other professionals involved in peoples` care like district nurses, McMillan nurses and GP`s to ensure all involved were up to date with people`s changing needs. One person said, "One of the most important issues for me was to liaise with NHS staff and GP. The team from Grove house does an excellent job, top marks!" This meant that people could be confident that if their needs changed responsive action of their choice was taken by staff and this was shared with the relevant professionals in a timely way.

People, relatives and staff were encouraged to comment on the way care was provided. There was a robust complaints procedure in place. Staff, people and their relatives told us they would be comfortable to complain and would do so if necessary, however they had no complaints about the hospice, only praise. One person said, "I can't think of anything negative; I have absolutely no complaints." Another person told us, "I can't recommend this place highly enough."

The registered manager provided us with detailed information about one complaint that had been made by a relative recently. They thoroughly investigated the complaint and responded appropriately. The clinical audit lead told us they were checking the surveys they carried out regularly to seek the views of people using the service. We saw that results were analysed and where people suggested areas the service could improve on these were developed in an action plan which was shared with the registered manager, the board of trustees and staff to ensure everyone worked collaboratively to improve the service. There was clear indication that where appropriate lessons were learned and actions were taken to ensure improvements had been implemented. The service received numerous compliments and cards with very positive feedback. People and their relatives made comments like, "The staff response to my call for `help` was excellent-above and beyond my expectations.", "The team gave me immediate support.", "No words can praise them enough.", "Fabulous team – Thank you so much. You took the drama out of the crisis. Very professional."

# Is the service well-led?

## Our findings

People and their families were all very positive about the care provided and the management of the hospice services. One person told us, "The management is very proactive. I am delighted and very thankful for everything they do." One relative told us, "The service is very well managed and organised. Everything works very smooth and staff know what they need to do." Another relative said, "I can say that this service is very well managed. Managers are accessible open and honest."

Every person we spoke with told us that all staff, regardless of their role were friendly, kind and supportive and gave them comfort and a `sense of calmness`. Our observations and discussions we had with staff demonstrated that across all areas within the service they were motivated and enthusiastic and committed to providing a high quality service to people and their families.

Staff talked to us with passion about the hospice and the people in their care. They told us they enjoyed their job despite the challenges and the nature of the work and they valued the support they received from their peers and senior managers. One staff member told us, "I am grateful to work here and to be able to make a difference to people." Another staff member said, "I feel valued and supported by my managers and seniors. I am delighted to be part of this team." One nurse we spoke with told us, "I absolutely love working here. The focus is on people and this was clearly the message I got from managers from my first day working here. I would like all the other health and social care professionals to be even more supportive of the holistic approach to care for the dying."

There was a clear management structure with senior staff allocated in lead roles; this included a registered manager for the service, clinical audit lead, head of education and a manager of each of the services offered by the hospice. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards.

The registered manager was involved in national organisations representative of hospice services and they were dedicated to constantly improve the service. They told us, "I work a lot in different organisations to develop and improve palliative care practices nationally." They organised an annual conference to support health care professionals to enhance their learning in end of life and palliative care. They extended the hospice at home service to offer support and training to staff in residential and nursing homes to ensure people could receive end of life care and palliative care in these establishments. This meant that people were able to choose their preferred place of death and were not required to move when they approached the end of their life.

The registered manager regularly evaluated the service they ensured regular surveys were sent to people their families and staff to gather feedback on their experience of the service. They measured if the service was safe, effective, caring, responsive, and well –led and implemented an action plan to improve on each

area if it was needed. For example following a survey, suicide and self-harm has been identified as an area of vulnerability for people and their family carers when caring for people at end of life. The clinical audit lead told us these findings highlighted a need for the development of a policy, procedure and training programme to support clinical and non-clinical staff to understand the risks and how to manage them. They developed a draft Suicide Policy and started a project which the audit department and the family support service. They told us if the Board of Trustees will approve the policy they will develop a procedure and workbook for staff. If agreed these will be followed by the provision of some workshops and education sessions to support staff, develop confidence and provide a resource to support on-going practice. This meant that the management was dedicated to constantly improve the service and respond to the need of the people and their families they looked after.

Volunteers were an important part of the service and provided support in a variety of ways. Volunteers who were trained provided support for people who used the hospice at home and to their families. Others helped with daily tasks in the day service, serving tea and coffee to people and visitors and greeting visitors at reception.

The service provided 24 hour care and support. People and their family members could access the service out of hours by telephone for both advice and responsive visits. There was a team of nurses and health care assistants available during the night to ensure they could respond to people`s needs. We saw that the staff performed six to eight visits every night. Most of these were not planned in advance, but the team responded to people`s changing needs. In addition the registered manager had developed links with a similar service that provided a 24 hour medical support for staff to ask for advice out of hours if it was a needed.

The registered manager worked with other organisations which provided a similar service for staff to health and social care providers and professionals to promote good practice through training and learning events. This enabled the management team to continually review the quality of the service provided and drive improvement. The provider also promoted learning and development within the wider medical community; they offered placements for trainee nurses.

The registered manager held talks at conferences and events to raise awareness of the services provided and to raise awareness about good practice in palliative care. They provided opportunities for families and staff to shape the service. Regular surveys were carried out which asked feedback about the service provided. We found that the surveys gave overwhelmingly positive feedback to the service. We noted that the comments people and relatives gave about the service used words like, `incredible`, `excellent`, `deeply appreciated` and `greatest admiration`.

The registered manager explained to us the role of The Board of Trustees, whose members had specific areas of responsibility for which they oversaw and were responsible for. The Board of Trustees had an active role in the leadership of the service and met every eight weeks, providing clear directives to enable the service to work well. Senior management at the hospice had the responsibility for running the service, under the direction of The Board of Trustees. The Chief Executive, Director of Care Services [registered manager] and the Lead Clinician attended board meetings and gave regular updates on all aspects of the service provided. We saw comprehensive reports on different aspects of the service provision and a long term service developments programme which was discussed at these meetings. This meant there was a good, effective and transparent governance system in place which ensured that the service people received was at a high standard.

There was a comprehensive auditing programme for all the services the hospice provided. These covered health and safety, medicines, incidents and accidents, training, care records and staff competency checks.

The management team was involved in research to establish the needs of the people in the community and to be able to offer a service which met these needs. For example we saw they conducted a research into offering overnight service to people with planned visits and overnight sitting service from staff. They measured the value of this service and what it meant for them and their families. The registered manager conducted this research in partnership with a university who was helping interpreting the data collected. They were hoping to apply for funding to meet the need of the people using the service. This meant that the service was shaped, responsive and flexible in the services they offered to people and their families.