

## Rennie Grove Hospice Care

# Rennie House

### Inspection report

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### Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

This inspection took place on 12 May 2016 and was announced. We contacted people and their relatives for feedback about the service on 18 May 2016.

Rennie House is registered to provide specialist palliative care, advice and support for adults and children with life limiting illness and their families in their own homes. They deliver physical, emotional and holistic care through teams of nurses, counsellors and other professionals including therapists.

At the time of the inspection there were 180 adults and 52 children 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.

Rennie 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 and children 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 and children`s own homes. Staff communicated any risks to people and children`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. The children services team from the hospice worked closely with children`s parents and social and health care professionals to ensure the best possible outcome for children with a life limiting illness.

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. The children services team was not providing a 24 hour on-call service, however when a child`s condition deteriorated the staff worked on a rota system and provided support to the children, parents and families over a 24 hour period.

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. Parents of the children who used the service were appreciative of the support they received had confidence and trust in the staff. They all felt the service was very safe. Staff told us they undertook training which enabled them to provide good quality care to people and children 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. Staff from the children services developed a close relationship with the team of paediatricians and specialists looking after the children`s health.

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.

Parents of the children using the service valued the service they received and praised staff for the long standing support they gave to them and their children often for years until children reached adulthood. Staff from the hospice supported children and parents in the transition from children services to adult services liaising with social and health care professionals to ensure a smooth transition.

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 management and staff team 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 adults and children`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 adults and children`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.

Adults and children's health needs were carefully monitored by nursing staff and if required appropriate referrals were made to health care 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 and children with a life limiting illness.

Staff supported the emotional wellbeing of adults and their relatives, children and their parents 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.

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 very 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.

Staff offered support to children and their parents and anticipated their needs which parents appreciated and valued. Children and their parents were offered support from staff in their transition from children to adult services.

Staff went over and beyond their line of duty to grant children and adults last wishes.

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.

The registered manager developed a service level agreement with a children hospice whose consultants developed the symptom management plan for the children Rennie House supported.

**Good** ●

# Rennie 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 12 and 18 May 2016. We told the provider 48 hours before our visit that we would be coming to ensure we could access the information we needed. 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.

The inspection was carried out by one inspector and a pharmacy inspector.

We spoke with eight adults who used the service, eight relatives and two parents of children using the service. We also spoke with seven nursing staff, two service managers, the fundraising manager, the professional development manager and the director of nursing and clinical services who was also the registered manager for Rennie House.

We reviewed seven care plans to see how the support was planned and delivered to adults and children. 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

Adults and their relatives were very 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, "They [staff] offer me tremendous help. I feel safe and reassured I can have them [staff] around if I need them. Another person said, "They [staff] are very experienced and knowledgeable. I feel very comfortable and safe around them."

Parents of the children who used the service were overwhelmingly positive about the support they received from staff. One relative told us, "They [staff] are very good. They are always around when we need them. They pre-empt the problems and worries we have. I trust them to leave my child in their care."

Staff were aware of their responsibilities for protecting adults against the risk of avoidable harm and abuse. They described how they would refer them to the appropriate organisation if they had concerns to ensure they were protected from potential abuse. One staff member told us, "We are well trained in recognising any possible abuse. We will fight our patient's corner. I referred an issue to the local safeguarding team yesterday."

Staff who provided care to children were very clear about their responsibilities in safeguarding children and how to provide safe and effective care to prevent any harm to children's health and development. One staff member from children's services told us, "The team is very well trained. We have experience in working with children. We attend `children in need` meetings and case conferences for vulnerable children." Children in need meetings are meetings where social and health care professionals discuss whether a child is in need of protection, what the child's needs are and what outcomes are intended for the child.

Staff told us and we saw they had safeguarding training and regular updates to ensure they were knowledgeable in safeguarding adults and children from abuse. We found several examples where staff reported incidents they saw or witnessed when visiting adults or children in their own homes to management and social care professionals.

Adults 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 `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 factors which could potentially present a risk to the person like stairs, narrow spaces and risks to their health and well-being. For example we saw for one person the risk assessment considered they were at risk of falls when they were going up the stairs. Staff arranged for hand rails to be fitted on both sides of the stairs for the person to have stability and be able to hold on with both hands when going up and down the stairs. Staff demonstrated good skills in recognising potential risks to adults and children, and put effective measures in place to mitigate these risks to promote better outcomes for people`s health and welfare.

Risk assessments were reviewed by nurses every time they visited adults or children in their care and were updated appropriately. Staff were aware of the risks that related to each person they supported 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 found a person very unwell when they visited. The person's GP recommended to the person to go to the local hospital for treatment. However the person refused hospital admission. After consultation with the person's GP staff were able to administer treatment in the person's own home and mitigate the risks of them becoming more unwell. Staff worked collaboratively with other professionals, GP's, district nurses team, social care professionals to ensure all agencies involved in people's care were up-to date and worked towards the same plan to mitigate risks and meet people's needs. This multi-agency approach helped to ensure 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 learnt. We saw an incident where staff from Rennie House received an urgent referral for a person whose health was rapidly deteriorating. The referral had not been logged on the electronic system. Following this incident the service manager conducted a thorough investigation and a team meeting was called to share learning and ensure these incidents did not happen again. This practice demonstrated a 'learning through mistakes' culture which improved the quality of the care people received from the service.

Adults and their relatives told us they could rely on staff; they were always in time and spent as much time with the person as needed. One person told us, "I don't know what I would do without them. I can rely on them visiting when we agreed." One relative told us, "They [staff] are like guardian angels; they are always here when we need help." Staff told us they were able to adjust their visits and time spent with people depending on their needs and the situation they encountered when they visited people. For example a staff member told us that on their recent visit to a person they found the person's situation changed and they had to spend more time with them. The staff member told us, "All I had to do is call the office and they arranged my remaining visits to be taken over by my colleagues. This meant a lot for me and the person in need."

The registered manager told us the demand for the services offered by the hospice increased significantly in the past year. They reviewed 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 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.

Adults using the service told us and relatives confirmed that they had their medicines when they needed it

and staff were quick to respond to any need they had. One person told us, "They [staff] suggested a stronger pain relief and talked to my GP and organised a prescription. I feel much better now."

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 people got their medicines when they needed them.

Children supported by the service had their treatment and symptom management plans developed by the children's hospital. They received medicines via the hospital and their medicines were mainly administered by their parents. Staff offered support to parents regarding symptom management and liaised with the hospital regarding the children`s treatment if there was a need for this. One staff member told us, "With better medical care and treatment children with life limiting illnesses live longer and reach adulthood. We support parents in how to cope and manage symptoms."

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 medication training. We also have syringe pump yearly updates."

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 that there were more medicines prescribed by a doctor for a person who was nearing the end of their life than usual. They contacted the doctor to discuss this to ensure it was intended by them and not an error. This highlighted a difference in prescribing procedures between neighbouring counties. This difference in practice was then shared amongst all the staff working at the hospice to ensure they were knowledgeable about this. Staff monitored and regularly audited the medicines they administered to people using the service.

## Is the service effective?

### Our findings

Adults and their relatives told us they received excellent care from skilled staff. One person said, "Staff are very good. They address my concerns, they are very knowledgeable and give sound advice." Another person said, "They [staff] offer me tremendous help. From day one they stood by me and helped me cope. They [staff] take a lot of pressure of my family. I am very grateful." One relative told us, "The situation we were in can only be called `desperation`. [Person's name] was discharged from hospital late evening and I had no help. I got in touch with the nurses at Rennie House and the support I needed was there in an instant. They helped me a lot."

Parents of the children supported by Rennie House Hospice were equally satisfied by the service they received. One parent told us, "The support we get is invaluable. I don't know what I would do without them. They keep in touch with everybody involved in [child`s name] care. They [staff] are very aware of everything and know what we need before we need it."

Adults and children using the service 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. Staff told us they received training which helped them keep up to date with current best practice and helped them deliver the best possible care for adults and children using the service. One staff member told us, "The education programme is second to none. What is nice that we are allocated lots of study time so it is no pressure in when to attend training."

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. This training was undertaken by relevant staff according to their roles and responsibilities. There was also specialist training in areas such as advance care planning and 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.

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, "After I joined the hospice team I was allocated a mentor who met with me regularly, weekly usually. Now I have regular supervisions and yearly appraisal. The team is very supportive and we 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. This 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 never worked alone in the six weeks after I started at the hospice." They continued to say, "The team here is great. We value each other`s opinion and managers will support and enable us to deliver the best care." This practice helped to ensure the care people received was consistent and staff were competent and skilled to meet people`s needs effectively.

Adults who used the service 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 and involves me in decisions around my care." One staff member told us, "We always ask people what they want and ask them for consent to their care."

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 their life. For example staff reported that they recently had discussions with a person regarding their wishes. They asked the person about a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form which they had in their notes completed by a consultant when they were previously in hospital. The person was not aware about this decision and following the discussion with staff they decided they wanted the decision removed. The staff communicated with the person`s GP and ensured that this information was recorded and acted on. This meant that staff respected people`s choices and supported them through their decisions.

Staff from children services told us they were listening to parents and acted as advocates for children and their parents. One parent of a child using the service told us, "[Staff] is not judgemental; they try and support us to take decisions which is in the [Child`s name] best interest."

Adults who used the hospice at home service had regular conversations about their nutritional needs and staff monitored their appetite. When they needed nutritional supplements and drinks staff contacted local GP`s for these to be prescribed. The staff from children services developed ` Guidelines for blended diets for children`. This was approved by a dietician and paediatrician consultants. These guidelines were meant to help parents and other services in providing a nutritious diet for children who had to be given blended food or assisted via a percutaneous endoscopic gastrostomy (PEG) or Radiologically Inserted Gastrostomy (RIG). These are systems by which people who are unable to take food or fluid by mouth receive supplements via a tube directly into their stomach. This meant that staff provided people and children`s parents with enough information to help ensure people and children received a healthy balanced diet.

Staff liaised with the community nurses and GP surgeries regarding peoples` health. Staff arranged visits from occupational health therapists, physiotherapists or other professionals to visit people in their own homes if this was needed. One relative told us, "Staff helped us get the support from an occupational health therapist and a physiotherapist. They helped us get the right equipment in place. If it wasn't for them we would have been lost between all these services. We did not know we could access these." This meant that the provider had access to all the resources available to maximise people`s health and promote their well-

being.

The staff had access to medical advice offered by a consultant from another hospice they worked in partnership with. Staff told us their first point of call for medical advice was people`s own GP`s. For or 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.

Staff from the children services worked very closely with consultants from the hospitals and doctors from the children's and young adult's hospice where the children using Rennie House were registered with. They had regular communication between these services regarding children's health and well-being. This helped ensure children with life limiting illnesses had their health maximised and were able to enjoy normal day to day activities like going to school or on holidays.

## Is the service caring?

### Our findings

People and relatives were very positive about the care provided by the hospice staff. They told us staff were friendly, approachable and showed empathy towards people. One person said, "I am so grateful for the staff`s support. They are kind and so caring. They are happy just to talk if I want to talk. They let me cry if I need to. They are my emotional support above all." Another person told us, "Staff are extremely kind and they show genuine concerns towards my feelings and needs."

We were told by parents whose children were using the service that staff were equally friendly and nice and professional at the same time. One parent told us, "They [staff] are amazing; they know exactly how much they need to be involved. They know how stressed I am, when I can cope and when I need their help." They continued to say, "Over the years they become like family members and I will be sad to lose them when [child] moves to adult services, however this is the way it needs to be and they are so professional but lovely at the same time."

People told us staff respected their privacy and dignity. One person told us, "They [staff] help me help myself. I really feel like a proper person." One staff member told us, "I aspired so long to work for a hospice. It is so dignifying for people that we can offer the support they need to achieve what they want in their final weeks, days or hours." Staff treated people as individuals and staff were knowledgeable and understood how to promote privacy and dignity for people in very vulnerable positions.

People we spoke with told us that they had made decisions about their care, which included advance decisions with regards to future treatment. People told us that every time they had a visit from hospice staff they had discussions about their care and they were involved and re-visited their support needs regularly. One person said, "I was involved from day one and everything they [staff] said they will do they did for me. They regularly discuss with me what they think but they let me decide what I want." Another person told us, "They [staff] come to see me regularly and ask what I need from them. They [staff] are happy for me to decide when and what help I need."

Parents of the children using the service told us, they were well informed and knew about the needs of their children and they led on what support they required from staff. One parent told us, "Staff will come regularly and relieve us from our day to day responsibilities. This is very good and we are grateful." One staff member from children services told us, "We go in twice a week to a family and offer personal care and support for their child to be ready for school. It may not seem a lot but they [parents] can have some time for themselves and not have to worry on those days."

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. 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 to die where they want to die. This gives people comfort and peace."

People had access to information about the services provided by Rennie 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.

## Is the service responsive?

### Our findings

People told us staff and the care they delivered was very responsive to their needs. Relatives and parents of the children who used the service appreciated that staff reviewed people and children's needs. They were thankful that staff kept all the agencies involved in their relatives or child's care up to date with any changes in their condition. One relative told us, "After [person's name] was discharged from hospital we were left alone until we were referred to the hospice. Staff were brilliant and helped us access everything we needed and they kept in touch with the GP and the district nurses team." Another relative told us, "The nurses are wonderful; they keep in regular touch with [name of the person] GP and have regular meetings with the GP and nurses. This is a huge help for us."

We heard from parents of the children supported by the hospice that staff supported them to attend appointments and kept all professionals involved and up to date with regards to the needs, symptoms and development of their children. Staff advised parents to record any new symptoms they observed so they were able to review and act promptly to manage these. One staff member said, "We advise parents to record or take photographs of any symptoms they observe and then we [staff] can identify the need for a referral to their doctor."

When adults or children were referred to the hospice initial assessments had been undertaken to identify their 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 individualised care and support and this had a positive effect on adults and children's life.

Staff from adults and children services were able to demonstrate their understanding of how to provide personalised care to people and children. People and children 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. Staff were able to give us numerous examples where they shaped the support they offered to the needs of the person and their family. For example we heard about a person and their family carer who was having difficulties coordinating their finances and this had a negative impact on the person and their family carer. The staff had contacted a benefit advisor from a local hospital and arranged a meeting for the person and their family carer. One staff member told us, "[Person] feels relieved now that the financial situation has been sorted and they are now able to relax and enjoy their days out."

We found another example when the hospice team were contacted by a distressed family carer requesting a first visit for a person who was nearing the end of their life, as they were not able to deal with the situation on their own. Staff described their visit as being very emotional and full of anxiety. However they were able to offer the support the person needed and they were able to refer the family carer to the family support team within the hospice. This helped the family carer understand and deal with their emotions and anxiety.

One person's last wish was to die at home. Following a hospital admission they had to move in to a permanent placement due to their declining health where staff from the hospice found them very unhappy



and sad which had an impact on their appetite. Staff from the hospice involved social and health care professionals in a best interest decision following their discussion with the person. They were able to organise the support the person needed to return home. The person told staff, "I fought for my country, thank you for fighting for me." One staff member told us, "It was such a privilege to afford the time to meet [person's] wishes. We found [person] today sitting up-right watching TV, eating and drinking and at ease and reassured that everyone was working towards their goal to go home."

Staff from children services equally helped children to achieve their goals and wishes. Staff gave us one example when they received a referral for a child in their teens having given months to live with a life limiting illness. When staff had discussed the needs and wishes the child had a list of activities they wanted to complete before they deteriorated physically. However most of the activities and goals involved outside activities and they were very anxious about going out of the house. The activities involved playing golf, learning to ride a motorcycle and have a family flying opportunity. Staff told us through observations and constant support they built a trusting relationship between a staff member and the child. They took the child out in their car to get them used to being outdoors first. They organised and found opportunities for the child to play golf. They supported them to learn and pass their motorcycle training test, following which their confidence increased. The child was able to travel on an airplane with their parents without any panic attacks. We heard that following the support from staff the child's general health improved and they were able to return to school where they met new friends and they were currently working towards their exams for the university of their choice. We found that staff supported this child for a period of 15 months with regular visits, supportive phone calls which together with the activities and their physical improvements changed the child's life and enabled them to look forward to the future. We talked to the parents of the child and they told us, "We are forever grateful for the support we got. Our child told the care staff, "I could not have done this without you." We are delighted and happy with everything they have done for us."

Adults and children'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 their care needs, changes to treatment, care plans and medication requirements. Staff contacted other professionals involved in people's care like district nurses, McMillan nurses and GP's to ensure all involved were up to date with people's changing needs.

Staff from children services helped children and their parents move from children services to adult services. Staff told us they were often faced with challenging situations in finding suitable placements for young adults because of the lack of services specialised in supporting young adults with life limiting illnesses. Staff liaised with social care professionals, attended multi-disciplinary meetings between children and adult services and helped parents to find support after their children left school. One staff member told us, "It is hard for parents to manage transition on their own. We have a team member dedicated to support families and help with the transition to deal with legal, power of attorney and mental capacity issues." This meant that the support given to children and their families considered their needs of transition between services and staff recognised and helped with the difficulties encountered in this process.

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. One person told us, "I am very happy with the service and no reasons to complain. I would talk to the staff if I would have any worries." One relative told us, "I have asked the nurses once to ensure staff who are visiting us to be the same ones if possible. I only had to mention this and they acted on it. If I have somebody new they will let me know in advance. I have nothing to complain about."

The service received numerous compliments and cards with very positive feedback. People and their relatives made comments like, "Thank you. Nothing was too much trouble for you [staff]. You [staff] were so patient and kind.", "No words can praise you [staff] enough.", "I cannot believe the weight lifted off me the moment they [staff] came into the house."

## 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 must be good. Everything staff do is marvellous so I have only praise." One relative told us, "I never had to go to management to resolve anything. Staff will do the talking. The service is well managed because staff are brilliant."

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 just love working here. Everyone [managers] listens to us [staff] if we need to increase support for people and generally they make us feel valued and respected." Another staff member said, "I cannot fault this service and management. It is not like any other place I worked before." One nurse we spoke with told us, "I think we all do a wonderful job. I like about the manager that they have a `can do` attitude. Our manager will say, "Go ahead and do it" every time a patient needs something. This means a lot for people and us staff."

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 children 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 quality of 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 the registered manager told us they received grumbles from people who were using the service about the lack of support they received over weekends and

holidays. These grumbles were not related to the hospice services however the registered manager felt it was their responsibility to investigate. They investigated and established that statutory services, social worker support and district nurses support were very limited over weekends. They have contacted local commissioning groups to organise meetings and discuss ways to solve this issue to ensure the support people received was consistent and met their needs.

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.

The service provided a 24 hour advice telephone line, which was accessible to people and their relatives. 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 24 hour medical support for staff to ask for advice out of hours if it was needed. Although children services within the hospice had not offered a night service staff told us they worked with parents on a rota system if a child was nearing the end of their life so staff supported them night and day.

The registered manager worked with other partner hospices and together they provided support for staff working in care homes, to health and social care providers and professionals to promote good practice. They delivered specialist end of life training and organised learning events. This enabled the management team to continually improve the quality of end of life care people received in the community. 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 for feedback about the service provided. We found that the surveys gave overwhelmingly positive feedback to the provider. We noted that the comments people and relatives gave about the service used words like, `incredible`, `excellent`, `deeply appreciated` and `greatest admiration`.

The manager for children services was regularly attending `Together for short life` forums regionally for children and young adults and meetings with social services to raise awareness about the lack of transition services for young adults with a life limiting illness. This meant that there was a continuous drive from managers of the hospice to encourage improvement of services provided to adults and children in the community.

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 demonstrated 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.