

The Primrose Hospice Limited

Primrose Hospice

Inspection report

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Date of inspection visit:
18 May 2016

Date of publication:
17 August 2016

Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 18 May 2016 and was unannounced.

Primrose Hospice is registered to provide personal care. Primrose Hospice provides people in the local community with opportunities to attend the day hospice, receive a hospice at home service and family support.

There was a registered manager in post who was also known as the director of care. 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 assessed any potential risks to people and preventive measures were put in place where required. Staff knew how to recognise and report any concerns to keep people safe from harm. The provider had lone working arrangements to ensure staff who worked in the community were safe. Accidents and incidents were recorded and practice improved upon so the likelihood of these happening again were reduced to ensure people's safety.

The provider had staff and volunteer recruitment procedures to ensure new staff were suitable to provide care to people who used the day hospice service and the hospice at home service. There were sufficient staff to meet people's needs and volunteers complemented the support provided.

People brought their own medicines with them to the day hospice service and there were arrangements in place to make sure they could be stored and administered safely.

New staff and volunteers received a thorough induction and regular training to make sure they had the knowledge and skills to deliver high quality care. The management team provided staff with support to inform their care practices and opportunities to share experiences.

People had choices about their care and their consent was sought by staff during the support and treatment offered. There was a strong focus upon advance care planning so people were supported to share their choices around their end of life care and preferred place of dying. Family members consistently told us the hospice at home service provided them and their relatives with the opportunity to realise their wish to receive their end of life care at home.

People were supported to receive a nutritious lunchtime meal when they attended the day hospice. There was a choice of menu and drinks and snacks were available. People enjoyed their meals and by people having a lunchtime meal it provided an opportunity for staff to assess and monitor people's nutritional needs. This enabled staff to seek assistance from other healthcare professionals where required so people

kept well.

People were at the heart of the day hospice and hospice at home service. Staff and volunteers understood what was important to each person and worked closely with each other and other professionals to promote their well-being and happiness. This included people having access to a physiotherapist, occupational therapist and chaplain so people had support for their physical, social and spiritual needs whether they received a service at home or at the day hospice.

People told us staff were caring and they enjoyed friendly banter with staff who they had good relationships with. Staff supported people in making memories about things which were important to them. People had access to a range of bereavement services which were provided to, people of all age ranges including children, before the death of a person and afterwards.

Staff had arrangements in place to ensure people's changing needs were responded to which included holding meetings with community healthcare professionals so people's needs were met at the right time and in the right way. This included people receiving help with symptom control and management at the day hospice and in the community.

People were confident about expressing any concerns to staff and when complaints were received action was taken to learn lessons and make sure people had satisfactory responses.

The management, staff and volunteers shared similar values and worked closely with each other. They all worked together in a friendly and supportive way. They were proud to work for the service and wanted to make a difference to how people experienced end of life care.

The registered manager had adopted different methods to benchmark the hospice services against to ensure best practices and improvements were continually sought. This included seeking people's experiences and reflecting on research to drive through improvements for people who used the services.

The registered manager was committed to the continuous improvement of the services. They maintained an annual quality account which reported on a range of auditing and monitoring systems to ensure the care provided reflected people's needs and preferences. The annual quality account was shared with everyone so they were able to look at the safety of people who used the services, clinical effectiveness and people's experiences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Staff knew how to recognise and report any concerns to keep people safe from harm.

Potential risks to people and staff had been assessed and where required preventative measures were put in place.

Staff numbers were regularly assessed to make sure staff had time to meet people's individual needs either at the day hospice or at home. Recruitment checks were completed to ensure staff and volunteers were suitable to work with people who used the hospice services.

Is the service effective?

Good 

The service was effective.

People were supported by staff and volunteers who had the knowledge and skills required to fulfil their roles in meeting people's individual needs and promote their health and wellbeing.

People were supported to access any specialist support they needed due to staff working very well with local palliative care and healthcare teams.

People's nutritional needs were assessed and monitored to ensure these were met. People enjoyed the lunchtime meal provided.

People were supported to make their own decisions by staff who understood that when people lacked capacity decisions needed to be made in their best interests.

Is the service caring?

Good 

The service was caring.

People were supported in a caring way with dignity, respect and kindness.

People were supported to have choice and to be involved in all aspects of their care.

People were kept at the heart of all staff practices which enhanced people's sense of wellbeing and assisted people to live well with their end of life wishes met.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care which was responsive to their changing needs due to the established partnership working.

People enjoyed a range of things to do for interest and fun which had added therapeutic benefits.

People were actively involved in devising their own advance care plans which recorded their end of life care preferences and choices so care was responsive to their needs.

People knew how to raise concerns or complaints if they had any.

Is the service well-led?

Good ●

The service was well led.

People believed the services were well managed and they received quality care which effectively met their needs.

Staff worked together in a friendly and supportive way. They were proud to work for the service and felt listened to by the management team.

A range of methods for measuring the quality of the services was used as the management team were committed to continually improve services and ensure they reflected the needs of the local community.

Primrose Hospice

Detailed findings

Background to this inspection

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

This inspection visit took place on 18 May 2016 and was unannounced.

The inspection visit was completed by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of palliative care (Palliative care is comprehensive treatment of the discomfort, symptoms and stress of serious illnesses) and end of life services.

Before the inspection visit, the provider completed a Provider Information Return [PIR]. This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

We checked the information we held about the service and the provider including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We sought information about the quality of the service people received from the local authority and the clinical commissioning team. In addition to this we received information from Healthwatch who are an independent consumer champion who promote the views and experiences of people who use health and social care. We used this information to help us plan this inspection.

We met and spent time with seven people who attended the day hospice on the day of our inspection and a relative. We saw the care people were offered and looked at two people's electronic care records with the nurse.

We met and spoke with the registered manager, the chief executive officer, the manager of the hospice at home service, nurse team leader, physiotherapist, chaplain, cook, family support worker, a volunteer and a student social worker. We looked at staff recruitment records, complaints and compliments and other records which reflected the provider's quality checking procedures.

Following our inspection visit we spoke with three people who used the hospice at home service and two staff who supported people in their own homes.

Is the service safe?

Our findings

All the people told us they felt safe when spending a day at the hospice and provided us with a variety of reasons why they felt safe. One person described they felt safe because, "The nurses help me get my balance." Another person said, "The nurses here do anything for you" and this is the reason they felt safe.

Family members we spoke with about the hospice at home service equally felt safe when staff came into their homes to support their relatives. One family member told us, "I never felt unsafe or uncomfortable with them (staff) being here, we completely trusted them."

There were arrangements in place to make sure staff had the knowledge and information to refer to in order to protect people from abuse. For example, in the Provider Information Return [PIR] the registered manager confirmed, 'We have a robust safeguarding policy in place and a designated lead with a social work background, and all staff are up to date on their mandatory safeguarding training for adults and children.' Staff we spoke with knew who the lead was and how they could approach them with any concerns they had or issues they wanted to talk through. Staff were also clear about who they would report any concerns to. They were confident the management team would listen and act upon any suspicions and or allegations of abuse or harm to a person.

People we spoke with indicated the staff worked in close partnership with other health and social care professionals so risks to their safety and wellbeing were identified and monitored closely. For example, one person told us, "I can see my heart nurse here, or at home, so I can keep her up to date with what's happening to me." Another person said, "They (staff) check I'm okay while I'm here: my blood pressure, that sort of thing." The registered manager and staff also described how they worked in close partnership with other professionals and saw themselves as very much part of the community palliative care team. They believed these working relationships provided effective communication and monitoring systems which assisted in identifying and reducing risks to people's safety and wellbeing.

Staff who worked at the hospice had access to and shared electronic records with community professionals where a wide range of possible risks to each person's wellbeing had been considered and assessed, such as risks relating to people's physical abilities and health conditions. The records staff had access to detailed any identified risks to each person and the action taken to reduce these. A staff member told us how avoidable risks to people were reduced. For example, any specialised equipment people required in their homes was also made available to them whilst they spent the day at the hospice. This included, specialist cushions for people to sit on to provide comfort and ease the pressure on key areas of people's body so the risks of them developing sore skin was reduced.

When people were referred to the hospice at home service the manager of this service told us they completed a referral form which contained an overview of people's needs. The referral form also identified the individual risks for each person to promote a safe environment and meet people's individual needs in the best possible way. Potential risks to people were identified and assessed so staff had this knowledge to inform the support they provided to people in their own homes to ensure risks were reduced. Staff

confirmed they were provided with sufficient knowledge about people's needs and any identified risks before they supported people in their homes. Staff told us they could contact the district nurses in the event of an emergency or if the person needed extra assistance, such as additional pain relief.

The provider had taken steps to make sure the safety of staff who supported people in their own homes, all of whom worked on their own. For example making sure any details staff needed to know in order to maintain their own safety were discussed with them before they supported a person. Staff spoken with confirmed this was the case but told us they had never felt unsafe when supporting people and knew who to contact if they did.

Staff told us, and records showed when accidents and incidents had occurred they had been analysed so steps could be taken to help prevent them from happening again. For example, when people had a pressure ulcer or when people experienced a fall the outcomes from the analysis were used to influence consistent staff practices.

The provider had recruitment processes in place to ensure staff were recruited safely, which minimised risks to people's safety and welfare. We looked at two staff personnel files and saw references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure only people who were suitable to work with people either in the day hospice or in their own homes had been employed. These checks were also completed for volunteers to further ensure people's safety.

We saw staff and volunteers worked together and had time to meet people's support needs without rushing which included assisting people with their care needs and fun and interesting things to do. For example, when staff needed to privately speak with people this was achieved without compromising the support to other people. People we spoke with had no worries about their needs being met safely and effectively by staff and volunteers. One person told us other people who had needed more support from staff, "Got what they needed, they got help to be fed too." The registered manager confirmed staffing levels were regularly reviewed as at times the numbers of people who used the service and their specific support needs could be unpredictable.

This was also true for the hospice at home service. The manager for this service told us staff availability was always checked alongside the person's particular support needs when a person was referred to the service. The manager said this was done before they were able to confirm their commitment in providing support to a person in their own home. People we spoke with were positive about the staff who had supported them in their own homes. One family member said due to the support they had received their relative was, "Able to die at home in the knowledge they were safe and had the support on hand during the night if they required this."

We spoke with a staff member about how people received their prescribed medicines while they were at the hospice for the day. They told us people brought in their own medicines and each person was assessed to ensure they were safe in taking their own medicines. Safety precautions were in place to make sure people's safety was not compromised should they be unsafe to take their own medicines. For example, medicines were required to have original written labels and containers for trained staff to be able to assist people with these. No medicines were stored at the hospice apart from pain relief medicine should people need this, such as if they had a high temperature. There were procedures for staff to follow about how many doses of pain relief people could have whilst they were at the hospice. Staff responsible for medicines showed they had this knowledge to ensure people were supported safely. People who received a service in their homes were supported to take their medicines by their family's as required.

Is the service effective?

Our findings

People who spent time at the hospice were complimentary about the staff who supported them as they felt staff were knowledgeable about their individual needs. One person spoke positively about how when they had felt unwell whilst at the hospice, "[Staff members name] the nurse looked after me very well, they called an ambulance and I went to hospital."

One family member whose relative received support at home said, "They (staff) all understand [person's name] condition and gave me lots of advice so I was able to cope with the illness." Another family member told us, "They (staff) definitely knew their stuff, I was confident with their care otherwise I would not have been happy to go to bed for some rest. I was exhausted."

The comments we received from healthcare professionals was equally positive about how effective staff practices were in meeting the needs of the local community. One local healthcare professional who had referred people to the hospice services told us they believed staff provided high quality care and support to people and their families which promoted their quality of life.

The registered manager made sure staff training was planned and monitored. They did this to make sure staff and volunteers had the right skills and developed their knowledge to be able to fulfil their roles and responsibilities. This was confirmed by staff who told us they had received training which included an induction which provided them with the skills they needed to meet people's palliative and end of life care needs. One staff member said, "Training is always on-going as learning never stops, we have plenty of training opportunities so we can provide specialist care." Another staff member who provided support to people in their own homes told us their training and experiences had enabled them to provide more effective care. They said, "Training is based around the patient's needs and is very varied so we meet their individual needs." They described a time when they used their knowledge and experiences of end of life care when a person died to ensure the person was made comfortable.

A further staff member said they felt supported and encouraged to complete training which gave them added confidence when assisting people. They said, "Training is excellent and I feel supported. Everyone is so different but what we learn helps us to help people in the best possible way for them."

There was a detailed induction for staff and volunteers which introduced them to the service and its aims which were to support people living with an advanced progressive illness and to provide respite to people's family members. One volunteer described how they felt very well supported in their role from the first day they started at the hospice. We saw how volunteers were used to effectively complement the staff team. For example, volunteers shared people's day with them and supported people to do the things which interested them when they came to the day hospice.

We saw staff had specific roles where they had developed their skills and knowledge to support people. For example, nurses who complemented the staff team and also linked their knowledge into the wider community palliative care team for the benefit of people who attended the day hospice. We saw this worked

effectively as nurses were competent in monitoring people's health conditions. For example, a nurse contacted a person's doctor to confirm they required a particular x-ray due to their assessment of the person during the time they had spent at the day hospice.

Another example was the role of the physiotherapist who further supported the staff team and people who used the services by assessing their physical health needs and providing guidance. Family members we spoke with told us how appreciative they were of the guidance and support the physiotherapist had provided to assist their relatives to have the equipment they needed. One family member described how the knowledge of the physiotherapist had meant their relative was able to remain at home which was their wish.

People spoken with told us staff were attentive to their health needs. A person told us, "The staff understand and recognise my symptoms and act quickly." People were supported with their health needs by nurses with many years' experience of palliative and end of life care. We saw people were comfortable and resting, or taking part in things they enjoyed doing without obvious pain or complex symptoms causing them difficulties. We saw and heard if staff recognised changes in a person's health since their last attendance at the hospice, this information was shared with community professionals. This was also confirmed by the registered manager in the PIR, 'Our nurse-led team liaises regularly with the wider palliative care team and primary healthcare teams in the locality to ensure seamless care for people who attend Day Hospice. We are also able to arrange for the input of the Consultant in Palliative Medicine if indicated.'

The management and staff team had been trained in, and showed a good understanding of, the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection. There were no Deprivation of Liberty Safeguards (DoLS) or authorisations by the Court of Protection in place for people who used the service. The registered manager was aware of when applications should be submitted. People were supported to make their own decisions and consent was sought when staff provided any care and support.

Staff spoken with told us when people attended the day hospice, it provided them with an opportunity to assess and monitor their nutritional needs. They described how this gave them an insight into whether people required additional support to effectively meet their nutritional needs. One staff member told us they had referred people to other specialist community resources, such as speech and language therapists and dieticians to make sure people had the support they needed to keep well.

People we spoke with were very positive about the lunchtime meals they enjoyed when they came to the hospice. One person told us, "It's the best grub this side of the west!" Another person said the food was, "Enjoyable" and a further person described the meals as being, "Good English food." A family member spoken with was equally positive and said the meals were, "Excellent."

We saw there was information in the kitchen so the cook and staff could refer to when preparing food for each person who attended the hospice on the day. The cook had received specific training to do their role which included food hygiene and safety. They told us they locally sourced the food and the meals were personalised to each person's taste and appetite so people could enjoy their meals. People also told us they

had seen meals specifically prepared and cooked to meet the diets people chose to follow, such as vegetarian diets. We also saw people were offered a variety of hot and cold drinks throughout the day and people were asked individually what they would like.

Is the service caring?

Our findings

People told us they felt cared for by staff and volunteers. People consistently said how fearful they had been when they first came to the hospice for the day but the, "Atmosphere of Primrose eased their concerns." One person told us it was their first day at the hospice but they felt relaxed, "Within the first ten minutes" and commented, "I can't believe how smart it is."

One family member who was visiting on the day of our inspection told us their relative had died two days before our inspection but said they felt comfortable being at the hospice, sitting with other people who, "Understood."

People who received support at home were also complimentary of the care received by their family member. One family member said, "[Person's name] had a laugh and a joke with them, they were all very caring and we were able to be together due to the support provided." Another family member told us, "They (staff) understand so much about what we were going through, it is unbelievable, we were surrounded by very caring people to help us get through the night."

There was a relaxed and welcoming atmosphere in the hospice and, throughout our inspection, we saw staff supported people in a warm and caring way. For example, staff and volunteers spoke politely to people and used people's preferred names.

People said they had good relationships with staff who took time with them, understood their needs and preferences, treated them with respect and ensured their dignity. We saw and heard banter between people and staff which enhanced people's wellbeing as one person's comments confirmed, "We are all treated like favourites. They (staff) are all the special ones really."

We saw people were supported by the student social worker to join in a reminiscence therapy session. During the reminiscence session everyone was sensitively supported to be involved with laughter along the way. We particularly noticed how a person who was new to the hospice was helped to feel welcomed during the session.

Staff and a volunteer spoken with told us they enjoyed their work and showed they had a strong commitment to provide care centred on each person. We saw staff and volunteers worked to the values of the organisation which were based on providing personalised care and support to people with life limiting and life threatening conditions. This approach had clearly been taken on board by staff. One staff member provided us with an example where staff had assisted a person to go to the ballet before they died. The staff member said the person needed specialised equipment to meet their health needs which needed to be carefully planned and arranged. Staff managed to do this so the person could achieve their wish.

Throughout our inspection we saw evidence of the staff and volunteers commitment to giving people as much choice and control as possible. Staff and volunteers were seen to be attentive to people's comfort needs without being intrusive. We saw staff assisted people to be comfortable and supported people to

relax in ways they wanted. For example, a group of people played dominoes together and told us they had enjoyed this. Another example was of a person who specifically wanted their pudding served in a particular way. We asked them if they had enjoyed their pudding and they said, "Yes, especially the cherry pie because I had both ice cream and custard on top!"

We saw and heard from staff how people's consent was obtained on an on-going basis and how people were involved in their care. The physiotherapist described how they gained people's consent and showed people respect by involving them in their care. For example, when touching people they always repeatedly asked for consent as they moved to different parts of their body. They also described to us how they informed people the door to their examination room was locked to protect people's dignity and privacy.

In the [PIR] the registered manager's told us they had purchased a specific piece of equipment for the comfort of people when meeting their needs alongside maintaining people's independence and dignity. We also saw staff and volunteers supported people in ways that took account of their individual needs and helped maintain their privacy and dignity. For example, people were accompanied to rooms on their own when they needed to speak with staff in private. Systems and guidance were also in place for staff to follow for the protection, handling and processing of personal confidential information relating to people's care. Staff recognised and understood these.

Staff who provided support to people in their own homes spoke about people in a respectful way and gave examples of how they promoted people's privacy, independence and dignity whilst providing care and support. One staff member described how they always made sure people were happy with any support they offered before they provided this. They also told us how they ensured people were warm enough and were covered up to respect their dignity when assisting people with their personal care needs.

Systems were in place that aimed for people to experience comfortable and pain free end of life care. If people received their end of life care at home the medicines required to achieve this were put into place in advance so they could be used when the person required them.

We saw people and their family members could access a range of support services to suit people's preferences and needs. For example, complementary therapist support and bereavement and spiritual support where people could choose to access a chaplain.

Is the service responsive?

Our findings

People we spoke with used different words to describe how responsive staff were in meeting their needs. The words used were, "Wonderful," "Accessible" and "Helpful." One person told us they were happy with their support and staff consistently responded to their care and support needs. Another person told us they were provided with support from the physiotherapist to assist them in doing exercises to support their breathing. They also said they were having complementary therapy. One family member told us their relative had enjoyed receiving baths and their hair styled.

In the PIR the registered manager confirmed, 'We share an electronic record with other members of the palliative care team in the community and acute sectors so often have quite a lot of information about patients before we first meet them.' We saw this was the case and staff told us this was particularly valuable as they believed it provided people with consistent care which was responsive to their changing needs. For example, when people had conversations about their advance plans and decisions these were shared to ensure people's end of life care was responsive to their wishes.

People's future care wishes were recorded in their care records. This included where and how people wished to receive their end of life care and treatment, such as in their own homes, a hospice or hospital. We saw people had been supported to make advance decisions about their future care in the event of them not being able to make this decision as they neared the end of their life. These included agreements which provided staff with the information about what action should be taken in the event of people's health conditions deteriorating or if they suddenly experienced heart failure.

We saw and heard how people were supported at the end of their lives in their own home. One family member described to us how staff had noticed their relative became poorly overnight and contacted the doctor. Their relative was provided with medicine to help their symptoms due to staff's responsive actions. They said, "I am just so impressed with their care. I don't know what would have happened without it." Another family member told us how the support they received at home from hospice staff had meant their relative's wish to remain at home was able to be fulfilled.

Staff and volunteers showed they were committed to ensuring people were provided with support which enhanced their wellbeing when they attended the day hospice. One staff member told us, "When we support people, we make sure it is quality time." We saw this was the case as on the day of our inspection we saw people participated in things they liked to do for fun and interest. This included reminiscing, playing dominoes, sitting and chatting. A person told us, "I can do what I want. It is so relaxing. We have a laugh and a joke." We also saw staff and volunteers chatting to people sociably and friendly which was done on a consistent basis and not only when they were supporting people with their care.

Staff we spoke with were able to tell us the individual needs of people and how they responded to people's care, emotional needs and wishes. For example, we heard from people who used the day hospice service and staff about how a recent day trip to a local garden show had been a source of enjoyment. People met a well-known garden celebrity and photographs were taken as a special memory for people to look at. People

were proud of their achievement as the hospice had been nominated for an award for a garden which had been designed.

Another example was the blessing of the union of two people at the hospice. There had been 40 guests and the provider supplied a 60 person buffet. The chaplain commented, "What was wonderful was the way that everyone pulled together to make it happen." We saw an arch from the day, which had been donated by a local garden centre stood at the entrance to the 'sacred space.'

The chaplain showed they were committed to ensuring the spiritual space in the hospice would be welcoming, "For all faiths and none." We saw books on the shelves inside the 'sacred space' covering everything from Buddhism to Wicca. Artefacts were also made available to people and were accessible from inside the cupboard areas. The chaplain also said they had made contact with an Iman as well as representatives from the Jewish and Catholic faiths and the British Humanist association. This was to make sure they were responsive when providing people with the spiritual guidance they needed as individuals. A relative commented, "Your lovely approach embracing believers and non-believers alike in such a way that they were all given hope." We also heard after a person's death, a moment of reflection using a candle was held at the hospice. The chaplain also told us they had been asked to conduct the funerals of people known to the hospice which was very much appreciated by their families.

Care and support was inclusive and responsive to the diverse needs of the people who used the service which included their family members of all age ranges. For example, there was a children's room with a puppet theatre, toys and crafts and a specialist children's worker who was employed to respond to children and family's needs. The specialist children's worker had set up an educational visit for some older children to visit the hospice. If people were not able to come to the hospice for counselling this could be arranged at their own homes so nobody was disadvantaged from receiving the support they needed.

Staff told us people could be referred to the Citizens Advice Bureau at the hospice to discuss any worries they had about benefits and their finances. They also told us people with lymphoedema (the swelling of one or more limbs or at any point in the body) could be seen at the hospice as a clinic was held there.

People had opportunities for making comments about their experiences of the services they received. These were used to provide the management, staff and the board with an insight into how effective and responsive services were in meeting people's needs. We saw people had shared their views about the hospice at home service. One person commented, 'I wasn't expecting any help but support from Primrose meant I could keep mum at home which is what we both wanted.' Another person said, 'The support we received during my husband's illness was overwhelming. We were so grateful.' A further person commented, '[Manager's name] has been very helpful in getting sitters in and enabling me to catch up on my sleep.'

A range of information was provided for people, their family members and friends, which helped them to understand the hospice services provided and relevant external support services and agencies. Accessible information was provided for people about how to make suggestions or complaints about their care. We saw there was a process where people's views including any complaints were captured and taken seriously by the management team as they used these to change any practices and as a source of learning. For example, we saw where a complaint had been received action was taken to review the practices in place. On this occasion procedures were strengthened to make improvements to people's experiences of the service they received. People we spoke with were positive about staff and the care they received and did not share any complaints with us.

Is the service well-led?

Our findings

People we spoke with all referred to the service in complimentary and positive terms. One family member told us, "It's the jewel in the crown and there should be more like it." People spoke about the staff and volunteers in equally complimentary terms.

Healthcare professionals provided us with their comments about the hospices services. One healthcare professional told us the hospice was a hugely valuable resource in the local health economy and provided an excellent service. Another healthcare professional commented the management team had developed strong quality checking procedures and was well led by both the executive and team leaders of the day hospice service and the family support service.

There was a defined structure to the organisation with a board of trustees, chief executive officer and managers and support services. Staff we spoke with were aware of the roles of the management team at the hospice. They told us the managers were approachable and had a regular presence at the hospice. The managers we spoke with showed they had a good understanding of the care provided which showed they had regular contact with staff and people who used the service. There was a registered manager in place who was also known as the head of care and a manager for the hospice at home service. Both managers spoke about how proud they were of their team of staff and volunteers. The registered manager showed they had an open, reflective and approachable management style. The manager's approach was clearly appreciated by staff. One staff member said, "[Registered manager's name] is supportive, but let's us get on with our job" and "There is a no blame culture" and if things are difficult, "We work it out and we learn from it." Another staff member told us, "[Registered manager's name] is really approachable and helpful."

Staff and volunteers worked together in a friendly and supportive way. One staff member told us, "I love my work, it is the best job. Very caring staff who are all willing to help with tips and advice is shared." Another staff member said, "We work as a team," and "I feel so privileged to work here." Staff told us there were different arrangements in place where they were able to gain support to do their work. For example, one staff member confirmed they could access an external counselling support service but had not needed to because of the quality of the informal support they received from colleagues. Another staff member described how they had been concerned about a person's decision in regards to their treatment. The staff member told us they had been able to resolve the issue by discussing with other members of the palliative care team on the same day which reflected the strength of the support they had from colleagues.

Staff we spoke with were aware of their role in reporting any concerns and they told us they would report concerns in accordance with the provider's whistleblowing policy. One staff member told us, "I would happily report concerns to external agencies if I needed to but I have never had the need to whistle blow."

We found there was a positive culture which was inclusive and supportive to both people and staff which enabled them to provide their feedback and suggestions about the hospice services. For example, people could have their say about what they would like and we saw 'you said' and 'we did' was used to show how people's suggestions had been listened to and action taken. We saw the suggestions for improvements were

noted and taken to the board of trustees, such as improving the access in the garden and pond area. Another example of improvements discussed was to focus upon the new garden room to make it welcoming and comfortable for people to use. There were plans to purchase new furniture to assist with making the improvements for the benefit of people who spent time at the hospice. The registered manager told us feedback was gained from people in a variety of ways which included a forum which was led by an external person where people were able to share their views and suggestions about the care and support the hospice services provided. For people who received a service at home, a questionnaire was sent and their views from this were reported on. This ensured areas of improvement and what worked well was included in the monitoring of services to ensure they remained centred on people's needs.

The organisation's vision and values emphasised respect for each other, put people at the heart of the service and focused upon enhancing the lives and wellbeing of people who used the services. Staff spoke openly with us about how they used these values in their everyday practice such as ensuring they tailored care and support to meet people's own life choices and wishes. For example a person's relative had contacted the chaplain distressed their family member may not live long enough to walk them down the aisle. The chaplain visited the family and conducted a short ceremony in their home, which was filmed by a friend. The person died soon after this ceremony and the family member plans to watch the video when they get married, as a way of connecting their relative with their marriage. Another example was of how people who used the hospice at home service praised and valued the staff for providing them with a much needed break from their caring roles. One relative confirmed, "I can't explain what they (staff) have done for us other than to say it meant the world by just having a good nights sleep for me and by [person's name] being able to die at home as this is their one wish to." We saw there had been an increase in the number of people who died in the place of their choosing which showed the commitment of the management and staff team in providing people with options to fulfil their choices.

The registered manager had a clear focus on the continuous development of the services to ensure the diverse and changing needs of the local community were considered and met. They told us about their ambitions to remodel the hospice day service to provide a day where people were provided with a range of therapeutic activities. For example, creative writing, art, photography or video (life-story work) and T'ai Chi (health promoting exercise). They also planned to offer people the opportunity to access other healthcare professionals on the day, such as the physiotherapist or occupational therapist, through appointments that would be available throughout the day.

Effective quality checks were undertaken to drive continuous improvement for the benefit of people who used the services, staff and volunteers. Checks were used to review and measure the performance of the hospice services people received and included care and support. The audit checks were seen by all the management team and, staff and reported to the board of trustees. Quarterly reports showed where there were any areas of concern these had been identified and action plans were put in place where needed so that the quality of care was not compromised. We saw any actions to be undertaken were followed through to see how effective they had been.

The registered manager was committed to benchmarking the quality of the service people received against research to help make sure they continually sought ways to improve the experiences of care for people. For example, the National Institute for Health and Clinical Excellence [NICE] quality standards for end of life care were used to promote best practice and make sure people were provided with high quality standards during their care and treatment journeys.