Rowcroft House Foundation Limited

Rowcroft Hospice

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Good** ●
Is the service effective?	**Outstanding** ☆
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Good** ●
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

Rowcroft Hospice serves the people of South Devon. They provide palliative and end of life care, advice and clinical support for people with progressive, life limiting illnesses and their families and carers. They deliver physical, emotional and holistic care including bereavement counselling support, a lymphoedema service which provides advice and treatment (for people who experience swellings and inflammations usually of arms and legs), an outpatient service, occupational and creative therapy, complementary and physiotherapy, chaplaincy, social workers and clinical nurse specialists and volunteer services. The hospice inpatient unit can care for up to 17 adults who require symptom control or end of life care. The average length of stay is two weeks. The service provides acute specialist palliative care for people and does not provide a respite service or have longer stay beds. The majority of people are cared for in the community.

The service continuously looked at the local community to see how best they could provide the service. This had resulted in the provision of the Hospice at Home service. Rowcroft's Hospice at Home service provides responsive end of life care and support to patients and their families in their own home or a care home in the last two weeks of life. The service operates 24 hours a day, 7 days a week with access to doctors, registered nurses and care assistants as well as ancillary staff and therapists. The Hospice at Home staff are all employed by Rowcroft and work with other health care professionals in the community. Services are free to people and Rowcroft Hospice is largely dependent on donations and fund-raising. A training centre also offers advice and support to staff in nursing and residential care settings in the community. The service had also recognised a need to provide specialist training and end of life care for people living with dementia and their carers and had established links with homeless communities.

This inspection was carried out on 11 and 14 January 2016 by one inspector, a pharmacist inspector, an expert by experience and a specialist advisor in palliative care. It was an unannounced inspection. There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They oversaw the running of the service and were supported by a leadership team that included the chief executive and directors and department managers.

Information about the needs of the local population had been used to develop specialist support such as the expansion of the hospice at home service. The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

Staff were trained appropriately and had a good knowledge of each person and of how to meet their specific support needs. Staff went that extra mile to ensure people's needs were met in a holistic way including support for people's loved ones.

People's feedback was actively sought, encouraged and acted on. People and relatives were overwhelmingly positive about the service they received. They told us they were extremely satisfied about the staff approach and about how their care and treatment was delivered. Staff approach was kind and compassionate. Relatives told us, "The care was first class, the staff were all so considerate and helpful no matter the problem and what a wonderful place." People's feedback about the caring approach of the service and staff was overwhelmingly positive and described it as "Fantastic" and "A1". Clear information about the service, the facilities, and how to complain or comment was provided to people and visitors.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place which included the checking of past conduct and suitability from previous employment to ensure staff were suitable to work with vulnerable people.

Staff knew each person well and understood how people may feel when they were unwell or approached the end of their life. They responded to people's communication needs. 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 according to their individual plans and provided outstanding care.

The environment was an older style building and had been well utilised for ease of access for people. It was welcoming, well maintained and suited people's needs. The clinics, therapies and support groups were held in a new purpose built building across the grounds. There was a beautiful outlook and well maintained grounds which were also accessible for people to enjoy.

Staff had received essential training including end of life care and were scheduled for refresher courses. Staff had received further training specific to the needs of the people they supported. All members of care and support service staff received regular one to one or group supervision and support with clinical supervision and professional validation. This ensured they were supported to work to the expected standards.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered the requirements of the Mental Capacity Act 2005.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences, restrictions and reduced appetite.

Staff communicated effectively with people, responded to their needs promptly, and treated them with genuine kindness and respect.

People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent or refusal before they supported them. Staff pre-empted and responded to people's individual needs and requirements. People and their relatives told us, "From our first contact with staff, my husband and I were helped in every possible way with kindness and efficiency. We could not have had better treatment".

People were involved in the planning of activities that responded to their individual needs. The hospice mainly cared for people with acute needs meaning they were unwell or at the end of their lives. Therefore, activities were more based on therapeutic methods such as therapies and spending time with people. Attention was paid to people's individual social and psychological needs.

The registered manager was open and transparent in their approach. They held a vision for the service that included "Let's make every day the best day possible." Staff demonstrated this vision in their practice and gave person centred, individualised care. Staff told us they felt valued and inspired by the registered manager to provide a high quality service. They described the registered manager as welcoming and friendly, someone who made people feel valued.

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 were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Robust and safe recruitment procedures were followed in practice.

The environment was fit for purpose and well maintained.

Medicines were safely managed.

Is the service effective?

Outstanding ☆

The service was effective.

Staff went that extra mile to ensure people's needs were met in a holistic way including support for people's loved ones.

Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation putting it into practice in a sensitive way.

People benefitted from a service which provided food and drink in an individualised way depending on people's end of life needs.

People were referred to healthcare professionals promptly when needed. Staff worked in partnership with health professionals, sharing end of life expertise, to ensure processes benefitted people and supported their choices in a timely way.

Is the service caring?

Outstanding ☆

The service was very caring.

People's feedback about the caring approach of the service and staff was overwhelmingly positive and described it as "Fantastic" and "A1".

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. People valued their relationship with the staff team who often performed beyond the scope of their duties to meet people's needs.

The service was very flexible and responded quickly to people's changing needs or wishes. Staff communicated effectively with people and treated them with utmost kindness, compassion and respect.

People were consulted about and fully involved in their care and treatment.

The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

Is the service responsive?

Good ●

The service was responsive.

The hospice used knowledge of the local community to develop a service which best met local needs.

People told us staff had outstanding skills and knowledge. They told us that staff understood and anticipated their needs which enhanced the quality of their support.

The service provided person-centred care based on best practice and focused on continuous improvement. People's care and support was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them.

The service took a vital and key role in the local community, for example providing training in discussing advanced care planning at an early stage and reaching out to minority groups to enable them to access end of life care.

Is the service well-led?

Outstanding ☆

The service was exceptionally well led.

The provider and registered manager provided outstanding and compassionate leadership and support to ensure people needs were met.

There was an open and collaborative culture within the team who worked effectively with people, relatives, volunteers and other professionals to shape the service on offer and ensure people's health social and wellbeing needs were met.

A committed and stable staff team showed willingness to learn from mistakes and improve because they felt supported and were well trained.

Information about the needs of the local population had been used to develop specialist support.

Rowcroft 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 carried out 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. At our last inspection in November 2013, no concerns were found.

This inspection was carried out on 11 and 14 January 2016 and was unannounced. The inspection team consisted of one inspector, a pharmacist inspector, a specialist advisor in palliative care 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-by-experience who took part in the inspection had specific knowledge of caring for older people who approached the end of their lives.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. The registered manager sent us 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 looked at the premises, spent time in the inpatient unit, the clinics and went out on visits with the community nurse specialists and a Hospice at Home nurse. We were able to visit people in their own homes with their permission. We looked at seven sets of records that related to people's care. We looked at the systems in place for managing medicines, spoke to staff involved in the administration of medicines, and examined ten people's medicines charts. We looked at six people's assessments of needs and care plans. We consulted documentation that related to staff management and four staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and the activities programme. We observed a 'ward round' and the administration of medicines. We sampled the services' policies and procedures.

We spoke with five people who were receiving care in the inpatients unit and three of their relatives and two outpatients. We also spoke with relatives of one person who was receiving care from the Hospice at Home service and one person and their relative who had visits from the community nurse specialist team.

We spoke with the registered manager/director of patient care, the chief executive, a ward administrator and ward clerk, three doctors, the head of community services, the chronic oedema service manager and the safeguarding lead, audit lead, director of human resources and support services, the housekeeper, catering manager, chaplain, the inpatient unit manager, the Hospice at Home manager and a Hospice at Home nurse. We also attended a community multidisciplinary team meeting (MDT). We also spoke with four registered nurses and five care workers on the inpatient unit and a GP and district nurse. We obtained their feedback about their experience of the service.

Good ●

Is the service safe?

Our findings

People told us they felt safe receiving the service. They said, "I am in the best place" and "You feel really safe here." Staff said, "Yes, people are safe here. I've not had any cause to not think that. I think you can say how you feel. There is someone you can talk to and you are listened to."

There were robust systems in place to keep people safe and minimise risk. Staff knew how to identify abuse and how to respond and report internally and externally. Staff knew how to access the safeguarding of adults and whistle blowing policies. These policies were up to date and reflected the guidance provided by the local authority. Staff training records confirmed that training in the safeguarding of adults was part of the induction for all members of staff. This was complemented by annual training and refresher courses which were up to date. Staff were also fully trained in child protection as they supported families. Volunteers were also included in safeguarding awareness training which was being developed.

Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. The PIR shared an example of how formal concerns were raised and investigated fully resulting in a report shared with the clinical governance committee. As a result the hospice became one of the first hospice service to sign up to the "Speak Out Safely" Nursing Times publication campaign. This openly encouraged staff to share any concerns. An action plan responded to concerns including training staff in how to balance privacy versus disturbing a person for personal care and mouth care assessment which was included on the electronic record. Staff were also visiting another hospice for learning.

There were sufficient care staff on duty, to support and care for people in the inpatient unit, community and Hospice at Home. The team of doctors worked across all services and visited people in the inpatient unit, at home, care homes, in out-patient clinics or in hospitals. One of the doctors was always on call at weekends and overnight for advice with a consultant in palliative medicine consistently available for further advice if needed.

Staff told us there were enough staff to care in the way people needed and at times they preferred. We observed staff were available to help people at various times depending on their wishes. People told us staff always had time to talk and they did not feel rushed or have to wait for assistance. Staff also told us there was time to be with people which was seen as very important as part of the hospice ethos. Staff worked on the inpatient unit with ample time for handover of information. Early shifts consisted of four registered nurses and four care workers and three registered nurses and two care workers in the afternoon. An administrator and two ward clerks covered seven days a week. On each shift there was a unit manager and two senior registered nurse managers worked alternate weekends to ensure good management cover. Additional staff were provided to respond to an increase in people's needs, which were calculated regularly using a dependency tool/risk assessment such as for increased falls. The hospice used agency staff if they needed to and tried to use staff that knew the hospice well for continuity.

Safe recruitment procedures were followed. Criminal checks had been made through the Disclosure and

Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable to work with vulnerable people. Proof of identity and right to work and reside in the United Kingdom prior to starting to work at the service had been checked. References had been taken up before staff were appointed and were obtained from their most recent employer. Disciplinary procedures were in place to ensure staff respected their code of conduct. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual and were reviewed and updated daily by nurses. Staff were aware of the risks that related to each person. For example, one person required various methods of assistance with changing their position depending on how they were feeling. The care plan showed staff had promoted independence but assisted using methods detailed in the care plan at other times. Barriers to independence were also recorded such as a tendency to shortness of breath and this had been safely managed. Risks were also communicated to the nursing team on handover and on a patient board. Risks relating to pressure sore prevention were very well documented with clear actions and records. Thought was given to balance risk management and people's preferences and comfort when they were at the end of their lives. For example, when a risk assessment showed a high risk but the person found the action such as using a particular mattress difficult, a more appropriate method was used. Records showed clear involvement with people about safe management of risk that was also acceptable and proportionate to their needs. Therefore measures were in place to keep people as safe as possible depending on their needs and preferences.

Medicines were supplied by an agreement with a local community pharmacy who also provided the clinical pharmacy service (advice, regular medicines checking and support) and medicines information. The service included the supply of stocks for in-patient use, and dispensing of individual medicines when people went home. Staff told us they were always able to obtain the medicines they needed. Staff recorded the medicines people brought in and checked them to make sure they would continue to receive the correct medicines. There was no clear record of the secondary check with the patient's GP, which could mean people may not be prescribed the right medication. However, there had not been any errors and we saw staff were in the process of reviewing these processes to make sure they were recorded immediately and met current good practice guidelines. This review had included gathering information from other hospice services to see how they managed the process.

The pharmacist was involved with the training of junior doctors on the prescribing of controlled drugs to help ensure these medicines were prescribed correctly. The pharmacist also attended regular pharmacy meetings with the medical and management team to discuss medicines issues and support the safe use of medicines. The prescription charts were all signed by the prescriber, any allergies were recorded and administration details were signed when medicines were given, or reasons clearly recorded for any omitted doses. This meant people could be assured they would receive the correct medication at the right time by staff who were trained appropriately.

There were separate charts for doctors to prescribe medicines administered in syringe pumps. Records showed that staff regularly checked these pumps were working correctly. Some people were prescribed pain-relieving medicines in patch form. Staff used separate records to document when they applied, and checked these medicines. This helped ensure that people would receive their pain relieving medicines safely. There was also a process to allow nurses to give a range of homely medicines that could be bought over the counter, agreed by the doctor. This allowed nurses to respond in a timely way to treat people's minor ailments.

There was no-one administering all of their own medicines at the time of our inspection, but there was a policy in place for this if people wished to do so and it was assessed by the nurses as safe for them. It was clear when 'as required' medicines were to be administered and we were satisfied that people received medicines when they needed them. Some of these medicines were prescribed without a maximum frequency provided but we saw that people's medicines use was reviewed daily and medical staff were always available for nurses to ask about people's medicines. We saw that managers had identified this and then reviewed and risk assessed the processes. Staff provided people with written information about their medicines when they went home, to help them take their medicines safely and effectively.

Medicines and prescription and order pads were stored safely. Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored securely. There were regular checks of these and staff followed up and reported any incidents where necessary. Medicines requiring cold storage were kept within a monitored refrigerator. There was a supply of medicines for emergency use. Staff checked these medicines regularly to make sure they were safe to use along with other emergency equipment.

Staff were able to access up to date information on the safe use of medicines. Comprehensive policies and procedures were available for staff and these were kept under regular review. An annual training day was arranged for the whole nursing team. This covered topics such as symptom control. E-learning modules were available online for staff and these were updated regularly, along with competency checks to make sure staff were handling and administering medicines safely. Staff were encouraged to have flu vaccination by the on site practitioner to further protect people in the hospice. Mandatory training on using hospice and own vehicles for hospice business was up to date.

Staff carried out regular medication audits which identified any recommended actions and these were followed up. Medicines incidents were reported and reviewed and there was evidence of learning. For example, staff had investigated the incident, looked at the possible root causes and then made recommendations to reduce the risk of a similar incident recurring.

The premises were cleaned to a high standard and records were kept to evidence frequent cleaning throughout the day. Cleaning standards were monitored to ensure people remained as safe as possible from risk of contamination. Systems were in place to make sure the staff were aware when a person had an infection. People's rooms were deep-cleaned using steam cleaning equipment before any admission. Systems in place for the segregation of laundry and the management of waste were implemented appropriately.

The ward appeared clean. It was free from unpleasant odours. Everybody entering the ward used hand cleansers each time they came in. There was an infection control nurse who worked with support from an inpatient nurse with an interest in infection control. Infection control practices were evident, items such as commodes and trolleys had stickers stating when they were cleaned. Infection controls audits were carried out regularly. Detailed infection control policies were in place and had been reviewed to reflect current national guidance. These included hand washing policy and standard precautions, such as instructions concerning how to deal with spills of bodily fluids. Hand washing audits had been introduced and staff were observed washing their hands after they had been in a person's room. Staff reported they would challenge others if they found that hand hygiene was not observed. Staff wore appropriate personal protective equipment (PPE) which was in ample supply. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe.

The kitchens had been totally refurbished a few years ago, and had modern facilities that could be easily cleaned. For example, storage shelving could be cleaned through the dishwasher/steriliser. The local environmental health food hygiene rating had awarded the hospice a 5 star rating (the highest possible rating). The hospice carried out a regular routine inspection of both the kitchen equipment, maintenance and cleaning practices including temperature monitoring.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks that included clear guidance for staff to follow. Staff understood how they should respond to a range of different emergencies including fire, and fire training was part of their induction. Staff took part in regular fire drills which helped them to remember the procedures and there was appropriate signage about exits and fire equipment throughout the home. Fire safety equipment had been serviced and was regularly checked. Staff also attended emergency training in managing anaphylaxis (shock), safe management of blood transfusions, and resuscitation.

Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. Maintenance issues were dealt with in a timely manner.

Accidents and incidents were recorded and monitored using an electronic patient record to identify how the risks of recurrence could be reduced. There were records showing external clinical incidents, internal and incidents relating to drugs, pressure sores or falls. All incidents are reported to the quality team who analysed the findings and ensured appropriate actions were taken. The quality team also completed notifications required by CQC.

Outstanding ☆

Is the service effective?

Our findings

People consistently said staff gave them the care they needed. People's comments included, "Each time I have been treated with the highest level of care", "From our first contact with the staff my husband and I were helped in every possible way with kindness and efficiency" and " We could not have had better treatment". One person said "The nurses are always considerate. Any questions I have are always answered and I've been supported to take advantage of all services available to me." Relatives told us, "It's great to know the community nurses are there for you. They know their stuff but also let us decide how we want to manage things in our own time. I like to manage the care myself and they look after me too." A district nurse working with the hospice at home service told us "We work so well with the hospice at home team. They can provide such a good service and focus on end of life care with their specialist knowledge. I've learnt so much too."

The service continuously looked at the local community demographic to see how best they could provide the service. The service had recognised a need to provide specialist training and end of life care for people living with dementia and their carers. The hospice had a social worker with a special interest in dementia and a dementia champion. They had developed training in "Death and Dementia" and "Planning Ahead" for people newly diagnosed with dementia in line with national guidance and dementia strategy. This had been designed in collaboration with people who live with dementia via a local dementia alliance group and the national Alzheimer's Society. The report findings related to the project were being published in March 2016. A presentation at an international conference described the benefits/impact for people living with dementia. For example, 'people with dementia should have as equal access to end of life care as those dying as a result of other diseases. Particular attention should be paid to supporting people with dementia in discussing and documenting their wishes as early as possible following diagnosis'. Although there was no-one during the inspection with dementia, the registered manager said how the training had already encouraged spouses and staff alike to raise advance care planning issues, so that when end of life care was needed, there was a plan in place detailing people's wishes. Advance care planning was important to the hospice and time was taken to ensure people had considered planning. The training had raised awareness that people living with dementia were often able to discuss issues despite their dementia. The dementia champion also trained people outside the organisation such as church community groups.

Training in dementia and end of life care was now a mandatory part of the new staff induction programme for all staff including volunteers. Each team had a named dementia link nurse. There was an activity box on the inpatient unit containing aids to help staff in communicating and supporting people with dementia. The hospice took part voluntarily in the national NHS patient led assessment of care environments project (PLACE). This had resulted in a dementia friendly environment with appropriate signage and flooring. For example, guiding people to bathrooms using pictures and plain flooring which is best practice to promote independence for people living with dementia. The maintenance programme had also included appropriate décor known to be helpful promoting independence for people living with dementia. A new training programme was being developed for a ward attendant role. This will include spending one to one time with people living with dementia. There was a recognised benefit for recruiting suitable volunteers to offer patients support on a one to one basis, especially those who have few visitors or have cognitive problems.

This emphasis on how to meet the needs of people and their carers living with dementia is an example of outstanding practice.

The hospice had identified that end of life care for the local homeless community could be improved. This was following a lack of end of life care for a homeless person in the community, who had not been able to access care. The hospice now provided training to the local health professionals working with the homeless. They had made links to encourage health workers to access and recognise end of life care needs for the local homeless population, which they were now doing. Staff were meeting with the local homeless agencies next month and providing two and a half days training. Their objectives were to help workers feel welcomed and to explore understanding about palliative and end of life care. Also to share knowledge about priorities of care and what these meant to the homeless and to assess and recognise who might need end of life care. The hospice staff helped raise awareness about local services and what the needs of homeless people and end of life care were.

Staff were knowledgeable about people's needs. Staff shared information about people's care using a comprehensive computer system which enabled all staff to access all of the information about a person and their needs. The inpatient unit had recognised a need for paper care plans by the bedside and printed handover information to enable easy access to important information and enable quick record keeping. These printed care plans gave a clear story of people's needs and were scanned and added to the computer system each week. For example, we could see how mouth care was delivered for a person with a sore mouth and progress followed. Staff knew how to communicate with each person. Care plans detailed how people communicated. For example, one person was very sleepy and communication was declining. We saw staff support the family and take time to communicate with the person when they had more lucid moments.

During the ward round, the medical director talked with each person on the inpatient unit and discussed their options with them. They then reported their findings with a team of doctors and ascertained the best way forward to manage people's symptoms. Handovers took place between staff shifts and updated information about new admissions, people's health condition, their mood, their appetite and medicines reviews was communicated appropriately. Staff said there was good communication between all staff, there were multidisciplinary meetings each morning, a midday handover with the doctors and night time handovers for night staff. This system ensured effective continuity of care so that staff were knowledgeable about people's individual care and treatment. We attended a multidisciplinary meeting with all staff present who were all able to present information to the team. Discussion included, adjustments to medication, specimen results, effectiveness of pain medication and monitoring of break though pain, affects of anxiety medication and possibility of opioid toxicity (where a build up of medication can cause a negative effect), use of night sedation and people's expectations and choices.

The hospice had an on site training unit called "Rainbow House" and an education department. New care and nursing staff had a thorough induction before they started working at the service. They worked in addition to staff numbers for two weeks or as appropriate. This included the shadowing of more experienced staff until they could demonstrate they had attained the level of competency required for their role. Competency checks were carried out regarding personal care and the administration of medicines. Staff were provided with a handbook that contained comprehensive information about the code of conduct and standards the provider expected them to uphold. During the first two months new staff had a list of who they needed to meet, what they needed to learn and what they needed to do. The induction pack included communication, the computer system, medication and procedure following death. A new member of staff said of their induction, "It's been good." Staff told us, "There is a lot of support from colleagues and support from the manager", "A lot of support and the education is good" and "The mandatory training has increased so much. We have dedicated trainers on site."

Training was provided by e-learning and face to face. There was other informal training given but not always documented such as the use of the bladder scanner. A training booklet showed all training available for staff. Staff said there was lots of training accessible. One staff member had also undertaken advanced training and competence assessment with feeding tubes, wound care and was able to give death certificates and valuables to bereaved families, which reduced any waiting. Another care worker had done a palliative care course, advanced communication and was now completing a national vocational qualification with staff support. Competency assessments followed practical training, such as for care workers who undertook female catheterisation who would need to pass in order to perform this procedure.

People were protected from discrimination. Equality and diversity training was mandatory for all staff supported by an equality and diversity policy. The hospice had links with the local clinical commissioning group (CCG) equality and diversity lead who had provided leaflets on protected characteristics and was preparing an advance care planning booklet in easy read for people with cognitive impairments.

Staff were supported and assessed using a thorough supervision and appraisal programme. New staff had an induction interview followed by 1, 2, and 3 probation review meetings. One care worker said, "The supervisions are confidential and I was able to off load and talk to someone neutral." They thought the appraisals were helpful as they set realistic goals together. Professional validation for nurses was supported by a dedicated person in the hospice. One staff member informed us of training modules that were available towards a degree as well as the training available on the computer and in the training booklet. This ensured staff had the knowledge and skills they needed to care for people effectively and opportunities for career progression.

Staff sought and obtained people's consent before they supported them. One person said, "I recall being asked to consent to treatment but have had no change to my treatment so there's no need sign again. Yes, they always give me explanations and possible outcomes" We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated a good understanding of the processes to follow. Staff were trained in the principles of the MCA and the DoLS and these were applied in practice. There was a "Regarding treatment decisions for patients" policy and staff were able to discuss issues such as the appropriate use of bed rails and lap straps on wheelchairs. When people had been unable to leave unaccompanied and needed continuous supervision to ensure they remained safe, their mental capacity had been assessed appropriately. A recent audit of documentation had resulted in clarification of who had responsibility for ensuring mental capacity assessments were completed in a timely way. This ensured people's rights to make their own decisions were respected and promoted when applicable.

When people had been assessed as being unable to make relevant and specific decisions, applications for the authorisation to restrict their freedom in their best interest had been submitted to the DoLS office. DoL's applications were completed by the in-house social worker in collaboration with the multidisciplinary team. Comprehensive records were made of how appropriate meetings had been held to discuss people's best interests and make a decision on their behalf, in accordance with the requirements of the MCA. For example, we heard how a sensitive situation had been managed. A best interest meeting with the multidisciplinary team had been held with the person's loved ones to discuss withdrawing an aspect of treatment, which was causing distressing symptoms. The person was unable to make that decision but following open discussion with the multidisciplinary team and the family was able to have a peaceful end of life with their family.

People praised the food that was served; their comments included, "Food is excellent, just like home cooking". A copy of the weekly menu was given to people on admission. A member of the catering team visited people twice a day to take their food order. People were asked about their likes and dislikes and how they preferred their food to be prepared. It was not possible to serve meals regularly to visitors to the unit, but under special circumstances, for example, if a relative needed to stay overnight, meals were available. The catering manager said of the kitchen, "We are proud of the fact that we are flexible. We go the extra mile – that's all the staff – we will offer whatever, with-in reason, the patient wants. We will offer alternatives. We are trying to encourage the patients along, trying to encourage them to eat something." They said they would pop to the shops to try and get people something they fancied eating.

People were referred to healthcare professionals when necessary. For example, before a person had returned home, the service's occupational therapist had visited their home to assess what equipment and adaptations may be required and ensure this was provided. Staff worked in close partnership with people's GPs when they supported people in the community. The service's clinical nurses specialists were 'attached' to GP practices in three geographical areas and attended regular 'Gold Standards Framework meetings'. All organisations providing end of life care are expected to adopt a co-ordinated process such as the Gold Standards Framework, which is a systematic, evidence based approach, developed to improve quality of care for patients with a life-limiting illness.

Hospice at home nurses had good relationships with local pharmacies and were able to access medication in a timely way. We attended a discussion with the hospice at home nurse and a GP and saw how they valued each other's views to achieve the best outcome for people. People were referred appropriately and without delay to consultants such as neurologists and oncologists, to hospital specialist teams such as the chronic pain team and specialist nurses such as tissue viability nurses. Communication ensured that end of life care was provided in partnership with the wider community for the benefit of people. Meetings were held together and one meeting had clarified how the "just in case" bags worked for people. These were bags containing equipment and medication that may be required in the future for people that were kept in people's homes. The discussion ensured they contained all the appropriate medication and were kept up to date. This ensured that staff responded effectively when people's health needs changed.

The hospice had also met with other specialists such as haematologists and oncologists (blood and cancer care specialists), to support patients in advanced care planning discussions including where they wanted to end their lives, as patients had not always been able to choose where they wanted to end their lives by having to go to hospital. The discussion resulted in changes being made to ensure resuscitation forms were clearer and consistently contained the relevant information. Information recently sent out to GPs about implications of Deprivation of Liberty orders in place at time of death. This information needed to be included on cremation forms before the medical referee could authorise cremation. This has enabled a more streamlined coroner's referral thus reducing the risk of delays for bereaved families.

The environment was an older style building and had been well utilised for ease of access for people. It was welcoming, well maintained and suited people's needs. The clinics, therapies and support groups were held in a new purpose built building across the grounds. The premises had been designed and decorated taking people's physical and psychological needs into consideration.

The hospice had won a national award for the "Best External Environment" for their inpatient garden. There were 22 acres of unspoilt grounds in the centre of Torquay. The hospice had applied and been granted funding to enable a landscape designer to work with the hospice working group, representatives from the estates, nursing, administration and occupational therapy departments and patients, and created an outside area that was accessible from all the wards. There were facilities for at least three beds to be wheeled outside, along with discrete seating areas for more ambulant patients near to the wards. We heard how people had benefitted from accessing the outdoors. The centrepiece of the terrace was a water feature providing movement, sound and a calming influence. Subtle lighting continued the enjoyment of the garden and water feature area into the night, while ramps from the terrace allowed safe journeys further away from the immediate ward area to other parts of the grounds such as the wild flower meadow, which was previously inaccessible. The judges said, "This is a garden re-design of the highest quality which has radically improved access for palliative care patients to the grounds of the hospice. The design is full of thoughtful touches including ramps for accessibility, the provision of parasols to provide shade, and electricity points so that beds can be wheeled out onto the terrace."

Outstanding ☆

Is the service caring?

Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided, and the manner in which it was delivered. All their comments were positive. One person sent us an email saying, "[Person's name] was transferred to Rowcroft and within an hour was peaceful. [Their] whole manner changed and they were no longer anxious or rambling. They were shown excellent patient care and respect. We have nothing but admiration for Rowcroft. The patient is definitely their number one priority. This is not only shown to the patient but the care and consideration for the family was incredible."

Other people's comments included, "The staff are compassionate and caring, they talk to me as an individual and empathise. They believe in what they're doing", "When you come in it's a very calm atmosphere, no noise, I find it whenever I come, it's the ambience. They all seem very committed they care about patients". A relative said, "The [hospice at home] service my family received was absolutely fantastic. A1. From the moment Rowcroft Hospice at Home were involved with my mum's illness I felt such a sense of relief, knowing I was not dealing with it on my own. The staff were amazing and I would not hesitate to recommend the service to anyone. "

We looked at people's testimonies on the iWantGreatCare website. This is a national website which services can sign up to to collect online feedback. The hospice had achieved a five star rating (the highest available). People's testimonies included, "Both my wife and I feel totally supported by the inpatient team and were welcomed back into the fold like old friends. The inpatient team always have time to stop and chat, from the consultants to the housekeepers and, of course, the wonderful volunteers who must be mentioned. I cannot see where there could be any improvement in the care and support provided by the Rowcroft Inpatient Team," and "We have been blown away, wow what an amazing place Rowcroft is, each and every one of them have made such a difference to us for which we will be forever thankful. An amazing team you should all be very proud of yourselves."

Staff were also positive about the care they were supported to provide. A staff member said, "The patients want for nothing." Staff comments included, "The work is really rewarding and makes a vital difference to people's lives", "I love the environment, staff are lovely and kind and have time to spend with the patients" and "It's a wonderful place to work, very special staff who are able to give good care to the patients. It is a privilege as a nurse to be able to give hands on care as a senior." Staff all spoke about how it was a wonderful place to work. Comments were, ""It's the best place I've ever worked" and "I think it is a fantastic place, I've worked in lots of other places and this is the nicest place I've worked from the patient's point of view. They get the best care and from a selfish point of view they really look after you." A quarterly review of the online comments also found the feedback was overwhelmingly positive.

Visitors were welcome at any time. We were also told that if close relatives had been called in and were required to stay at the hospice there was a bed, partners could stay and when possible, beds could be pushed close together.

There was a homely feel to the service in the inpatient unit. There was a social atmosphere where people were encouraged to chat if they wished and were listened to. Staff were smiling and engaging, they stopped to listen to people and responded to them with genuine interest. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they conversed with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names. While we were in the nurses' station a doctor came to discuss a patient with the nurse in charge. The doctor was concerned that visitors were causing them to become agitated. The way both professionals discussed the issue demonstrated their profound understanding of the complexity of personal relationships at a stressful time. They demonstrated their care for the patient and family.

We heard from the registered manager examples of how staff had overcome barriers to go the extra mile for people. One person had a visit organised so they could see their horse. They said in the hospice newsletter, "My family were extremely fortunate that our dear mum was able to spend time at Rowcroft Hospice. She loved going out into the immaculate gardens and seeing the stunning wildflower meadow. We were very grateful to be allowed to bring the dogs in to see mum and this always bought a smile to her face. Rowcroft is a truly amazing place which has managed to provide us with some memories to treasure." Two nurses also told us how wonderful the reunion had been for everyone. They said, "It is nice that we can wheel the patients outside so they can feel the sun on their skin", "I think staff go above and beyond" and "We do whatever it takes. It's the little things that make the difference." Staff had also been able to organise for another person to visit a place with special memories in the country. The person had told the hospice staff, "I was scared of going out but spending a couple of hours chatting with the staff has made a big difference."

There was a chaplain on site who worked part time. They were available for spiritual care of any denomination or belief. Hospice staff were looking at further ways to capture people's spiritual, cultural and religious beliefs. There was a community nurse specialist with a special interest in this role. The hospice also employed an oncology support specialist who worked alongside members of the multidisciplinary team to offer support on psychological/spiritual aspects of care. Staff said, "It is very much whatever is important for that individual, it's not just the physical it's the emotional as well." One person had wanted a particular service. The chaplain was not able to carry this out themselves, but had arranged for an appropriate person to fulfil the request.

The chapel was a calm and inviting area and was tailored for Christianity but could be used by others. Candles were available to light and people were invited to write prayer requests onto small heart shaped paper. One person was able to attend their daughter's wedding which was arranged in the hospice chapel. The family said in the hospice newsletter, "It became clear that [person's name] would not be making the trip for our wedding so just thirty-six hours after first mentioning it to [the chaplain], we were married in the Chapel in front of our closest family. It was a wonderful, joyful day, made possible by the tireless commitment of everyone at Rowcroft to support their patients and their families." There were many other examples showing how caring the hospice staff were in helping to provide care and positive memories for people. One person used to be a professional musician, but hadn't played for a long time. They had been supported by the music therapist so they could play again and had joined the Rowcroft choir.

There was bereavement support for staff and families. Staff were in turn supported by the management team if they experienced emotional difficulties due to the nature of their work and were also able to receive counselling. Staff felt part of a team as their views and opinions were listened to. The staff team had regular meetings. A meeting was arranged for example with a specific agenda focusing on communication skills asking the team to present their ideas at the meeting. Then there was consideration of how to put into practise the team's ideas and make an action plan for implementation and evaluation.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. There was a comprehensive information booklet that included the service's mission statement, the range and nature of services available, the structure of the medical team, Out-patient clinics, how to complain, and a list of information leaflets that were available such as strong medication and driving. The service had an updated website that contained clear, comprehensive information and that was user-friendly.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in 'advance care plans'. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they wished to be their legal representative. These advance decisions were recorded, effectively communicated to staff and respected. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. People and their relatives were included in the discussions about the way the risks were managed to ensure people's preferences were considered. The registered manager told us and the chief executive spoke of choice for end of life as most important. They said, "We try to do everything we can to enable people to die where they choose." At a doctor's meeting they discussed one person's care, which needed their wife to be involved with the care and further discussion around treatment. This then happened.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. Each person in the inpatient unit had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered. Staff said, "There is a lot of good symptom control here. The care is extremely high as there is good nurse to patient ratio". Thought was given various ways to help relieve pain and anxiety. For example, there was a microwave for heat pads to help with pain relief and discomfort, these were easily cleaned, and had timed instructions on them. If used there would be an individual risk assessment completed.

All staff knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal needs. People were assisted with their personal care needs in a way that respected their dignity.

During our visit a person died. We saw their family, and dog, were with them. After the person died the family were supported by staff and given time to talk in the private space available. After the family left, the ward was curtained off so that the deceased could be moved with dignity and privacy. The hospice told us they were able to signpost people to appropriate local community services and this included care for pets. The hospice bereavement service provided pre-bereavement support and a range of one to one and group support for six weeks post bereavement. This was through hospice staff, trained volunteers and counsellors.

Good ●

Is the service responsive?

Our findings

People and their relatives told us that the way staff responded to their needs was, "Fantastic", "So easy" and "Priceless". They felt the Hospice at Home service and community nurse specialists in particular were easy to access and a lifeline for people and their families. People we visited couldn't believe they were able to access such good care and felt strengthened by the support.

There was an extensive collection of testimonies and feedback from people, friends and relatives who expressed how responsive the staff had been to people's needs. All were extremely positive and thanked the staff. For example, "[Staff name] was always kind and compassionate, listening and sharing with me that I was normal in what my thoughts were. The referral process was very quick and effective and very relevant. Thank you." Recent comments on the national review website included, "They are extremely helpful and happy to help in between my appointments", "They have really helped me during a difficult time" and "You make such a difference to many individuals' lives!"

People could be referred to the service by a member of the Rowcroft community specialist team, GP, hospital district nurse and social care teams, care home manager or members of the out of hours healthcare teams. Referrals could be taken 24 hours a day, 7 days a week. The service aimed to respond to urgent referrals within 24 hours. All requests for routine admissions were considered at a daily admissions meeting. One person said that a recent visit had identified they would be better off at the hospice. The admission was very well organised.

The service was clear about their local demographic and what the needs of the local community were and followed national guidelines such as the National End of Life Care Strategy. The aim of the National End of Life Care Strategy is to enable people to die in the place of their choice. Referral to the hospice was usually prompted by the presence of uncontrollable symptoms, major difficulties in adjusting to a terminal illness, or the need for in-patient end of life care. Many people wished to be cared for in their own home. The chief executive said, "For Rowcroft, getting people out of hospital back to their own homes [when they choose] for end of life is a key issue". About 70% of services were provided in people's homes and care homes. In Rowcroft publications the focus was on, "Helping families to stay together for longer and make the most of the time they have together".

The hospice had therefore invested in a Hospice at Home service. This had been expanded due to increased need. The hospice had previously run a day centre but as people were travelling long distances in a rural area, this service had been discontinued and alternative support signposted to other organisations. This service was for people with a prognosis of less than two weeks, regardless of diagnosis, who wished to be in their home in the final days of their life. Their aim was to support patients and their families to achieve their preferred place of care or where there was a sudden deterioration and the person was too unwell to move from their home.

The hospice at home service aimed to prevent unwanted hospital or hospice admission and worked closely with NHS and social care staff in the community, who helped to facilitate rapid discharge to preferred place of care at end of life. There was a clear referral criteria for all areas of the service and the whole team provided 24 hour care. We heard examples where people had been able to go home for end of life care as they wished and others where prompt symptom control had resulted in a peaceful death in the place people wished to be.

The hospice website also stated, "We are happy to become involved earlier with patients who have learning difficulties to enable us to build trusting relationships with them". All staff had been trained in equality and diversity and the service as a whole had links with the CCG equality and diversity officer. This showed the service was responsive to local need as a whole and also to individual need. Joint visits with a member of the primary health care team could be arranged where appropriate and referrals were through a dedicated contact number including out of hours. The registered manager told us that for the second year, the Hospice at Home service data had demonstrated it was a national leader in responsiveness to the needs of the frail elderly and those people with non-cancer life limiting illnesses.

Rowcroft worked in partnership with other local services. For example, it had been recognised that people could be confused about the services available by Rowcroft Hospice and Macmillan Cancer Support. Rowcroft worked with Macmillan to produce a leaflet "Supporting Devon Together" showing how they worked in partnership together. Macmillan Cancer Support professionals support people with specific cancers and work to improve the provision and co-ordination of cancer and end of life care in the local area. The leaflet stated "Both charities work independently to support people with life-limiting illnesses and ensure that they and their loved ones have access to help, information and services that are timely and effective. At all times both charities believe that their different services should complement one another". This had helped people benefit from targeted support and enabled health professionals in sharing information, to provide a cohesive service in palliative and end of life care.

Hospice staff worked closely with local health professionals in a range of roles from GPs to district nurse teams and domiciliary and care home providers. They had built up a responsive relationship to ensure that gaps in care could be filled. For example, during our visit to a person receiving end of life care at home the nurse was able to quickly arrange for extra personal care hours, follow up visits from the district nurse and ensure the person had all the correct equipment. The district nurse was then able to pick up the equipment while the hospice at home nurse managed symptom control. The GP quickly met with the hospice at home nurse to ensure medication was available. The nurse also had good links with local pharmacies and discussed what medication would need to be readily available. The process was efficient, responsive and focussed on the person and their family's needs.

One doctor told us of a responsive example saying, "the nurses did a fantastic job done with all the team." This had enabled one person to go home and spend their last days in their own bed as they wished. The doctor told us that it was a massive collaboration of the multidisciplinary team, as the person lived on their own. There had been collaboration between the whole unit team, hospice at home, the community care team, GP, out of hours doctors, district nurses and the ambulance service in a timely way. The doctor said, "There is a good relationship between secondary and primary care, social services and local GPs."

Another person receiving care from the community specialist team said, "My situation is rubbish, but Rowcroft make it a lot better." They were being supported to ensure they had enough back up medication and support for the person's carer. Various options were discussed for them to consider such as personal care visits and night sits. The carer told us how they thought they were doing ok until the nurse visited who made things so much better. For example, they now had a regular taxi and were able to go out for respite.

There was excellent communication on a multidisciplinary level. The computer system contained a wealth of information that was able to be accessed by all staff so they could follow people's journey from diagnosis to being provided care from hospice services. They were able to identify any issues with people attending and had a "toolkit" of support to offer. This meant they had a range of options to offer people that they may not have thought about. The system was constantly reviewed and additions made such as icons to alert people to nutritional allergies. Alerts could be made to inform staff of particular issues such as if people requested not to receive named visitors. This was kept confidential. The electronic system was enhanced by bedside paper care plans on the inpatient unit to enable staff to document practical care more efficiently. These were reviewed every five days or more frequently as required. The handover sheets gave a high-level overview of each patient.

When people remained in the inpatient unit for a short period to have their symptoms managed, there was effective transition management to ensure they received continuity of support at home. Care plans written by inpatient nurses were included in discharge information to inform care given at home. This ensured staff were fully informed of any changes in people's health, medicines or treatment when people moved from one service to another. One person said, "I have a six monthly review of my treatment where it's agreed for the following six months. I can't speak highly enough of my consultant as they always do the very best for me."

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the inpatient unit, and when people received support from the Hospice at Home service, staff sat with people, enabling them to spend as much time as they needed and encouraged them to ask questions, discuss their options and reflect upon them. People felt valued and understood because people and staff worked as a team to ensure each support plan was unique and responded to specific needs. For example, the hospice at home nurse spent time listening to the family who were visibly less anxious by the time she left. They had been able to discuss issues they had not thought about and were reassured that the person at the end of their life was comfortable. The nurse also discussed how and who would inform other family members, and they were able to take on some of these tasks to enable the family to spend time together.

Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. Staff knew when a person preferred a late breakfast, a shower in the morning, or that they preferred to sleep on top of their chair at certain times, but staff continued to ask people's preferences as they provided care. For example, one care plan detailed how a person's needs were fluctuating and care was tailored to how they felt throughout the day. A member of staff told us, "The nurses routines try to fit into the patients, we work around them. For example, if a patient wants a bath in the afternoon, they can have a bath in the afternoon. Working around the patient rather than them having to fit into your routine. It is less task orientated here. If someone wants their breakfast later they can have it".

One person said, "I get well looked after by all the staff, they take time to talk to me and listen to what I want. They also support my carer, by warming up his own food which they bring." Another person said, "Even the cleaner knows I've a family member who visits early so they clean around my area first thing" and a relative said, "They know when I visit and greet me. [Person's name] likes it here and so do I."

Admission assessments to the inpatient unit ensured that people received a management plan of their symptoms, emotional and spiritual support, pain relief and specialist care. People were discussed daily in a multi-disciplinary team meeting each morning. The hospice was not a long term placement. If someone was stable enough to be moved they would be. These discussions would be held with the patient and their families. We heard about one person who had an infection. The doctors had discussed with the person what sort of treatment they wanted and what the likely outcomes would be of the various options. The person was able to take time to consider if they wanted intravenous antibiotics or not. Staff said, "We try to do whatever it takes [to respond to people's needs]." We were told that, although it took some arranging, a mobile dentist was brought in to assess one person's mouth and they provided treatment whilst the person was lying in bed. Following this intervention the person was able to eat a normal diet again with assistance.

The hospice provided an outpatient chronic lymphedema service. The service aims to improve care for all people with chronic oedema by raising awareness of the condition, providing education, support and advice to health care professionals and managing people requiring specialist intervention. The chronic lymphoedema service team had undergone training in Tripudio movement (a gentle exercise to music) specifically for people with chronic oedema and had introduced this to the package of care available.

People were involved in the planning of activities that responded to their individual needs. The hospice inpatient unit cared for people for short periods in an acute setting. There were no long stay beds (for example, some hospices have long stay beds funded by continuing NHS care). This meant that generally people were not well enough in the inpatient unit to be able to participate in organised activities. Therefore, activities were more based on therapeutic methods. Attention was paid to people's individual social and psychological needs.

A range of therapies were offered such as massage, aromatherapy, acupuncture, reflexology, reiki, relaxation techniques and mindfulness based stress management for patients, carers and bereaved relatives. The therapies were adapted to suit the needs of each individual. The team of therapists, which included paid staff and volunteers, worked across the whole service, the inpatient unit, outpatients, in the community and in outreach centres. Up to six therapy sessions were offered, free of charge, with the aim of enhancing relaxation and improving quality of life. These may aid symptom control and relieve stress and tension. Therapies took place in the inpatient unit, in the music and art studio and in peoples' homes. We saw the music therapist in the inpatient unit corridor playing classical guitar music, this was unobtrusive and relaxing to listen to. Some volunteers visit to play the piano and harp. There was also an art work scheme which enabled the units to display a variety of local art work, which was changed regularly.

The service took a key role in the local community and was actively involved in building further links. The hospice maintained a high profile in the community and was regularly prominent in the local press through fundraising events. Links with the community were actively sought and encouraged by the leadership team. For example, a fundraiser "colour run" had been organised to celebrate the opening of a new link road. Volunteers and staff contributed to the planning of events. This raised awareness of the hospice services available, promoted donations to benefit people and helped to reduce any stigma.

People were proactively encouraged to give feedback about the service. For example, using the national website iWantGreatCare. There were many comments posted and the recent feedback showed a five star (the highest achievable). The website feedback was reviewed monthly with the staff team including any staff mentioned by name. This was to celebrate excellent practice and to reflect and improve on areas identified as required as requiring improvement. The feedback was overwhelmingly positive. A result of the feedback, the ward clerk designed an interactive board to display comments and feedback to all staff and visitors on a monthly basis. Additional feedback was actively sought about every aspect of the service and people, their visitors and staff were invited to make suggestions using a comments box displayed in the entrance. Where two people had made negative comments, these were both contacted directly offering to meet and discuss the situation. One family took up the offer and had a conversation with the team, which proved to resolve their concerns. The other individual did not respond. No further action was required.

On-going satisfaction surveys were carried out and responsive action was taken to address shortfalls that were identified as a result. For example, one response had resulted in an investigation. Recommendations and learning had been achieved resulting in additional staff training in communication with extra training modules being developed. Senior staff were working more closely with more junior staff in making appropriate judgements towards the end of life with people and a nurse had been to another hospice to learn and share systems and ideas.

Outstanding ☆

Is the service well-led?

Our findings

There was an open and positive culture which focused on people. This was reflective of the outstanding leadership and management of this service. People received care and support by staff who upheld strong values about person-centred care, and positive connections were promoted that enhanced their experience of the service. People were placed at the heart of the service and the registered manager led by placing emphasis on continuous improvement in all aspects of their care. They had a plan to drive improvements in the service and worked in partnership with other organisations to that effect. People's feedback about the way the service was led said, "I cannot fault the management, they are spot on. I feel I can go to them with anything, they are very supportive." Relatives told us, "There are no improvements to be made."

There was an effective leadership team that oversaw the running of the service, that included a chief executive (the provider), the registered manager, who was the director of patient care, and other department and clinical directors. They had particular experience and expertise in leadership, nursing and palliative care. The registered manager had also been awarded an Honorary Assistant Professorship at the University of Nottingham. These awards are given to distinguished practitioners in their fields who collaborate in research and strengthen ties between universities and those engaged in practical experience. This benefitted people in a number of ways. For example, providing opportunities that would not otherwise be known, to take part in research projects. For example in 2015 the hospice staff used a training course developed by the faculty, which was delivered to people supporting lay carers enabling them to have a better understanding on how to support patient carers. Another research project was to take part in piloting a new DVD training tool with real patient/clinician conversations to enhance communication skills training. This training enabled hospice and healthcare community staff to improve their skills in communicating with patients and their families. The registered manager also shares their knowledge with staff and recently gave a lecture to staff on leadership and management in end of life care. A research proposal for funding to test an 'advance care planning brief intervention' is in progress. If funded, the registered manager said this will have a significant impact on patients across the locality as it will provide a tool that can be used to train all general nurses/doctors to use, giving more patients the opportunity to plan ahead for their future and be involved in decisions about their care.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. All the staff we spoke with told us they had confidence in the way the service was managed. Staff praised the provider and the leadership team for their approach and consistent, effective support. They said they could come to the registered manager, provider or any of the service managers for advice or help. All of the staff we spoke with told us they felt valued working in the service, and felt motivated to maintain high standards of care. The registered manager worked shifts in the inpatient unit and stepped in to deliver nursing care to people when there were unexpected shortages of staff. The registered manager took an active part in monitoring standards of practice. The staff told us they were inspired by the registered manager's examples and values.

Staff reported that the registered manager was good and supportive. Comments included, "I think it is a wonderful place to work, and I absolutely love it", "I thought it would be a sad place to work, but it's not a sad place. There are the sad moments, you'd not be human but on the whole it's a good place and lovely. It's supportive and warm" and "It is a privilege to work in a team where people are people not just patients. Each person is treated as an individual, so to be part of somewhere that can accommodate that is a privilege. People tell me that it is a relief to be somewhere where staff speak to you rather than at you. It is very noticeable the difference". One member of staff said that this was the job for them "Due to the support we give to each other and the standard of supervision and support we get from our managers and the support with our training."

Staff commented on how well they felt listened to and supported by management. There was a culture of collective responsibility between teams and services, which was evidenced at the handover meetings. Staff stated they were able to raise concerns including whistle blowing through a range of channels. We saw how this was taken seriously and how a recent whistleblowing challenge resulted in an investigation and recommendations which were actioned.

Staff representatives attended staff communication and consultation groups to share ideas, consult on changes and discuss challenging issues. The chief executive offered regular lunches and invited named staff to "We Lunch, I Learn" sessions, which helped different staff teams mix with each other and did a management "walkabout" on the inpatient unit monthly to meet staff. Issues raised from these sessions included, whether vending machines would be useful for families and to ask what issues arose on the unit. Staff told us they received compliments from managers which they valued and said, "Yes, I am valued. Staff thank me and praise me, we also have a debrief with the senior nurse on duty if we have had a difficult day. She also stated that "The doctors also value my contribution and ask my advice, we have real team meetings." Another staff member said, "Everybody works together as a team, everybody brings something to the team. You are heard and listened to."

The service was forward thinking and constantly looking at ways to improve the service for the local community and in a wider sense improving end of life care as a whole. Rowcroft's mission included, "Believing we have a duty to influence the national agenda on end of life care" and there were many examples of this. The hospice had carried out a "Patient Care Services Capacity and Demand Initial Study" which provided a summary of information on service capacity to meet the current and future demands for their services. These looked set to increase and the hospice had set out what it predicted the challenges would be and how to meet them. The chief executive had presented a report in person for the national enquiry into end of life care to the Health Select Committee in parliament to discuss how end of life care looked for the future. They had also attended the national Hospice at Home yearly conference for information sharing. This helped to raise awareness of the increasing needs for end of life care in the community as a whole and assist with funding. The hospice was constantly discussing improvements for the future. For example, there were plans to increase the single rooms and make the chapel a more multi-faith space. The chief executive was clearly passionate about the work they did and proud of the staff team. They told us how pleased they had been to see a housekeeper sitting with a person looking at their photos, a clear example of putting people first before tasks. Their ethos was, "The best end of life care is shared care." This was evident throughout the service.

The chief executive was a member of the "Joined up Cabinet", a team of providers working together with the clinical commissioning group (CCG) to further integrated working. We heard of good examples of this in practice such as work benefitting people in their care relating to consistency of resuscitation documents and effective provision of 'just in case' boxes. The director of patient care and clinical director met regularly with the End of Life Clinical Pathway Group looking at wider quality and service developments in end of life care.

With the expansion and projected need for the Hospice at Home service the service had recognised that investment in training non medical staff (nurses in the community) to prescribe medication would benefit people. They had shown how this would have a better outcome for patients to reduce delays in accessing medication to manage symptoms. One community registered nurse had now undertaken over 100 prescriptions to manage symptoms for people at home, without the need to get a prescription from the GP, therefore saving time. Another registered nurse was about to qualify and two more were being trained.

The service liked to offer opportunities for a wide range of careers. They ran an apprenticeship scheme where people worked at the hospice whilst on an accredited course. For example, the community secretary was a business apprentice and other staff in finance and fundraising. This helped to ensure a good quality of staff from different disciplines. Staff said, "The hospice feels it wants to also give people a chance to grow into a position."

There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. Where appropriate, audits were discussed with the clinical management team, a clinical governance committee and the board of trustees. Audits of incidents were discussed at clinical governance committee meetings to explore how risks could be further managed. We saw the Rowcroft hospice annual audit programme. This included co-ordination of care, audits of consent, bereavement support and access to external health professional notes. For example, actions had been taken to improve the documentation of spiritual/cultural and religious aspects of the care plans to improve person centred care.

They were also pro-active in instigating audits based on national guidelines and up to date legislation. An audit of how the hospice managed people living with dementia was carried out and attention had been paid to appropriate signage and flooring. A recent audit of medical gases was instigated by the service following new national guidelines, and had resulted in relocation of storage areas with improved accessibility. Another audit had resulted in clearer guidelines and responsibility for assessing mental capacity to ensure care plans included this assessment by doctors in a timely way.

The hospice used a benchmarking system which was a collation of information such as pressure sore occurrence and falls in comparison with other hospices in the south west. This showed the hospice had had a higher occurrence of pressure sores. This prompted a "deep dive" investigation which resulted in a finding of variable reporting, meaning that some sores had been included which were not pressure sores. Consequently training was provided for staff by the tissue viability team at the hospital to ensure staff were reporting and identifying possible wounds effectively. Staff were now more aware of how to manage "moisture wounds" for example. They further monitored how the service was doing and highlighted what other improvements could be made. Staff had also commenced a secondment with Hospice UK, which enabled them to share the benchmarking inpatient safety matrix nationally. There were now 100 plus hospices sharing comparable data. The quality and patient safety committee discussed a wide range of topics. For example, an antimicrobial stewardship programme) to address antibiotic resistance was being discussed with the pharmacy committee. They had also noted the incidence of pressure sores was reducing and how .

Some audits were carried out regularly to ensure compliance with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care that defines clinical best practice. NICE provides specific quality statements and measures to provide service providers with definitions of high-quality care. Such audits to measure how the service performed were completed either monthly or quarterly, were documented and used effectively to monitor the quality of the care provided. They included community team referral times (urgent and non urgent) and assessment times following referral, which had improved.

The service worked in partnership with other organisations to ensure they provided a high quality service. For example, clinical commissioning groups, local surgeries, hospitals and external health care professionals and agencies. Rowcroft also hosted the motor neurone disease multidisciplinary team meetings in the community. This had discussed sensitive and challenging issues such as people's future plans relating to the use of ventilators and sharing information with specialist consultant nurses. There were links with Addaction, a charity for people with addictions. One case involved how health professionals could support the person and each other in managing a difficult home situation. The hospice had co-written guidance on palliative care prescribing for people who were substance abusers with another local service.

The service used more extensive audits to inform their partnership working with other organisations. These were 'stand-alone' audits that included in-depth research and looked into a particular aspect of practice. An audit on people's documentation about their resuscitation status had identified that documentation was handled by a wide range of health professionals, which sometimes resulted in people not being in the place they chose for end of life care. It had identified a need to participate in a robust national electronic system to prevent inappropriate resuscitation. As a result, the service worked with the Clinical Commissioning Group (CCG) to develop a system to ensure local access to end of life information across organisations, such as people's decisions about resuscitation. Other partnership working focussed on improving the use of "just in case" bags to ensure they remained ready for use in people's homes for multidisciplinary teams across organisations.

There were various ways in which people could comment on the care provided other than online. There were feedback forms for people to leave comments for the inpatient team, chronic oedema service and community team. An on-going survey called "Did you get great care today?" was offered to people on site, by post and also at reception after some people said they did not fill them out when sent in the post. There were also patient user focus groups which met regularly such as the Rowcroft User Advisory Group and a separate one for the oedema user group. Their mission statement said the remit was, "To comment upon the services provided by the Hospice. To help improve and extend the services provided. To raise awareness locally of the services provided by the Hospice. To promote dialogue between staff, patients, carers, friends and relatives. To enable service users to express open and honest opinions. To assist and advise staff in working towards improving quality assurances and to assist with the quality assurance initiatives such as the patient, carer and staff surveys". The meeting minutes showed these were effective in enabling people to discuss any issues, put forward ideas and be involved in the running of the hospice.

Satisfaction surveys and complaints were scrutinised to identify whether people's experience of the service could be improved. There were clear examples of how this happened in practice effectively. For example, one smaller, anonymous comment on a survey form had been made into a formal complaint so the service could process it fully and learn from findings. Overall, the focus was again on people, for example surveys were not sent to co-incide with Christmas post.

All records relevant to the running of the service that we saw were well organised and reviewed regularly. All records were kept securely and confidentially. The policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated on a continuous basis. A computerised system scheduled policies for regular reviews and these schedules were adhered to. Staff were made aware of the updates and knew where to locate the policies for guidance. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.