

# Dorothy House Foundation Limited (The) Dorothy House Hospice Care

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

# Summary of findings

## Overall summary

The inspection took place on 27 and 28 September and 6 October 2016 and was unannounced. We previously inspected the service in December 2013 and found no breaches of regulations in the standards we looked at.

The inspection team included a lead inspector, pharmacist inspector, a nurse specialist 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 provider is The Dorothy House Foundation Limited, a registered charity. It employs 430 staff and over 1200 volunteers. The service covers an area of 700 square miles and accepts people from Bath and North East Somerset (BANES), and parts of Wiltshire and Somerset.

Dorothy House Hospice is located in Winsley, just outside Bath and has just celebrated 40 years of providing care for local people. It is registered for 10 beds and provides specialist palliative and end of life care for adults, with life limiting illness or complex symptom management needs. At Dorothy House six people were being cared for at the inpatient unit when we visited. End of life care is for people who are considered to be in the last year of life. The service used referral criteria to identify people who would benefit from admission, and the average length of stay was 11 days. The inpatient unit provided 142 people with a compassionate and dignified death in the last year. People could access the service in a variety of ways, via referrals from local GP's and consultants in the NHS, or from people or family members/carers (with the person's permission).

The inpatient unit had eight single rooms and one double room, with ensuite bathroom facilities. A restaurant was available and there were lots of quiet spaces for people and families to use. A wide variety of art and craft work, pictures and paintings were on display, which provided a calm and tranquil ambience throughout. A purpose built extension included a stunning chapel/spiritual space with lovely views over the beautifully landscaped grounds. There were ample car parking spaces, including disabled access spaces.

A hospice at home night sitting service provided care for people receiving end of life care at home and for two nights a week, so carers could have some rest. An Enhanced Discharge Service provided home care over 24 hours so people, who wanted end of life care at home, could be discharged from hospital at short notice.

A 24 hour advice line which offered people, relatives, hospital and community based professionals support and advice on palliative and end of life care. Day care services were offered at Winsley, which included social groups, activities, creative art therapy, complementary therapies and carer's support groups. Two outreach centres, one at Trowbridge and the other at Peasedown St John provided a relaxed and informal drop-in and signposting service for anyone affected by a life-limiting illness, including family members and carers. The centres hosted group workshops and community groups, and had treatment rooms. Dorothy House nurse specialists were based at the outreach centres and visited people at home to support and provide

pain management and symptom control and worked closely with local GP's and community nurses.

Volunteer roles included administrative support to inpatient and day patient units, bereavement, complementary therapies, volunteer drivers, gardeners and retail services. They also offered befriending services to people and provided respite for carers.

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

People, relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff using words such as "excellent" and outstanding."

An evidence based assessment tool helped people to self-report their physical, emotional, social and spiritual needs. This was completed at regular intervals to ensure outcomes that mattered to people were always met. People received effective end of life care because staff had link roles which championed best practice, for example, in skin care and prevention of pressure sores, falls prevention, nutrition and hydration and infection control.

The hospice had improved end of life care for people living with dementia. For example, through staff training and by making improvements to help people navigate their way around the environment. Specialist crockery and cutlery assisted people with cognitive difficulties to eat and drink independently. Hospice staff worked with a local mental health trust to support them to provide high quality end of life care for people with dementia. This meant people, with complex mental health needs, could remain in the specialist unit and receive end of life care from staff who knew and understood them.

Hospice staff worked with a dietician to develop an innovative nutrition assessment tool for people receiving palliative and end of life care. This enabled staff to support people at the end of their life to eat and drink what they wanted for as long as they wanted and recognise when the person was no longer well enough to do so. People had access to high quality food and drink, for as long as they were able and wished to. Excellent catering services met people's individual nutrition and hydration needs.

The hospice was doing outstanding work supporting children and young people facing bereavement and following the person's death. They helped children and young people explore their feelings, prepare for what was going to happen and find ways to cope with the changes in their lives.

Staff went that extra mile for the people and families they supported. For example, arranging weddings at the hospice, supporting a person to make their peace with an estranged relative and arranging for a dying person to see their beloved horse again. The hospice used 'Life Stories' as a way of supporting people to leave personal messages, letters or keepsakes for those they loved and cared about and to create memoirs.

A volunteer 'Companion Scheme' provided people with opportunities to develop new friendships and gave carers the opportunity to have a break, so they could continue to support the person. To celebrate national carers' week, staff arranged a cruise along the Kennet and Avon canal for carers, and offered practical support by caring for their loved one, so they could attend.

People received co-ordinated person centred care which responded to their changing needs through outstanding partnership working. For example, to improve equity of access to palliative care and end of life

services for hard to reach groups such as homeless people and prisoners. A 'Transitions Project,' did innovative work to help young people with life limiting conditions to make the transition from children's to adult end of life services at an earlier stage, by designing services with them to meet their needs.

A range of innovative activities and crafts were provided by the Creative Therapies Team, assisted by volunteers. 'Creative keepsakes' provided a personalised opportunity for any family to work together creatively to make beautiful works of art with their family. They developed a piece of art together that was meaningful to them such as a painting a pot, ceramics, making a plaster cast of hands.

People received co-ordinated, person centred care, when they used different services or moved between services such as the hospital, GP practice and hospice services. Hospice medical staff worked in the local NHS trust and community staff worked closely with GP's, community nurses and other professionals and used the same electronic record system, so could communicate more effectively.

The service was committed to continuous improvement. For example, they reviewed and streamlined existing services to make them more accessible. To increase involvement of people in evaluating services and consult them in the development of new services, they commissioned Healthwatch Wiltshire to set up a user group to consult on service developments. They were developing clinics to offer people outpatient treatments nearer home in more relaxed hospice settings to meet people's needs and reduce hospital appointments.

People received consistently high quality care because the leadership team had high expectations of staff, and encouraged staff to take on new developments and innovate. For example, through projects to develop services for homeless people and prisoners and by extending their skills to offer more services to people. Staff increased the amount of time they could spend with spent more time with people through the use of 'The Productive Ward' programme. This supported staff teams to develop more efficient work systems and make improvements to the ward environment.

People received care at a time and pace convenient for them because there were enough skilled and experienced staff. Staff could spend time with each person offering them assistance, support, comfort and reassurance. People said staff made them feel safe and cared for. Staff knew how to recognise and report signs of potential abuse, and any concerns reported were investigated.

People received their medicines on time and in a safe way. All appropriate recruitment checks were completed to ensure fit and proper staff were employed. They were cared for in a clean and hygienic environment. Staff reduced the risks of cross infection for people through good hand hygiene, and regular cleaning.

People's human and legal rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). People knew how to complain and any complaints received were thoroughly investigated with lessons learned. Staff were open and honest when things went wrong and were committed to learning from people's feedback and experiences.

The provider had a range of robust systems to monitor the quality of care provided, which included feedback surveys, audits and quality monitoring checks. They continuously made changes and improvements in response in response to their findings.

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

We always ask the following five questions of services.

### Is the service safe?

Good 

The service was safe.

People were supported by enough staff so they could receive safe care at a time and pace convenient for them.

People were protected because staff were trained to recognise potential signs of abuse. They knew how to report concerns and were confident they would be investigated and dealt with.

People were safe because individual and environmental risks were assessed and steps taken to reduce them. Risks were managed positively and staff respected people's lifestyle choices.

People received their medicines on time and in a safe way. Robust recruitment checks were undertaken to ensure staff and volunteers were suitable to work with people.

### Is the service effective?

Outstanding 

The service was effective.

People, relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff.

The hospice used a best practice assessment tool which helped people to self-report their physical, emotional, social and spiritual needs. This helped staff identify and check they were meeting the needs that most mattered to people.

The hospice had reviewed and improved the hospice environment to make it more 'dementia friendly.' They sought expert advice and used colour themes to help people navigate their way around.

The hospice developed a bespoke nutritional assessment tool for people receiving end of life care. This enabled staff to support people to eat and drink what they wanted for as long as they wanted and to recognise when they were no longer well enough to do so.

People received evidence based care based on best practice from experienced staff with the knowledge, skills and competencies needed to support their complex needs.

Staff had an excellent understanding of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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

The service was caring.

The hospice was doing outstanding work supporting children and young people facing bereavement to cope with the changes in their lives.

Staff developed exceptionally positive, caring and compassionate relationships and treated people with the utmost kindness, caring, dignity and respect.

Staff went that extra mile for people such as by organising weddings, helping a person make their peace with an estranged relative and for people to spend time with beloved pets.

A volunteer companion scheme' befriended people and gave carers a break.

The hospice helped people in innovative ways to leave personal messages, letters or keepsakes for those they loved and cared about.

People were comforted because a range of bereavement services continued to support loved ones after their death.

**Outstanding** 

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

The service was responsive.

People received exceptionally personalised care which responded to their individual needs and preferences.

People received co-ordinated person centred care which responded to their changing needs through outstanding partnership working. Staff had improved equity of access to end of life for hard to reach groups such as homeless people and prisoners.

Hospice staff had developed home care services for people having end of life care at home.

**Outstanding** 

A 'Transitions Project did innovative work to help young people with life limiting conditions to make the transition from children's to adult end of life services at an earlier stage.

A 24 hour, 7 day a week palliative care advice line provided advice for people, their carers and for health professionals.

People were maintained their independence for as long as possible through information, advice equipment and by being taught to manage their symptoms.

People knew how to raise a concern or complaint. Staff were open and honest with people when things went wrong and made continuous improvements from people's experiences.

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

The service was well led.

People, staff and external professionals consistently gave us exceptionally positive feedback about the quality of end of life care.

The leadership team had high expectations of staff, and encouraged staff to take on new developments and innovate.

The service promoted a positive culture that was open, inclusive and empowering, which placed people and families at the centre of the service.

People received co-ordinated person centred care in flexible and innovative ways through outstanding partnership working.

People benefitted because the service continuously made improvements and had received a number of good practice awards.

**Outstanding** 

# Dorothy House Hospice Care

## **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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 26, 27 September and 6 October 2016 and was unannounced. The inspection team included an inspector, pharmacist inspector, a nurse specialist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses end of life care services.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR, previous inspection reports, all contacts we had about the service and notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

During the inspection we spent three days at Dorothy House Hospice, and visited all departments there and we visited the Peasedown St John and Trowbridge outreach centres. We met people and relatives using those services and spoke with staff. We also telephoned people and relatives to get their feedback about hospice community services.

We spoke with 20 people, 15 relatives/friends or other visitors across all areas of the service. We observed staff interactions with people and looked at five people's care records, including six people's medicine records.

We met with 31 staff and looked at six staff files and recruitment, training, supervision and appraisal



records. We met with the chief executive, the registered manager (medical director), and both nurse executive leads in the inpatient and community services. We also met with medical staff, nurses and healthcare assistants, occupational and physiotherapy staff, catering, facilities and housekeeping staff. We spoke with members of the family support team including social workers, the chaplain, complementary therapy and counselling staff, as well as volunteers and staff working in education. We attended a multidisciplinary team and staff handover meetings. We sought feedback from professionals working with the hospice such as community nurses, GP's, hospital specialists, commissioners and Healthwatch, (the consumer champion for health and social care) and we received a response from five of them.

## Is the service safe?

### Our findings

People felt safe and well cared for at the hospice. One person said, "My situation is terrifying, the reassurance they bring is a great help." A staff member said, "The level of care provided means people feel valued, cared for and safe."

People were safely cared for by sufficient numbers of skilled and experienced staff. They said staff checked on them regularly day and night and responded immediately to call bells. Staff were attentive, and could spend as much time as people needed offering them assistance, comfort, support and reassurance. The hospice used a dependency tool, which identified people's individual support needs and adjusted staffing levels as people's needs changed. Where the dependency tool showed a person needed one to one care because of their complex needs, the nurse in charge had authority to arrange additional staffing, so there were no delays. The hospice had a bank of experienced staff, and existing staff did extra shifts, when needed. This meant people received continuity of care and skilled support.

In the morning there were five to six staff on duty, three registered nurses and two healthcare assistants as a minimum, and two registered nurses and two healthcare assistants in the afternoon. At night, there were two registered nurses and a healthcare assistant. Twenty-four hour advice and support was provided by a team of doctors included three specialist palliative care consultants, an associate specialist, speciality doctors and junior doctors in training. The duty rota showed recommended staffing levels were maintained.

Robust recruitment and selection processes ensured staff and volunteers were safe to work with vulnerable people. Appropriate pre-employment checks were done, such as obtaining references from previous employers and carrying out Disclosure and Barring Service (DBS) checks which highlighted any criminal convictions. The DBS helps employers make safer recruitment decisions and helped prevent unsuitable people from working with vulnerable people who use care and support services.

People were protected by staff and volunteers who were knowledgeable about the signs of potential abuse and understood how to keep people safe. Appropriate safeguarding policies were available which included contact details for the local authority, police and other agencies. Staff and volunteers attended safeguarding adults and children training, relevant to their role and safeguarding procedures were more robust. The hospice had a designated safeguarding lead with a background in social care and mental health. They provided support and advice for staff and executive team on safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff were confident concerns about potential abuse would be taken seriously and responded to.

For example, a safeguarding notification was received from the service following disclosure about suspected physical abuse. Staff supported a young person and worked with the family and other agencies, to arrange a family support meeting. They worked to safeguard the young person and make decisions with them about their future.

Risks were managed positively so each person could make choices and feel in control of decisions about

risk taking. For example, when a person wished to continue using a hot water bottle for comfort and pain relief, although not the safest option, staff worked with them to respect their wishes and minimise their scalding risk.

People were protected because risks for people were proactively identified and managed. Comprehensive individual risk assessments were completed, for example, in relation to people's risk of falling, developing pressure ulcers, nutrition and moving and handling. Detailed care plans identified measures to reduce risks as much as possible. For example, how to reduce a person's risk of developing pressure sores by using pressure relieving equipment regular repositioning and skin care. Any pressure ulcers which occurred were reported to identify avoidable factors and continually improve practice.

Accidents and incidents were reported with action taken to reduce risk of recurrence. For example, following a person having a serious fall, the service reviewed their falls prevention policy in line with 2013 NICE falls guidance and made recommendations. They included reviewing night staffing levels, updating the falls prevention policy, and staff risk assessment training. A handover sheet highlighted people at increased risk of falling, so staff knew to visit the person regularly to anticipate their needs. All rooms were fitted with movement sensors, as previously some rooms did not have them. These alerted staff when people got out of bed, so they could go and offer them assistance. Work was underway to fully implement electronic care records. This was in recognition that having a mix of paper and electronic care records increased the risk staff may not have all relevant risk information in one place. In line with their duty of candour, the service made the person involved and their family aware of the outcome of the investigation, lessons learnt and the improvements implemented.

Accidents/incidents were monitored and used to continually improve safety and reduce risks. A new health and safety lead increased staff awareness of health and safety issues and was improving health and safety systems. They were updating health and safety policies and had established a new health and safety board. Accident/incident reporting forms had been redesigned and a central database developed for collating all accident/incidents reported. This made it quicker and easier to identify trends and themes, for example, in relation to falls.

A series of workplace inspections had been taken place using photographs to identify and discuss ways to reduce health and safety risks. For example, in relation to fire safety, reminding staff about keeping fire exits clear at all times and keeping fire doors closed. Accidents and incidents reported were reviewed by the Health and Safety and Clinical Governance Committees to agree any additional actions needed. The hospice participated in the Hospice UK national inpatient benchmarking project so accidents and incidents were compared to similar services, to highlight any areas of concern.

Environmental risk assessments were being reviewed to ensure they were completed in accordance with health and safety executive guidance. For example, detailed risk assessments about the fire risks related to the use of oxygen. Staff completed specific training about safe storage and how to change oxygen cylinders in accordance with the medical gases policy. Where people were using oxygen, hazard signs were on display outside their rooms warning about the flammable risks. No smoking was permitted within the service, and a covered gazebo smoking area was provided outside, so people/visitors could smoke away from the building. Where staff were working in people's homes, a risk assessment was completed to identify any risks both outside and inside the home. This ensured the person's home was a safe place for the hospice staff to work.

All staff undertook annual fire training and quarterly fire drills. An external company had recently undertaken a fire risk assessment, with further actions taken, such as replacing some fire doors to meet most recent fire

regulations. As part of review of fire policy, the service developed a personal evacuation plan for each person. This showed ongoing improvements to improve the safety of the environment.

An estates team carried out an ongoing planned programme of repairs and maintenance. Contracts were in place for specialist companies to check and service all medical equipment. The hospice had a major incident plan to ensure continuity of the service for people, for example, in the event of the loss of utilities such as water, gas and electricity or an infection outbreak.

An organisational risk register highlighted areas of greatest risk and showed actions taken to further minimise risks. This was reviewed quarterly by the board of trustees. The risk register system was being reviewed and updated by the senior management team, to ensure it captured clearly all clinical as well as health and safety and other risks.

People received their medicines on time and in a safe way, and were kept comfortable and pain free. Medicines were supplied by the pharmacy department of a local NHS hospital trust, who provided staff with medicines information and out-of-hours services. Medical staff and a pharmacist checked the medicines people brought in although these checks were not always recorded in accordance with the policy. Inpatient prescription charts and medicines people took home with them were checked to ensure people received their prescribed medicines safely and correctly.

None of the people in the inpatient unit looked after their own medicines at the time of our inspection, although there was a policy for allowing people to do this, if it was assessed as safe for them. Medicines were prescribed, on dedicated treatment charts and any allergies recorded. They were well completed, with reasons given for any omitted doses. It was clear when 'as required' medicines were given to help control people's symptoms. Nurses were authorised to give a range of discretionary medicines, under a local protocol, agreed by the doctors, which allowed them to respond in a timely way to treat people's minor symptoms. A separate section was used by doctors to prescribe medicines to be given, by injection, in syringe drivers, which is good practice. Records showed staff regularly checked syringe drivers were working correctly. People's medicines were regularly discussed and reviewed at a daily multidisciplinary meeting.

Medicines were stored safely and securely, and disposed of in accordance with the legislative requirements. There were plans to improve the medicines room, and to install air conditioning, which will help ensure medicines are consistently stored at suitable temperatures. Staff received training on giving medicines and the use of syringe drivers and competency checks were undertaken to check nurses gave medicines safely. Regular audits were undertaken to check that medicines were being managed safely and any recommended actions followed up.

People were cared for in a clean and hygienic environment. Housekeeping staff had suitable cleaning materials and equipment and followed a cleaning schedule. All visitors to the hospice were provided with hand disinfection gels and staff used hand washing facilities, gloves and aprons appropriately. There was an infection, prevention and control lead nurse who was responsible for the infection control audit programme, staff training, and policies, and had links with regional and national networks. For example, audits of staff hand washing practices, housekeeping/ cleanliness and antibiotic use were carried out. The most recent environmental health visit to the hospice kitchen had awarded the kitchen the highest rating of five stars.

## Is the service effective?

### Our findings

People, relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff using words such as "excellent" and "outstanding." One person said, "The nurses are attentive, and doctors are good at symptom control, there is time to talk and everyone is very very kind." Another said, "The support and advice around managing all aspects of pain management has been excellent." A person being supported by a Dorothy House specialist nurse said, "They come around at least once a month to make sure I'm alright – now I feel I'm part of a network of people". A recent survey showed 94% of people said the pain relief was very good. A professional said, "There is good continuity of care for patients ...and good follow up when the patient is discharged."

Each person admitted to the hospice had an individual assessment of their personal care, level of pain, nutrition, moving and handling, and pressure area care needs. In September 2016, staff on the inpatient unit started using the King's Fund - Outcome Assessment and Complexity Collaborative (OACC). This evidence based questionnaire assessment tool helped people to self-report their physical, emotional, social and spiritual needs. This allowed people to identify their main concerns, any symptoms or worries so staff could help meet those needs. The tool was completed at regular intervals to monitor and ensure outcomes that mattered to people were met. For example, one person identified pain as a significant problem for them, others were worried about falls, and how they would manage at home. For a person experiencing a lot of psychological distress about their family, staff arranged family support counselling to help them.

People's care was reviewed daily or more often by nursing and medical staff and treatment plans updated as their needs changed. Twice weekly multidisciplinary meetings were held to discuss people's care. We joined a multidisciplinary team meeting with staff at Peasdown St John outreach centre via a videoconferencing link. Community based staff discussed the care needs of people and sought advice from medical staff, therapists and other members of the team. This meant each person's care was proactively managed and adjusted according to their changing needs.

People received effective end of life care based on best practice evidence. Staff had link roles to champion best practice. For example, in skin care and prevention of pressure sores, falls prevention, nutrition and hydration and infection control. A nurse spoke about their tissue viability link role and said they attended a conference and visited other units to look at skin care. They introduced a bespoke end of life pressure ulcer risk assessment tool, which helped staff identify factors that might make people more at risk of skin breakdown. They were involved in updating their local policy, and in the purchase of moving and handling and pressure relieving equipment. They provided educational resources for other staff to read, shared information at staff meetings and supported and monitored skin care in the unit. This ensured staff were using best practice skin care which minimised people's risk of developing pressure ulcers.

The hospice improved end of life care for people living with dementia. A dementia working group mapped their service against the Southwest Hospitals Standard in dementia care, and sought expert advice from the King's Fund and incorporated the recommendations of A Patient Led Assessment of the Care Environment (PLACE) to make the hospice environment more 'dementia friendly.' As a result, three colour themes were

used to help people identify and navigate their way around. White toilet seats were replaced with contrasting blue ones, and blue handrails were fitted in toilet areas and improvements made to the lighting. Equipment such as large display clocks provided clear information about day, date and time. Specialist crockery and cutlery was purchased to assist people with cognitive difficulties to eat and drink independently. Signage around the hospice was replaced with word/symbol signage so it was more easily visible to people with perceptual difficulties. Other improvements included purchasing music such as 'bird song' to promote people's sense of well-being. These improvements reflected best practice evidence of what works best for people living with dementia.

The hospice education department did training for staff in a mental health trust to support them to provide high quality end of life care for people living with dementia. They provided practical training on end of life nursing care to keep people comfortable and pain free. This meant those people, with very complex mental health needs, could remain in the specialist unit and receive end of life care from staff who knew and understood them. This avoided unnecessary distress and was in accordance with best practice recommendations in the National Dementia Strategy. In return, staff from the mental health trust provided training to hospice staff on caring for people living with dementia. Staff learned about what it's like to live with dementia and demonstrated a good understanding of the different types of dementia, and the ways in which it affected people. Over 120 hospice staff and volunteers signed up to the Alzheimer's society 'Dementia Friends' scheme. Both organisations developed action learning sets, which meant staff continued to work together to share their knowledge and expertise.

The nutrition group worked with the dietician to develop an innovative Patient Led Assessment for Nutritional Care (PLANC) tool for people receiving palliative and end of life care. Two versions of the tool were developed, one for people receiving palliative care, who were not expected to die in the near future, and the other for people approaching the end of their life. Staff explained how the tool helped them open up sensitive discussions about the emotive issues of food and drink. It helped staff to recognise when the person was no longer well enough to eat and drink. For example, when their level of consciousness deteriorated, or a swallowing assessment identified a swallowing or choking risk. Staff received relevant training to manage those risks.

People were supported to eat and drink what they wanted for as long as they wished. They were asked about their food preferences, allergies and any specific dietary needs. If a person needed a special diet, the chef discussed their individual requirements with them. People could choose their meals from a menu, including their preferred portion size. The chef regularly prepared 'homely foods' for people such as cottage pie and a range of salads and individual meals in response to specific requests, for example, for lemon sole, pig trotters or oxtail. In day care services, a 13 day menu plan was introduced, so people attending day care were offered a different menu choice each time they attended.

Mealtimes were protected, so no visitors or doctor's ward rounds were permitted, which meant people could enjoy their meal without interruptions. Food served was attractively presented to tempt people with poor appetites. If a person didn't wish to eat the main course offered, they were offered an alternative, such as salad, jacket potato, omelette or sandwiches and relatives could bring in favourite foods. Out of hours, staff had access to a ward kitchen and could prepare snacks such as cereals, toast, soup, yoghurts, rice pudding, jelly and ice cream.

People's comments about food included; 'Lovely fresh food made to a high standard;' 'I don't have much and the bits I do have been tasteful and plenty of choice;' A recent survey showed 100% of people rated the quality of the food as good or very good. Where nutrition/hydration risks were identified, people were referred to a dietician. Staff knew how to increase people's calorie intake, for example, by adding cream or

butter to their food and offering high calorie drink supplements. Where people had no appetite, staff used frozen ice lollies, pineapple cubes, ice or artificial saliva and regular mouth care to keep their mouth moist and comfortable. A complementary therapist had developed a mouth wash using honey, and lemon oil to treat people's dry mouth, which several people said they found helpful.

People received effective end of life care because staff training followed best practice guidance. An education programme provided capability within other local health and social care organisations, through education and training, to deliver high quality end of life care for local people. Nursing staff were taught how to assess pain and use syringe drivers for effective pain relief. All staff were taught how to promote people's comfort and the importance of advance care planning. Other training included experiences of people with life limiting illness, such as motor neurone disease. The education department worked closely with the University of the West of England, so nursing staff could gain additional qualifications at degree and masters level.

Hospice staff had a range of skills and experience, and received excellent training, updating and opportunities for ongoing professional development. All new staff including bank staff and volunteers underwent a thorough induction, which gave them the skills and confidence to carry out their roles. New healthcare assistants completed the national Skills for Care Certificate programme and existing staff completed it as part of their yearly update. Staff statutory and mandatory training included moving and handling, first aid, infection control and fire safety training. A training database meant department managers could monitor and ensure staff completed all required training.

Health related training included diabetes, catheter care, managing nausea and vomiting as well as nutrition and hydration. Other training included caring for people with motor neurone disease, managing breathlessness, chronic oedema (swelling). Competency assessments such as drug calculations, use of syringe drivers and suction equipment were carried out. Staff had access to a library where books, journals, and other online resources helped them keep up to date. Workshops were held for registered nurses on revalidation to help prepare them for this Nursing and Midwifery Council requirement.

Staff received support with their practice through regular supervision and appraisals. A confidential counselling service was provided for staff, which some staff really appreciated. A training needs analysis looked at the future training needs of hospice staff and identified additional skills needed so staff could take on extra roles. For example, clinical skills to support people having more treatments in day services, such as blood transfusion, and prescribing for nurse specialists. Also, to provide healthcare assistants with additional skills and competencies to support people at home with more complex needs. For example, people with artificial feeding tubes.

Hospice staff understood the importance of working together to provide seamless care for people. There was a daily medical review of all people on the inpatient unit and multi-disciplinary team meetings held were attended by medical and nursing staff, a social worker, occupational and physiotherapy staff, the chaplain and bereavement lead. Comprehensive discussions took place about the care of each person and those of close family members. A future plan of care was agreed, and decisions made were immediately documented in people's electronic care records. Physiotherapists and occupational therapists helped people experiencing difficulties with mobilising, falling and breathing difficulties. This included arranging equipment to help them be as independent as possible, such as mobility equipment, moving and handling aids and electric beds. This meant people's care and treatment was actively managed.

People were asked for their consent for day to day care and were consulted and involved in all care and treatment decisions. Staff received training on the Mental Capacity Act (MCA) 2005 and Deprivation of



Liberty Safeguards (DoLS) and had supporting policies and procedures. Each person's mental capacity to make their own decisions and consent to their care was regularly assessed and reviewed, as their condition changed. Where people lacked capacity, staff respected people's wishes, set out in advanced care plans, even when the person was no longer well enough to communicate them. Staff consulted relatives, staff and other professionals in 'best interest' decisions about the person's care and treatment.

Although there was a section in the electronic care records for documenting assessments and decisions related to the MCA, we found 'best interest' decisions were documented in a variety of places. We discussed this with the safeguarding lead who had also identified this during a recent audit. Discussions were underway to standardise documentation of best interest decisions, as part of the full implementation of electronic care records in January 2017. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found they were.

People's individual needs were met by the environment of care at the hospice. The building was light and airy, with suitable adaptations for people with disabilities such as corridors suitable for wheelchair access, grab rails fitted and height adjustable Jacuzzi bath and wet room facilities. People had spacious ground floor rooms, so those confined to bed could access the outside space outside through wide patio doors. The nurse call bell system on the inpatient unit had recently replaced, as staff were not satisfied with the reliability of the previous system.



## Is the service caring?

### Our findings

People received outstanding care from exceptional staff who developed positive, caring and compassionate relationships with them and their families. Comments included; "The care is outstanding;" "brilliant" and "excellent." One person said, "The compassion and kindness shown during our stay was stunning." Another said, "You couldn't fault this place, I feel at home here." Other feedback included; 'You have showered me with kindness and caring;' 'A supportive and holistic service...sensitive to individual need, positive, caring and compassionate.' And 'The care given to my dear husband was filled with love, respect, dignity, and empathy.'

People said the hospice was a happy place, in which they felt supported and cared for. They described a welcoming family atmosphere, the kindness of staff and the mutual support. A relative said, "The care is excellent ...staff are encouraging and have a sense of humour." Another relative told us about a member of staff who developed a strong rapport with the person, they laughed and joked with them and always gave them a kiss on the cheek. The person's health had since deteriorated, and were no longer conscious but the staff member continued to kiss them, which their relative said gave them comfort.

The hospice vision said, 'Dorothy House hospice provides compassionate caring for our community, supporting people with life limiting illness to live well and die well. A staff member speaking about the ethos of care said, "We look at the person beyond the illness." There was a culture of caring, staff were highly motivated, and spoke with sensitivity and compassion about people and families they cared for. Staff said it was a "privilege" to work at the hospice.

Staff went that extra mile for people and families they supported. The chaplain had applied for a special license and staff had arranged a wedding, provided flowers and a celebration meal, for a dying person who wished to get married but was not well enough to leave the hospice. They supported another person to make their peace with an estranged relative, which brought them joy and peace of mind. They arranged for a person having end of life care to see their beloved horse again. Staff organised a vet to transport the horse into the hospice grounds outside the person's bedroom so they could see and stroke them again. Family pets were welcomed and two family dogs were with their owners when we visited. Dogs from 'Pets for therapy' and 'Pat a dog' schemes also visited regularly, which some people loved and found therapeutic.

The hospice provided a comprehensive bereavement service for people and families, which included individual or group sessions and a 'drop in' bereavement support two days a month. A counsellor described how they helped people work through relationship issues, grief and loss and taught them to use coping strategies and set new goals. Speaking about how they were supporting a dying person to negotiate future plans for their child with an estranged partner, they said, "There is something important about enabling people to find their power, being a patient can take away any sense of self." There were plans to recruit more volunteer counsellors to provide psychological support for people and families in the next 12 months.

A children and young people's team were doing outstanding work supporting children and young people facing bereavement. Qualified children's therapists supported children and young people to explore and

express their feelings, prepare for their loss and find ways to cope with the changes in their lives. They offered one to one sessions, workshops and advice to anyone caring for or supporting children and young people. A range of approaches were used including play therapy, memory boxes, life stories and creative arts. A staff member usually met with the child and their parents initially to find out about each child and explain the various ways in which they could support them. For example, helping families to tell children a loved one was dying, to say goodbye and make lasting memories. A dedicated room called 'The Den' was filled with a variety of toys, games, pictures, books, a dolls house, and arts and crafts designed to appeal to children of different ages.

For example, one staff was working with a child who had recently lost a grandparent and was having some behavioural problems. They established the child was worried about losing other family members so helped the child to express their feelings and reassure them and worked with the child's parents and their teacher. Another staff was supporting a young person whose parent was dying to spend precious time with them, and was helping their other parent. Workshops for adults helping to support children following bereavement were held, which offered practical guidance and coping strategies and the opportunity to meet others in a similar position for mutual support. The children and young people's team also worked with local schools, which meant more children benefitted from bereavement support.

Friends and family could visit at any time, a family room with overnight accommodation was available, so relatives could take a break, make a drink or snack, and get some sleep. A relative said how much they appreciated thoughtful personal touches, such as the toiletries provided in the relative's room. Speaking about the staff support another said, "They've always been there for us, whenever we needed them."

Volunteers supported people and relatives in the hospice, in the inpatient unit and day hospice, arranging flowers, serving meals and drinks and offering help and companionship. A volunteer companion service visited 35 people having end of life care at home regularly to befriend them and offer their main carers some respite. This service was providing much needed support and companionship to the person and ensured their main carer had a break and some relaxation time, which helped their resilience so they could continue to care for the person. Feedback on the service included; 'I look forward to him coming, having a laugh makes me feel better; 'I have made a good friend;' and 'Improved quality of life, good to get out.' One person said they appreciated the volunteer accompanying them shopping because they had lost their confidence in going out alone. Other volunteers visited people and chatted with them about subjects of mutual interest. A relative said how much the person enjoyed the volunteer companion reading to them, and meant they could go to the post office to pay some bills.

A four week carer's course helped carer's understand and adapt to the changes in their lives. A carer said, "I need to learn to pace myself and to help [the person] cope as things progress. A carer handbook outlined the support available from Dorothy House Hospice, and provided valuable tips on taking care of themselves and sources of advice and support. To celebrate national carer's week, staff arranged a special event for carers, a cruise along the Kennet and Avon canal, and offered to care for their loved one, so they could participate.

People, relatives and external professionals particularly said they valued the support provided by the hospice to home team for people dying at home. One said, "I would personally like to thank the angels that were sent to help our dad for the last couple of weeks at home. You all made it possible for our dad to have quality of life and dignity right to the end." Another said, "I can still feel the wonderful relief I felt when I was told to have a shower and to sleep."

People said staff treated them with dignity and respect, which was confirmed by 100% positive response in

the most recent survey. One person appreciated that staff knew about them so they didn't have to explain or repeat the story of events leading up to their admission. Privacy curtains inside the door meant the person could have their door open if they wished, without passers by being able to see them. Dorothy House nurse specialists didn't wear uniform when visiting people in their own home, which protected their privacy and confidentiality. In the inpatient unit, staff comforted a person by gently holding their hand and hugged a relative when they became upset and tearful. People and relatives said staff were always popping in to check they were comfortable, pain free and check if they needed anything.

Staff were trained in communication skills and compassionate behaviours and excelled at giving people information and explanations, and sensitively managed difficult and challenging conversations. One person said, "I was able to explore options, they explain things to you clearly as you go along," another said, "[Staff name] was fantastic explaining the next steps." A relative said, "They tell it to you straight, it is hard to take in bad news first, so a really soft approach is good."

People and families said staff consulted and involved them in planning their care, in decision making and to express their views in a wide variety of ways. Survey feedback in July 2016 showed 100% of people confirmed this. A family support team member attended all multidisciplinary team meetings so could signpost people to advocacy services, if needed. A wide range of 'plain English' literature and information leaflets were provided so people received information in a format to suit their needs. For example, contact details of deaf interpreters, easy read and large print information leaflets, posters and audio tapes of local news and a spoken version of the patient handbook was planned. For people whose first language wasn't English, a translation service (covering 100 languages) was available to help staff consult and involve the person in decisions about their care and treatment. A staff member told us how successful this had been recently when planning care with a Russian person.

During 2016, a hospice working group made further improvements to meet the diverse communication needs of people in accordance with the Department of Health accessible information standard. For example, new referral forms identified and recorded people's individual communication needs, and flagged them up in their electronic care record, and provided staff with information about how to meet them. This was shared with other services such as the person's local hospital and GP practice (with their consent). A staff training programme was developed, which included deaf awareness training and practical tips such as how to look after hearing aids.

Staff had done multifaith training and were knowledgeable about how to meet people's spiritual, religious and cultural needs. A resource folder on the inpatient unit provided information for staff on a range of faiths and beliefs such as Buddhism, Judaism, Christianity, Islam and a multifaith calendar highlighted important dates. Where people had dietary restriction related to any religious or cultural beliefs, these were catered for. All were welcome to use the chapel where daily services were held and which provided a quiet and tranquil space to spend time for quiet reflection. The relative of a person who died at Dorothy House still visited the hospice chapel in order to keep their memory alive. They wrote, 'I sit for a while in that chapel and remember our life journey together. .... my sorrows fall and it is a peaceful, blessed place for me.'

The spiritual team comprised a chaplain and five volunteers who offered spiritual, emotional and religious support to people, families and staff, regardless of their faith, culture or community. The hospice had recently reviewed their spiritual care provision to better meet the needs of people with more diverse religious views, faith and cultural beliefs. This included developing a new chaplain and spiritual care coordinator post, which they had recently filled. They linked with local clergy and leaders of other faiths. For example, they worked with members of the local Muslim community on end of life care.

The hospice used 'Life Stories' as a way of supporting people to leave personal messages, letters or keepsakes for those they loved and cared about and to create memoirs. People were able to record what mattered most in their lives, on CD/DVD, through poetry, drawing, photographs or memory boxes. Each person decided what stories they wished to tell and who would be able to access them. A leaflet about this said, 'Telling life stories is not saying goodbye. It is not giving up hope, quite the opposite. When you tell your stories you are saying, this is who I am, this is what I did and what I believed ... This is why life matters, why I matter and why I will not be forgotten.'

People were supported to have a comfortable, dignified and pain free death. Following death, a temperature controlled room called 'Orchard View' meant relatives and friends could spend time with their loved one and staff could continue to support them. Regular memorial services were held which provided opportunities for friends and relatives to come together and remember loved ones. In partnership with Hidden Woods, a 'Muddy Footprints' day for bereaved families in a woodland setting provided a fun activity day and an opportunity to remember a parent who had died.

The hospice received overwhelmingly positive feedback, the provider information return showed the hospice had received 443 compliments and thank you cards in the past year. One person wrote 'Thank you to everyone at this incredibly inspirational hospice.' A relative said, "Beautiful people who did so much for my sister before she passed away and helped my brother in law with grieving."

## Is the service responsive?

### Our findings

People received exceptionally personalised care tailored to their individual needs, wishes and preferences. A person admitted to the inpatient unit said, "I was nervous but the staff were so kind, patient and caring with me that I felt much calmer and knew I'd be OK." Another person appreciated the little touches, like being able to have ice cream and the use of scented aromatherapy oils which smelt nice. A relative said, "She wanted to come here, we can bring the dog in and bring her flowers." Health professionals working with the hospice praised their physiotherapy, occupational therapy and social workers, who helped people apply for benefits and services they needed. One professional described the "fantastic out of hour's service" they used a lot for advice and said, "I think they are great, very highly thought of in the area."

Staff went that extra mile to meet people's individual needs. A dying person in the inpatient unit needed 24 hour nursing care but really wanted to take their child shopping to buy them a present. So, nursing staff arranged transport and accompanied them so the person saw their child choose their preferred toy and have a family meal out together. They were delighted to have achieved their wish and died peacefully two days later. Another person wanted to surprise their partner with a shiny new car. As they weren't well enough to go home, staff arranged for a private ambulance to take the person to watch the car being delivered. Although they were too weak to leave the ambulance, they saw the surprise and delight on their partners' face when they were presented with their new car.

Staff treated people in a very holistic way and worked together to improve all aspects of their life. They spoke about the importance of setting small manageable goals for people, such as watching a favourite film or having a massage. Staff told us about other ways they personalised the service for people, for example, by arranging 'date nights' for couples with a special meal, film or a takeaway.

Hospice staff arranged twice yearly holidays breaks to Centre Parks, for up to seven people to have a four night break. People and staff said they thoroughly enjoyed it and written feedback showed how much it meant. One person said, 'Thank you so much for making me laugh, cry, relax wonder, eat, sleep and breathe. One of my favourite ever holidays.' Others comments included; 'What a fabulous time I had ... I will truly never forget the experience; 'You certainly gave me the holiday I wouldn't have had.' A relative said, 'He seems to have come home with more energy and enthusiasm.'

Staff worked with people and those close to them to develop individualised care plans that reflected how each person wanted to receive their care, treatment and support. People's care records included details of what was important to them, so staff and families could help them achieve those outcomes. People were supported, if they wanted to, to develop an advanced care plan, which captured their preferred place of end of life care, views about resuscitation and any withdrawal of treatment. This meant their wishes were known and could be carried out.

Hospice staff responded rapidly to changes in people's needs. One person said, "They're all very proactive, coming out to discuss the problem within a week of diagnosis;" Other comments included; "Prompt attention when needed." A relative said, 'My husband was an extremely challenging case with complicated

and uncontrolled pain on admission. The medical staff worked tirelessly to resolve his pain problems and make him comfortable.

A nurse-led contact centre prioritised all referrals to the hospice community services. A nurse did an initial assessment and developed care plans with people to meet their needs. For example, a nurse we spoke with had received a referral from a person's GP, their health had deteriorated suddenly. The nurse spoke with the person's wife about their health needs and arranged for a Dorothy House community nurse specialist to visit the person at home. Referrals to the inpatient unit were managed by the medical team in consultation with the nursing team and the referrer, usually the GP or consultant.

A relative rang the 24 hour advice line when a person experienced breakthrough pain and breathlessness. A Dorothy House nurse specialist visited them and arranged for their admission to the hospice for assessment. Although they had only been in the hospice for a few hours, they said already they were feeling more comfortable and relaxed. Their relative described their feeling of relief being able to hand over the person's care needs to hospice staff. This meant they could spend precious time with their loved one, instead of rushing around organising their care. The person struggled to take their tablets, and doctors identified a soluble alternative which they were delighted about. An occupational therapist found the person a chair they could sit in comfortably, which made their breathing easier. This meant the person, family and their pet dog were able to go out in the grounds and enjoy precious time together in the autumn sunshine.

Dorothy House hospice also offered people with long term conditions such as motor neurone disease or chronic obstructive pulmonary disease admission to the inpatient unit for short periods of respite. This meant various professionals could visit them, review their care and give their main carer a break and a rest. A person admitted for respite said everyone was very kind, they enjoyed their stay and loved the Jacuzzi bath.

A family support team provided outstanding practical, emotional and bereavement support to people and families, which helped them adjust to the impact of people's illness. For example, helping people apply for benefits, advising them about their rights and supporting them with housing and equipment needed to help the person maintain their independence at home. Having social workers directly employed by the hospice meant people, and families benefitted from their expertise and close links with other agencies such as social services and housing.

Physiotherapists and occupational therapists supported people, to maintain their health and retain their independence for as long as possible. For example, providing support and advice with mobility and assessing people's needs for equipment such as electric beds and mobility aids. Therapists used 'tool kit' approaches to teach people to self- manage symptoms such as breathlessness and fatigue through relaxation techniques. A newly opened rehabilitation and exercise facility called The Sulis Gym at Dorothy House enabled people with life limiting conditions to exercise in a safe environment. One person said, "I feel really good about myself, big improvement." Another said, "I was using a cane to walk but after four weeks with the physio, I no longer need it."

A variety of groups and services such as 'Tea@3' and 'Coffee club', informal 'drop in' sessions were held for people affected by the diagnosis of a life-limiting condition. A four-week programme helped people with energy conservation, sleep, diet, and offered an array of complementary therapies. A 'Plot to plate' allotment group provided opportunities for keen gardeners to grow fruit and vegetables. A wide range of activities and crafts were provided by the Creative Therapies Team, such as 'Sewing bee' and 'Creative keepsakes.' This provided a personalised opportunity for a person and their family to work together creatively to make beautiful works of art. Options included painting, ceramics, plaster cast hands,



decorative boxes and card making. The creative process helped and supported the family coming to terms with their situation by developing a piece of art together that was meaningful to them.

People received co-ordinated person-centred care when they used or moved between different services through outstanding partnership working. Hospice staff linked with a number of groups, organisations and networks, for example, domestic violence forums, and child bereavement groups. A 'Transitions Project,' did innovative work to help young people with life limiting conditions to make the transition from children's to adult end of life services at an earlier stage. A transition nurse specialist post and a transitions working party were formed to raise awareness of young people's needs and develop services with them closer to home. They engaged with young people and their carers/families and sought their views about what they wanted to influence service design. They formed a young people's group and two young people did a video interview about their experiences. They surveyed GP's and developed collaborative relationships to share experiences and expertise with other adult and children's services. Young people emphasised the importance of having Wi-Fi-internet access at services and the benefits of having a wheelchair accessible spaces to meet up with other young people, without adult supervision. The nurse specialist said the project had taught them a lot more about the needs of young people with disabilities, such as cerebral palsy and Duchenne's muscular dystrophy.

They worked with a young person to plan a weeks' respite in the hospice for them and made sure staff had the skills and equipment needed to manage the person's complex nursing needs. For example, the person couldn't use a call bell, so they arranged alternative equipment, so they could call for help. When the hospice didn't have any DVD's the person was interested in, staff brought them in from home. The young person gave very positive feedback about their stay. This initiative met the best practice recommendations of 'Together for Short Lives.' In 2015 the hospice presented their findings at the national hospice UK and at the South West conferences. Since then, the hospice had continued to fund the transition nurse specialist post part time to further develop these services.

The hospice had done outstanding work to improve equity of access to palliative care and end of life services for hard to reach groups such as homeless people and prisoners. A working group looked at the issues facing some marginalised groups and developed partnerships with relevant statutory and charitable organisations to enhance their end of life care. They worked with Health and Education South West who helped fund end of life training for staff working with homeless people and gypsy and traveller groups. For example, a project funded by Burdett Trust for Nursing (an independent charitable trust which promotes and advances nurse education, research and training for the benefit of the public) funded a Dorothy House nurse specialist to explore the needs of homeless people. They established closer partnership working with health, police and housing and voluntary organisations such as the YMCA. The nurse explained the average age of death of homeless people was 42 and how, as they had no address, they could not register with GP services..

Homeless people often had complex healthcare needs related to drug and alcohol abuse and were reluctant to engage with healthcare professionals. For example, the hospice nurse worked with hostel staff to provide end of life care for an alcoholic person, with end stage liver failure. They visited the person to find out about their needs, provided training for hostel staff and worked with other agencies that could help. They arranged for person to be admitted to the hospice for assessment. They said, "It wasn't easy, changing culture, overcoming barriers." The person stayed five days, felt better and was discharged back to the hostel with an ongoing plan of care. The person said staff were kind, professional, and they felt cared for and were not stigmatised. Staff reviewed their care and considered how they might approach meeting the care needs of other homeless people in the future. The hospice has also continued to fund this role. Another Dorothy House community nurse specialist established links with prison services to provide end of life support to

prisoners. These initiatives were in accordance with recommendations the 2016 Care Quality Commission's 'A different ending – Addressing inequalities in end of life care.'

People received co-ordinated, person centred care, when they used different services or moved between services such as the hospital, GP practice and hospice services. Hospice staff used the same electronic record system as the Royal United Hospital Bath and most local GP practices. This meant they could access information from other professionals about appointments, investigations and test results. Staff said this was particularly helpful at multidisciplinary meetings and when advising people or professionals via the advice line, especially where multiple professionals were involved in providing their care. Hospice staff wrote detailed treatment plans in discharge letters.

The hospice provided a 24 hour, 7 day a week palliative care advice line for people and their carers and for health professionals such as GP's, district nurses and hospital staff. Nursing staff provided advice on symptom control and management of pain relief and the doctor on duty was available for more complex queries. Data showed the service was well used and has continued to grow.

Dorothy House nurse specialists met with primary care staff regularly to discuss and plan care and treatment for people having palliative and end of life care at the practice. Where needed, hospice medical staff did joint home visits with GP's or district nurses to help advise and manage people's symptoms and pain relief.

A hospice at home night sitting service was developed by the hospice in collaboration with Somerset, Bath and North East Somerset and Wiltshire Clinical Commissioning Groups (CCGs). This was in response to a local need to provide support and respite for families/carers supporting people to die at home. This service was highly valued by people, families and hospice staff and 13 people were receiving this service when we visited. A staff member said, "Hospice at home is one of the best things we do, and makes it possible for people to stay at home."

Dorothy House hospice consultants worked at the Royal United Hospital (RUH), Bath. They did weekly ward rounds and provided specialist advice to doctors and nurses and all out of hours support. They attended the trust's weekly multidisciplinary team meeting, discuss and advised staff on people's care. In May 2016 a Dorothy House nurse specialist commenced a two year jointly funded nurse specialist post with the Motor Neurone Disease Association and the RUH. The nurse was in the process of setting up a six weekly combined motor neurone disease clinic (with palliative care, neurology, and respiratory expertise) to improve the co-ordination and proactive planning of care for their complex needs. These joint clinics will mean those people receive all their care and specialist advice at one appointment.

People and relatives said they had no concerns or complaints about the hospice. A compliments, concerns and complaints leaflet outlined the ways in which concerns could be raised in person, by phone or e mail or through the use of suggestion boxes. It included details of Healthwatch and advocacy services. A complaints register logged complaints received, and showed actions taken and any lessons learnt.

Staff were open and honest with people when things went wrong and were committed to learning from people's experiences. The provider information showed two complaints had been received in past year. Full explanations were given about the investigation, its findings and any actions being taken to address concerns. Responses offered unreserved apologies where any aspect of care fell below the standard expected. For example, the provider information return the service highlighted how the service had reviewed the way food was provided for visitors following a concern raised by a relative. This showed the hospice responded to constructive feedback as an opportunity to make further improvements. Complaints were



reviewed by the Clinical Governance Committee, to ensure they were dealt with rigorously.

## Is the service well-led?

### Our findings

People, staff and external professionals consistently gave us exceptionally positive feedback about the excellent quality of end of life care at the hospice. A person said, "This was a painful difficult and emotional time, they were always full of understanding, help and tolerance." A relative said, "I would especially like to thank the medical staff, not only for their outstanding provision of [person's]'s medical needs but also for the compassion, patience and respect they showed her during her stay." Another said, "When my wife was diagnosed . . . . we were supported for a year by the brilliant Dorothy House Hospice." Survey comments included; 'Superb service' and 'I would rate this hospice and team of staff and volunteers as exceptional, it is probably the best in the country and should be seen as a model.' Professional feedback included; "There is excellent multidisciplinary working within the hospice;" " The nurses make Dorothy House so incredibly different to anywhere I have been before, these attitudes have encouraged me to be a better nurse."

Staff spoke with pride about their service, and an "encouraging atmosphere." Comments included; "I have a dedicated and amazing team of staff who are continually trying to improve;" "It's an exemplary service, I'm proud to be part of it." Staff said the best things about the service included; "Being able to give the quality of service that people need and deserve;" "Making people's experiences the best they could possibly be;" and "Staff values of being patient and family focused." Other staff described being able to work autonomously, the "supportive environment," and flexible working arrangements which accommodated their own caring responsibilities. One said, "Staff are extremely well taken care of, there is no hierarchy, everyone's' contribution is valued and that improves staff morale."

Dorothy House Hospice was led by a dynamic and purposeful senior executive team and board of trustees. The medical director was the registered manager, executive clinical leads led the hospice and inpatient services and outreach services and community teams. In the inpatient unit, medical leadership was provided by the registered manager and another consultant and there was a nurse manager and deputy. The registered manager said, "The staff team are committed to what they do and it shows in the high standard of care."

The service promoted a positive culture that was open, inclusive and empowering. Staff were committed to care that placed people at the centre of the service. They were open to new ideas, innovation and continually improving care. For example, at each board meeting, members were told the story of a person using the hospice service. The chief executive said people's stories were a powerful way of keeping the impact of the work of the hospice at the heart of their work.

The provider's objectives, vision and values of the service were in line with Gold Standard Framework (GSF), 'One Chance to Get it Right' and recent NICE guidelines on end of life care. A strategic plan, 2012-2017 set out a clear mission statement and vision. The mission statement said; 'Our purpose is to ensure the very best care is provided wherever and whenever it is needed.' A five year plan identified nine key objectives, and a work plan detailed the steps being taken to deliver the strategy. This was regularly monitored by the board of trustees. Each department had a continuous improvement plan which showed their progress. For example, in the inpatient unit, the improvement plan included the introduction of electronic care records

and measuring patient outcomes.

The leadership team had high expectations of staff, and encouraged staff to take on new developments and innovate. They supported staff to apply for project funding and bursaries to pilot new approaches to care and evaluate their effectiveness. For example, working with an NHS mental health trust to improve end of life care for people living with dementia and with Health and Education South West to develop end of life training for staff working with homeless people and gypsy and traveller groups.

The hospice used 'The Productive Ward' programme, an innovative method to improve quality of care by increasing direct patient care time and staff satisfaction through improved productivity. The programme supported staff teams to improve their internal processes and the ward environment. Speaking about the initiative, the unit manager said, "It's so motivational for staff," and another staff member said, "It gives us ownership of our unit, no change is too small."

Staff visited other hospices to get ideas and told us about a range of ways improvements they had made. In the inpatient unit an occupational therapist worked with a volunteer with IT expertise to develop an innovative electronic whiteboard, which they were planning to present at the Hospice UK conference. This provided a 'live' depiction of the hospice at any one point in time for planning purposes, and to aid communication between staff. For example, about each person's needs and level of dependency, staffing, bed availability and people awaiting admission. Other examples of efficiencies included reorganising the linen cupboard, using a simple but effective colour coding system, so staff could find things quickly. In the stock room, staff stored supplies in boxes with the reordering information displayed, which made replacing things easier and prevented overstocking. Improvements were planned to the 'Orchard View' suite for bereaved relatives to spend time with their loved one.

The hospice had developed strong collaborative partnerships with local Clinical Commissioning Groups, Health and Wellbeing Boards, and other health and social care providers. They demonstrated a commitment to developing joined up, innovative, flexible services and to developing sustainable models of care that improved the health and wellbeing of local people. For example, during 2016 hospice staff worked with other health and social care organisations, as part of a joint bid to identify a single organisation for coordinating services in Bath and North East Somerset from April 2017. The initiative 'Your care, your way' involved extensive consultation with the local community about the type of services local people wanted.

They worked with Wiltshire and Bath and North East Somerset Clinical Commissioning groups and the Royal United Hospital, to develop a 72 hour rapid response discharge service. This initiative provided a high quality rapid response home care services. It prevented unnecessary hospital admissions and enabled people needing end of life care to be discharged from hospital more quickly. A health professional said, "They do a good job, they can get people home as soon as they have improved because of all the expertise around them."

Working in partnership with the Royal United Hospital, staff identified a need for satellite treatment clinics at hospice locations so people, with life limiting conditions, could have their outpatient treatments nearer home in a more relaxed setting. For example, blood and platelet transfusions for people with blood related cancers and treatments to benefit women with advanced breast cancer. These initiatives were in accordance with the Ambitions for Palliative and End of Life Care (2015) framework for local action and the recommendation of the King's Fund Place based systems of care (2015).

A hospice five year strategy 2016-2021 showed their commitment to continuous improvement, user involvement and innovation. It also highlighted plans to embed a rehabilitative approach to palliative care,

so people with life-limiting and terminal conditions could manage their conditions and live as independently as possible. Local people worked in partnership with the hospice to influence service development. For example, in 2016 the service commissioned Healthwatch Wiltshire to increase involvement of people in developing services. This included forming a user group, and training a facilitator to lead 12 meetings and discussions per year. They sought feedback for Dorothy House from the carers of 86 people who died there, to help identify with improvements. A hospice community engagement co-ordinator and engage extensively with the public including many hard to reach and marginalised groups. For example, a drop-in 'Tea@3' service was started in response to feedback from carers in Trowbridge.

The executive team supported leadership and management development at every level. Management and leadership education and training was provided in house and by accessing external courses, expertise and support. For example, the executive lead nurses were attending a King's Fund leadership development programme. The chief executive had reviewed the skills, knowledge and membership of the executive team and commissioned the services of an independent consultant to work with the board to develop their strategic skills, and a board development day planned for October 2016. Trustees said they were encouraged to be challenging, and to engage in strategic debates about the future direction of the service. One said, "There is a sense of ambition amongst the senior management team for the service to be as good as it can be."

A workforce plan highlighted the numbers/skills of staff needed to meet future service needs. The hospice were looking options such as apprenticeships and at return to practice for registered staff. They were also exploring community specialist nurses extending their skills to undertake abdominal assessment, catheterisation, taking blood samples and nurse prescribing. This would reduce delays for people as more aspects of people's care and treatment could be done by Dorothy House nurse specialists, which would avoid waiting for a GP or community nurse to visit.

In September 2016 Dorothy House Hospice had reviewed their service against the findings and recommendations of the 2016 Care Quality Commission's report, 'A different ending; end of life care review'. The service had already established links with their local Polish community, and met with black and ethnic minority senior citizens group to promote their services and hear their views about end of life care. The review highlighted the need to establish if further work was needed in relation to other marginalised groups identified by the CQC report. For example, people with learning difficulties, black and ethnic minority ethnic/multi faith groups, for travellers, people with mental health needs and lesbian, gay, bisexual, or transgender people.

A number of service reviews had been undertaken to ensure hospice services were responsive to people's needs and were as efficient and effective as possible. For example, a recent review of the family services team, day support unit, outreach centres, bereavement, creative and complementary therapies had been undertaken. The review recommended all referrals be routed through one point of access so people and families had a consistent, equitable and clear way of accessing services.

The executive team hosted bi-monthly coffee mornings for staff and volunteers and took it in turn to speak about developments in different aspects of the service. Community staff attended by video link from the outreach centres. This provided an innovative way to consult with staff and volunteers and keep them up to date with developments, and gave staff opportunities to ask questions and challenge the executive team. An annual staff award event recognised and rewarded staff and volunteers for their contribution at a celebratory event. For example, volunteer of the year, team of the year, outstanding contribution and leadership awards.

Staff were consulted and involved in changes, through local team meetings, a staff newsletter, and a staff consultative committee. Suggestion boxes were available for staff and volunteers, which were reviewed regularly by the executive team and responded to via the staff intranet. For example, providing a staff smoking shelter. Minutes from the most recent staff consultative committee in August 2016 discussed the results of the quarterly staff survey, which focused on morale and work life balance. Responses showed generally positive results with improvements reported in work life balance, pride in organisation and feeling valued, although some staff reported feeling stretched, particularly community based staff. Other issues discussed were the development of a new staff intranet, which provided access to policies and procedures, the staff newsletter, minutes of meetings and other items of interest. A volunteer survey showed that 93%-94% of volunteers were satisfied or very satisfied with their support and overall volunteering experience.

The hospice used the 'Friends and families test' to capture people and families experiences on the inpatient unit. Feedback was sought on welcome, person centred care, dignity and respect, support for family, cleanliness, quality of food and drink. Twenty nine responses from 1 Apr to 30 June showed 100% of respondents rated overall the quality of hospice services as very or good, and would recommend the service to friends and family needing similar care. Action had been taken to address any issues raised, for example in relation to food choices at supper time and a lack of car parking spaces. The deputy manager had plans to use a display board to share the survey feedback and action taken. A newsletter kept people and supporters of the hospice up to date with developments. This included fundraising events planned, and stories about people's care that raised awareness of the services offered by the hospice.

In preparation for the Care Quality Commission (CQC) inspection and rating visit, the service completed a self-assessment against the CQC Fundamental Standards and commissioned staff from another hospice to complete a 'Mock CQC' visit on 30 November 2015. The external report was positive and highlighted minor areas for further improvement, which have since been implemented. A trustee provider visit was carried out annually. The last visit, in June 2016, confirmed environmental issues highlighted at the November 2015 visit had been addressed, and reported positively on education programmes being developed to support succession planning.

An audit programme for 2016-17 showed a wide range of audits undertaken by the hospice. These included infection control, documentation of mental capacity, nutritional assessment and evaluation of the volunteer companions' service. The ward manager used the Hospice UK benchmarking tools to audit pressure area care, falls and medication errors and compared their findings with other similar services. This meant the service was prompted to explore reasons for any variations in practice.

Staff from Dorothy House hospice attended various Hospice UK network meetings to keep up to date and share good practice ideas and innovation. Each year, Hospice UK had a national conference and this year, staff were planning to present their 'interactive whiteboard.' Several other good practice initiatives were also included in the poster exhibition, such as a project on 'Death and dying – what should young people know.' This involved people attending day care working with a group of sixth form college students about death and dying.

Many hospice staff were members of local and regional good practice sharing networks groups, for example, the ward managers, complementary therapists and chaplaincy. The registered manager was a member of South West End of Life Care Expert Reference group and End of Life care champions. Dorothy House Hospice staff also worked in close collaboration with other local hospices to promote high quality end of life services.

They hospice had recently set up a sharing good practice knowledge exchange to get to know about the

work of other organisations in the area and forge networks. For example, the second knowledge exchange meeting held on 27 October 2016 included a speaker from the Bath Ethnic Minority Senior Citizens Association and hospice staff spoke about their volunteer companions' service.

The hospice received an award from the Foundation of Nursing Studies for their work on developing a nutritional assessment tool for people having end of life care. Other awards included an allotment project award, an award for the volunteer companion's service. 2016 award nominations included a National Council for Palliative Care Awards for a bereavement project and for a public health award. In June 2016 the hospice was awarded a national quality standard for mentoring and befriending projects and renewed their Investors in Volunteers accreditation, and they were pursuing accreditation with the Mentoring and Befriending Foundation.

The service was committed to continuous learning from accidents, incidents, complaints and from training. At monthly meetings staff received feedback about any issues that had arisen in their own and other areas. The service had introduced a Duty of Candour register, to demonstrate the hospice was fulfilling its legal duty to inform and apologise to people, if any mistakes in their care led to significant harm. The registered manager sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly.