Cornwall Hospice Care Limited

Mount Edgcumbe Hospice

Inspection report

Cornwall Hospice Care - Mount Edgcumbe
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Overall summary

Our rating of this location improved. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
End of life care	Outstanding ☆	Our rating of this location improved. We rated it as outstanding because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

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Summary of this inspection

Background to Mount Edgcumbe Hospice

Mount Edgcumbe Hospice is operated by Cornwall Hospice Care Limited. The hospice primarily serves the communities of Cornwall and provides inpatient services to people who are living with a life-limiting condition and people at the end of their lives. It also accepts patient referrals from outside this area.

How we carried out this inspection

We carried out a comprehensive inspection of the service under our regulatory duties. The inspection team comprised of a lead CQC inspector and a specialist nurse in palliative care and was overseen by an off-site CQC inspection manager.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

This inspection took place on 24 August 2022 and was unannounced.

After the inspection, we held telephone interviews with key people we were not able to speak with during the unannounced inspection.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- Staff worked alongside other agencies to provide palliative care to people such as the homeless and people with drug and alcohol addictions.
- Services for patients with lymphodema were tailored to their needs and patient led.
- The provider had contributed to the development of the Cornwall and Isles of Scilly end of life education strategy.
- The provider had a range of services, such as a virtual community friendship café, a listening ear service and online resources.
- The education team provided training across the county, including for care homes. The team worked collaboratively with other providers to ensure training such as Dying Matters and End of Life Learning Path was available across the county.
- The provider offered a range of community projects to support patients, families and professionals, such as adult walking bereavement support groups.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Overall	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding

Outstanding

End of life care

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Outstanding
Well-led	Good

Are End of life care safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

At our previous focussed inspection in July 2018, we found the system for monitoring staff training did not ensure all mandatory or any additional training had been completed. At this inspection, we found the education department provided managers with detailed information about staff training. Medical and nursing staff received comprehensive training which met the needs of patients and staff. All nursing staff completed a range of mandatory training which included fire safety, infection control, fluids and nutrition, moving and handling, Mental Capacity Act, equality and diversity and end of life care training.

Staff were also required to complete role specific mandatory training. For example, staff completed training for blood transfusions and syringe driver training. Staff training for Adult Basic Life Support level two was 100%

The education team worked closely with the registered manager to monitor compliance with mandatory training, and staff were alerted when they needed to update their training. Staff confirmed they were given enough time to do training. Staff told us they were able to request additional training.

The registered manager ensured staff could access online training appropriate for the service. Staff told us they were able to request additional training, and this would be provided for them.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Medical and nursing staff received training specific for their role on how to recognise and report abuse. The service had clear safeguarding processes and procedures.

Outstanding ☆

End of life care

At our last comprehensive inspection in August 2014 we found staff were unsure how to make safeguarding referrals. At this inspection, we found staff knew how to make a safeguarding referral and who to inform if they had concerns. We also completed a focussed inspection in July 2018 where we found safeguarding children training was not provided. At this inspection, we found staff had received safeguarding children training. Staff had access to an up-to-date safeguarding policy. Staff we spoke with were able to clearly articulate signs of different types of abuse and the types of concerns they would report or escalate to the registered manager. One member of staff told us about a time they were concerned and asked the registered manager for guidance out of hours, and this had worked well.

Staff training for safeguarding adults' level two was 100% for doctors and 83% for other staff. Safeguarding adults' level three was 100%. Staff training for safeguarding children statistics were similar, 100% of doctors and 81% of staff who needed safeguarding children level two had completed this training, and 100% of staff who needed safeguarding children level three had completed. Safeguarding training included female genital mutilation (FGM) training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff followed safe procedures for children visiting the hospice.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve infection prevention and control practices if needed. The clinical governance board had effective oversight of audits.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. An audit programme was used to increase and maintain standards and help prevent the spread of infection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment. The service had appropriate handwashing facilities and sanitising hand gel was available. Staff were bare below their elbows and washed their hands before and after each patient contact. Personal protective equipment such as latex-free gloves, aprons and antiseptic wipes were readily available for staff to use at the service. Staff cleaned equipment after patient contact and equipment was labelled to show when it was last cleaned.

In the twelve months before the inspection there had been no incidences of healthcare acquired infections at the location.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The environment was suitable for its purpose. The building was light and airy, with a covered access into the building for ambulances and other vehicles.

Outstanding ☆

End of life care

The building was purpose built and had suitable adaptations for people with disabilities such as corridors suitable for wheelchair access, grab rails fitted and height adjustable Jacuzzi baths. People had spacious ground floor rooms, and some people confined to bed could access the outside space outside through wide patio doors. Patients could reach call bells and staff responded quickly when called.

The service had a lymphoedema clinic, an occupational therapy and physiotherapy room where outpatients were seen.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. Service contracts were in place to ensure medical equipment such as beds and wheelchairs and equipment such as fire extinguishers and fire alarms were all serviced in line with manufacturers recommendations. Resuscitation equipment was checked weekly.

Environmental risk assessments 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.

The service had suitable facilities to meet the needs of patients' families. A room was available for families to stay overnight. The service had a multi-faith room with reading materials for many faiths. People were able to light candles to remember their loved ones.

The service had complementary therapy rooms, staff training and seminar rooms. Staff had access to a well-equipped staff room with a small patio for their rest breaks.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

People were protected because risks for each person were identified and managed. Comprehensive individual risk assessments were completed in relation to people's risk of falling, malnutrition and dehydration, and about moving and handling risks. Detailed care plans identified measures taken to reduce risks as much as possible. Risks were shared with all staff in twice daily safety briefings, in patients' notes and on the staff board in the clinical office. Risks were updated as the patient's condition changes.

Staff used nationally recognised tools to identify deteriorating patients and escalated them. Staff used Integrated Palliative Care Outcome Scales (IPOS), which measures the main symptoms and concerns which palliative care patients themselves report.

Staff told us they followed the hospice sepsis policy but did not need to use National Early Warning Score (NEWS 2). The NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis, in hospitals in England. However, when transferring patients between services, staff used the same language as the NEWS 2 tool.

Outstanding ☆

End of life care

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared information and during daily meetings, so everyone understood the patients' dependency scores. Staff shared key information to keep patients safe when handing over their care to others.

After the inspection, we spoke with some staff who provided community services. Where staff were visiting 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. Staff had the benefit of a personal alarm system which was linked to a national centre.

The provider had an advanced nurse practitioner (ANP) who supported patients in both hospices as well as the community. An advanced nurse practitioner can assess and examine patients, determine an appropriate treatment plan and prescribe. The ANP visited patients both at home and in other care settings to assess if the patient would benefit from being admitted to the hospice. Where appropriate, hospice staff worked in collaboration with community services to enable patients to remain at home if they wished, whilst also supporting the patients' families.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

At our focussed inspection in July 2018, we found staffing levels were not assessed or related to patient dependency. Filling shifts at short notice was challenging for the ward and impacted on the work being undertaken. At this inspection, we found the provider had addressed these concerns. The registered manager used a ward staffing and dependency score. The tool supported nursing staff in safe admission. The tool was simple to use and included patients' dependency as well as staff numbers, this ensured patients were admitted safely and ensured adequate staffing.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had an escalation procedure where additional staff could be secured if there was a sudden absence or if a patient's needs or dependency increased. Twenty-four-hour advice and support was provided by a team of doctors. The duty rota showed recommended staffing levels were maintained.

Patients told us 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.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service employed a medical consultant. The service also employed a specialist for lymphoedema, which is a long-term (chronic) condition that causes swelling in the body's tissues.

The medical staff matched the planned number. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. GP's who were completing palliative care training worked as locums.

Outstanding ☆

End of life care

The service always had a consultant on call during evenings and weekends.

The provider had a recruitment policy which stated all staff had to have a Disclosure and Barring Service (DBS) check before starting their employment at the location. All staff had an up-to-date DBS check. We reviewed staff personnel files and all staff had proof of identification, full employment history and an up-to-date curriculum vitae on file. The service had obtained at least two references for all staff in line with their policy. We also saw employment offer letters, evidence of induction training, qualifications, and professional memberships were kept on file.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed patients' notes and found them mostly to be completed in full and were up to date. They included relevant risk and clinical assessments including escalation and ceiling of care plans, known allergies, nutritional and pain assessments, medical and nursing clinical management plans and pathways. Clinical care records were multi-disciplinary and enabled the phase of illness to be identified. Staff used the integrated palliative outcome scale (IPOS) phase of illness and advance care planning, which supported patients to identify their main concerns and whether they had any unmet needs. Communication with patients and their families was clearly documented throughout the records.

The healthcare team supported patients and their families to record information in treatment escalation plans, (TEP) and resuscitation decision records (RDR). These identified which treatments would and would not be helpful if a patient became unwell and helped to avoid unwanted or futile cardiopulmonary resuscitation (CPR). Patients who were admitted with a TEP had this reviewed as soon as possible after admission. Records were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records.

Staff had a flexible approach and responded when things went wrong. Staff used an electronic prescribing system, but this has had wi-fi challenges. Staff had access to a printed paper chart back up to use if necessary.

The service had an up-to-date information governance policy, and a data retention policy. The registered manager was the information governance lead for the service. The service was registered with the Information Commissioner's Office (ICO).

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service had worked with the acute hospital trust to implement an electronic system to prescribe medicines and to record their administration. This system was used across all NHS hospital services and adult hospice services in Cornwall. This meant that information about people's medicines was more readily available when people transferred between services. These electronic records were complete and up to date with clear recording of allergies and reasons if medicines were not given.

Staff followed national best practice to check patients had the correct medicines. Staff checked patient's identity and allergies before giving medicines. People had access to emergency kits which contained medicines known as 'just in case' medicines.

End of life care

Staff reviewed patients' medicines regularly and provided patients and their carers with specific advice. When patients went home, they were provided with a discharge summary that explained their medicines and how to take them in an easily understandable manner. This was discussed with patients before they left the service to make sure they knew how and when to take their medicines.

Access to medicines was restricted to authorised staff only. Regular monitoring and checks meant that all medicines were in date and stored at the correct temperature. However, the medicines fridge had last been checked two days before our inspection. The service stored and monitored controlled drugs in line with national guidance. Staff stored and managed prescribing documents, such as FP10 prescriptions, in line with the provider's policy. The use of emergency medicines had been risk assessed. Emergency medicines for anaphylaxis were stored in a tamper evident trolley.

The service had access to pharmacy support. Ordered medicines were delivered frequently during the day and a process was in place to ensure deliveries were available if urgent medicines were needed outside of normal times. The pharmacist attended the weekly multidisciplinary team meeting to ensure that patients medicines were safe and effective.

Staff completed audits to make sure medicines policies were followed. Staff reported incidents and near misses which fed into the monthly clinical incident forum to identify themes and any learning needs.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

At our focussed inspection in July 2018, we found reported incidents were not assessed for severity. This did not ensure a consistent response. We also found training had not been provided to all staff who were required to investigate incidents. At this inspection, we found the provider had taken action to address these concerns. Staff also recorded clinical incidents such as a person arriving at the hospice suffering pain as a result of the transport.

Staff knew what incidents to report and how to report them. Staff had access to an electronic system for reporting incidents. Accidents and incidents were reported with action taken to reduce risk of recurrence. There was evidence that changes had been made as a result of feedback. For example, the incidence of patients developing pressure ulcers was reducing because staff monitored the suitability of mattresses and changed them where necessary.

Managers debriefed and supported staff after any serious incident. Staff were able to take part in a team de-brief if necessary.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. In line with their duty of candour, the service made the person involved and their family aware of the outcome of the investigation, lessons learned, and the improvements implemented.

Staff met to discuss the feedback and look at improvements to patient care. Staff received feedback from investigation of incidents, both internal and external to the service. Every incident was logged and monitored for trends. Accidents and incidents were discussed at clinical incident forums, and lessons learned identified. The provider submitted all incidents to Hospice UK and rated them. Staff were involved in the discussion to agree the harm level and rate as low, medium or high levels of harm.

Outstanding ☆

End of life care

Are End of life care effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

At our focussed inspection in July 2018, we found staff were not familiar with relevant national guidance and recommendations to ensure they were providing up-to-date care and treatment. At this inspection, we found staff followed up-to-date guidance. The hospice undertook a comprehensive range of audits throughout the year to ensure healthcare was being provided in line with standards. The hospice used the audits as a quality improvement tool to improve patient care and outcomes. The audit identified the areas to improve, which included staff training.

Managers completed ward audits, where they looked at areas such as the cleanliness of the environment, hand hygiene and equipment being in good order. Audits of clinical incidents showed the provider had 25% fewer incidents than similar services.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A process was in place for policies to be updated with any new or amended guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory training. Patients had an individualised plan of care which reflected their personal needs. If the patient was at end of life, this was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with national standards and guidelines.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. 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 visited everyone every morning to discuss their choices. The chef had access to a multi-faith file, which gave information about suitable foods and special dates for each faith.

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 did not wish to eat the main course offered, they were offered an alternative 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.

Outstanding ☆

End of life care

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Pain was a common symptom suffered by patients cared for by the hospice and its services. Staff used recognised tools for assessing patients' pain, including a pain assessment tool for people with an advanced dementia. Patient pain levels were regularly reviewed, and staff gave pain relief in line with individual needs and best practice. Staff assessed patients before and after any intervention such as moving them. Distraction techniques such as complimentary therapies and music were available. Nursing staff were taught how to assess pain and use syringe drivers for effective pain relief. Anticipatory medicines were prescribed for patients who needed them.

Staff monitored patients for distress cues, for example patients who because of cognitive impairment or physical illness had limited communication. Staff told us how they used charts with faces on for patients with learning disabilities or cognitive impairment to help them describe pain. Staff also regularly assessed patients' ability to tolerate oral medicines with alternative administration routes prescribed if necessary, such as intravenous infusion.

Staff prescribed, administered and recorded pain relief accurately. Patients received pain relief soon after requesting it. One family member said, "Everyone was so attentive to my husband, ensuring that he was never in too much pain and always keeping on top of it."

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Managers used the results to benchmark themselves with Hospice UK against other adult hospices. Results from audits of falls showed patients had fewer falls and falls were no harm or low harm, compared to higher levels of falls and harm in comparable services. The service had similar favourable results from audits of pressure ulcers on admission and medication errors.

Managers and staff used audits to improve patients' outcomes. Outcomes for patients were positive, consistent and met expectations, such as national standards. For example, 'a positive difference' may well be preventing deterioration, maintaining mobility, or lessening the impact of symptoms, rather than improvement. Staff had reduced the numbers of patients with pressure ulcers by monitoring the use of different kinds of mattresses. Managers monitored the numbers of patients engaging in developing advanced care plans and provided training for staff to improve this.

Hospice staff understood the importance of working together to provide seamless care for people. People's care was reviewed daily or more often by nursing and medical staff and treatment plans updated as their needs changed.

Outstanding ☆

End of life care

Comprehensive discussions took place about the care of each person and those of close family members. 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 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.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Hospice staff had a range of skills and experience, and received training, updating and opportunities for ongoing professional development. All new staff including bank, locum staff and volunteers underwent a thorough induction, which gave them the skills and confidence to carry out their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were champions within the service who actively supported staff to make sure people experienced good healthcare outcomes leading to good quality of life.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff said this was an opportunity for them to discuss their professional development. Staff also benefitted from clinical supervisions either individually or in groups.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff were supported through an appraisal process where staff were able to review the past year, the year to come and agree competencies. The annual appraisal also had a mid-year review to monitor progress.

Managers identified poor staff performance promptly and supported staff to improve.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Links with health, complementary and social care services were good. Where people had complex/continued health needs, staff always found ways to improve their care, treatment and support by identifying and implementing best practice.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Patients were reviewed daily by the medical team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Outstanding ☆

End of life care

Consultants led daily ward rounds Mondays, Wednesdays and Fridays and were on call any other time, including overnight and weekends.

Patients were reviewed by consultants depending on the care pathway. Patients were reviewed daily by doctors. The provider employed two specialist doctors, two clinical fellows and one GP trainee. GPs in training spent six months with the service.

Patients could access the lymphoedema clinic when they needed to. The clinic supported 195 patients but did not have a waiting list. Staff discussed the patient's needs with them and treatments were tailored to meet the needs of the patient.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Out of hours there was always an on-call executive team member to escalate staffing concerns if needed. A consultant, doctor and senior management were also available out of hours.

The provider had a 24-hour, 7-day a week palliative care advice line for patients and their carers and for health professionals such as GPs, district nurses and hospital staff.

Health promotion

Staff gave patients practical support to help them live well until they died.

Staff gave patients practical support to help them live well until they died. Staff made sure patients were comfortable and able to be as pain free and symptom free as possible. Staff provided practical support to help patients manage long-term conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

At the previous inspection in August 2014 we found staff did not have up to date knowledge regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS). At this inspection, we found 91% of staff had completed DoLS training and 85% of staff had completed MCA training. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Each person's mental capacity to make their own decisions and consent to their care was regularly assessed and reviewed, as their condition changed. Staff consulted relatives, staff and other professionals in 'best interest' decisions about the person's care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Patients were consulted and involved in all care and treatment decisions.

Outstanding ☆

End of life care

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff respected people's wishes, set out in advance care plans, even when the person was no longer well enough to communicate them.

Staff clearly recorded consent in the patients' records.

Are End of life care caring?

Outstanding ☆

Our rating of caring stayed the same. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

All staff, including volunteers, were aware of the importance of providing compassionate care and the impact their actions had on the patient and their families during this time of their lives. Support was given by caring and empathetic staff who put patients and those close to them at the heart of everything they did. All conversations and observations, without exception, with staff during our inspection demonstrated this. Big and small acts of kindness were embedded in how staff cared for patients, whether it be arranging a wedding, arranging movie nights or holding a patient's hand when they were scared.

For special occasions staff organised events such as a wedding, a birthday party, a last trip to the theatre and visits from much-loved pets. One patient's final wish was to say goodbye to their horse, so staff worked with other agencies to transport the horse to the hospice.

One family provided feedback to the service and said, "There is one memory I will never forget, when one of the doctors came to see her he lowered her bed, knelt on the floor (as he was very tall) and holding Mum's hand he softly spoke to her as if it was his own Mum. So caring. It was a huge comfort to us all being cared for at Mount Edgcumbe."

Patients said staff treated them well and with kindness. Patients described the exceptional quality of the service by commenting, "Staff are simply beautiful, they can't do enough for you" and, "Staff are wonderful, par excellence."

People said staff and volunteers always treated them with the utmost dignity and respect. Curtains were fitted inside the door of each bedroom, which provided complete privacy for care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and their relatives and consistently took account of this when providing care and treatment.

Outstanding ☆

End of life care

One patient told us they “felt held and wrapped up in a warm blanket” and said they were very happy with the care and support staff provided. Feedback from patients and families was overwhelmingly positive. For example, one person said, “I was falling apart, totally devastated and extremely emotional but [Name] didn't judge me, she listened, let me discuss with her my fears and between us, tried to find a positive way forward. I am so grateful for all the support and encouragement she gave me!”

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The hospice provided a comprehensive bereavement service for people and families, which included linking with external sources and providing support for bereaved children.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Feedback included, “Each visit I made was difficult but rewarding – it was made so much easier by the fact that every individual charged with looking after Mum made sure that not only was she in comfort, but that my sisters and I were too” and, “All of the nurses and health care assistants were amazing, not only to my husband but also to myself and our children. Nothing was too much trouble, and they are all so very kind and caring.”

Mount Edgcumbe Hospice was supported by local religious leaders who were ‘on call’ and could be contacted when needed. Their role was to support people of any faith, and those with none, with whatever helped them cope with a life limiting illness. We saw there was a room for ‘reflection’ which was furnished to ensure that all faiths would be welcomed. Staff told us people could also use free rooms and the gardens in and around the hospice for spiritual support or solace. People told us these areas were valued.

Staff had completed multifaith training and were knowledgeable about how to meet people's spiritual, religious and cultural needs. Where people had dietary restriction related to any religious or cultural beliefs, these were catered for. All were welcome to use the quiet room set aside which provided a quiet and tranquil space to spend time for quiet reflection.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff spoke with patients sensitively and appropriately dependent on their individual needs and wishes. Hospice staff knew what mattered to people and had excellent interpersonal and communication skills, and quickly established a rapport with them. We witnessed many kind and gentle interactions and staff spent time with people, chatting to them in an unhurried and relaxed way.

Some ward staff had been trained to give soft-touch massage with pre-mixed oils. A qualified complimentary therapist prepared the oils. Staff had also been trained to use a diffuser to help people, for example manage symptoms such as nausea.

Patients in the lymphoedema clinic were involved in deciding how often they needed to be seen, were asked what they needed, and treatments were tailored to the patients’ need. One member of staff said, “We’re with patients on their journey.” The treatments were patient centred and holistic, for example, family members were also brought in for meetings with the patient’s consent, so staff could teach them how to help.

Outstanding ☆

End of life care

Leaders at the hospice were committed to improving the quality of services offered to patients and their relatives. For example, the service had invested in 'cuddle beds' for the in-patient unit. The cuddle bed did everything a normal hospice bed did but, at the touch of a button, the cuddle bed widened into a double bed, so patients and their families and friends could all get on a bed together.

People were supported to have a comfortable, dignified and pain free death. Following death, a temperature-controlled room was available, and relatives and friends could spend time with their loved one and staff could continue to support them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave overwhelmingly positive feedback about the service.

Staff supported patients to make advance decisions about their care.

Are End of life care responsive?

Outstanding ☆

Our rating of responsive stayed the same. We rated it as outstanding.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospice staff had worked to improve equity of access to palliative care and end of life services for people such as homeless people and people with drug and alcohol addictions. Following a south west drug related death conference, which included a range of professionals including acute and community healthcare trusts, local GPs, housing, community drugs and alcohol teams, an improving access working group was set up. This 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. The hospice recognised that people who were homeless have a much-reduced life expectancy, with an average age at death of 44 years. By providing training to hostel staff and working with other professionals, staff improved the standard of care provided for these patients because patients with mental health conditions, drug or alcohol dependency were discussed in GP's meetings, to plan and evaluate end of life care for these patients. The improving access project had also started running Death Cafés in the hostel grounds which had been very well attended. The service met the standard of 'Homeless Friendly' and no-one would be refused a bed due to their drug or alcohol difficulties.

The service worked closely with local commissioning groups, professionals working in care homes and national organisations to look at how people in deprived areas accessed care.

The service ensured people living with a dementia and those living with a learning disability were able to access services. All staff completed dementia awareness and learning disability awareness training.

The service had systems to help care for patients in need of additional support or specialist intervention. Mount Edgcumbe Hospice provided support to adults with progressive, treatable but not curable life-limiting conditions or with severe frailty, and their family (including children) and carers. Services provided included physical, psychological and/or spiritual support. The service also provided a Lymphoedema clinic, neighbourhood hub and provided therapy services.

Outstanding ☆

End of life care

Managers planned and organised services, so they met the needs of the local population. The service provided a range of resources which had up-to-date end of life and palliative care information for patients, carers, family members and healthcare professionals. The provider had a community service which offered a wide range of services to support people with practical advice and information.

Neighbourhood hubs provided support, practical advice, information and treatment for people living with a palliative/terminal illness or a deteriorating progressive disease and their carers. This service was delivered by occupational therapists and physiotherapists.

The service provided a virtual community friendship café, offering a virtual space for support and information, a place to share experiences, wellbeing activities and advice, bereavement support and virtual friendships. This was a social media group for those feeling socially isolated, carers and people coping with a long-term illness or bereaved. This also helped younger people who might not wish to attend the hospice, connect with the service. The provider's website offered virtual tours so people could see what was on offer.

A 'Listening Ear Service' was a telephone service for people who were isolated and vulnerable and had experienced the recent death of a loved one. 'Walk Talk Kernow' were adult walking bereavement support groups. Whilst walking in nature, each group provided a space for those who were bereaved and seeking social connections. The service provided a useful links directory which was an on-line resource providing contact details for local and national organisations, covering a range of topics including cancer, mental health, planning for end of life, bereavement and general health.

People received co-ordinated person-centred care when they used or moved between different services through partnership working. Hospice staff linked with several groups, organisations and networks, for example, child bereavement groups. Data showed that 92% of patients passed away in a place of their choosing.

The community team distributed 'What Matters?', an e-newsletter for those approaching or planning for end of life in Cornwall. This newsletter was distributed across the county to health professionals including GPs, social prescribers, nursing homes and funeral directors for them to print/pass on to their patients/clients.

The service had plans to open bereavement help points similar to Walk Talk Kernow, but in venues around the county in the weeks following our inspection.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

People valued their relationships with the staff team and felt that they often went 'the extra mile' for them, when providing care and support. Patients told us staff were exceptional in enabling people to remain independent and had an in-depth appreciation of people's individual needs around privacy and dignity. People told us about the difference the service had made to them, such as using techniques to release areas of restriction in their movement. The lymphoedema clinic was the only service of its kind that provided a carers support scheme, we found the community team looked after carers as well as patients. Patients providing feedback about the care and support they received from the staff of the lymphoedema clinic gave staff a 97% score for the overall rating of their service. Patient feedback was positive in a number of areas including specialist support, quality of life improvements and satisfaction. Everyone was 100% 'very satisfied' with the way in which their condition was explained to them, feeling involved about their treatment plan and the support they received.

End of life care

The service also focused on people's wellbeing and developed innovative ways to support and help them, both psychologically and practically. Family support was seen as key to people's wellbeing and the needs of people's families were also supported. People and relatives appreciated that staff involved them in regular reviews of their care. People told us that staff listened to them and involved them in the development of their care plans. People were supported, if they wanted to, to develop an advance 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. People's relatives told us that they had been encouraged by staff to voice their opinions, which made them feel their views mattered.

The provider worked closely with other healthcare providers to improve advance care planning and make medicines for homeless people and people with drug and alcohol addiction at the end of their lives better available. This group set out to deliver a further conference which focussed on palliative & end of life care for the homeless and for those with drug and alcohol problems, bringing together professionals from both areas to deliver the conference.

The service was involved in a project to provide a palliative care nurse for 12 months working with homeless people which promoted equality, diversity and inclusion by recognising and acknowledging that homeless people often struggle to access palliative care due to their complex needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

The hospice had effective processes to manage admission to the service. Referrals came mostly from GPs, specialist palliative care nurses, community clinical nurse specialists and the local acute NHS hospital. Patients could refer themselves if they had been diagnosed with a life-limiting condition. The hospice was able to meet the needs of patients who would benefit from the service at the point they needed it. The hospice did not have a waiting list.

Staff supported patients when they were referred or transferred between services. There were discharge processes to ensure patients could be safely discharged home to their preferred place of death, wherever possible. These included liaising with other hospice services such as occupational therapy team and pharmacy to ensure an appropriate care package was in place.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. The service had an up to date complaints policy, which outlined procedures for accepting, investigating, recording and responding to local, informal, and formal complaints about the service. The provider's policy outlined the process to learn from complaints and learning was shared across the provider.

Outstanding ☆

End of life care

It was easy for people to give feedback and raise concerns about care received. Staff made changes following feedback. For example, staff working in the lymphoedema clinic built relationships with patients by making phone calls instead of sending letters out to patients. This was because they realised one young person wasn't responding because letters were coming from a hospice, so staff changed how they contacted people.

If any patient or family provided any negative feedback and wished to discuss this, a member of staff contacted the family. Feedback was discussed at the clinical governance committee.

The service received 130 written compliments during 2021/22. Patients and families overwhelmingly gave positive feedback about the quality of the care and the kindness and support from staff. Comments included, "I just wanted to express my intense and unending appreciation to the doctors, nurses, care teams and volunteers who looked after and supported our mum".

Are End of life care well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was compassionate, inclusive and effective leadership at all levels. 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 consultant and doctor. Leaders had the experience, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The leadership team was visible, approachable and well respected by the staff within the service. The registered manager told us that the service had an open-door policy and staff confirmed this was the case.

The hospice leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the services. Senior members of staff we spoke with had been in post for several years and had good knowledge of the service and its systems and processes.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Outstanding ☆

End of life care

The provider had a vision for all people living with a terminal illness in Cornwall to be able to access the care and support they may need at a time and in the place that was right for them and their families. The provider engaged with other healthcare providers to decide how resources should be allocated to achieve objectives and monitored progress with regular meetings.

The work the provider did leading the Cornwall and Isles of Scilly End of Life Education Group ensured the group developed their 'End of Life Care Education Strategy'. It was developed to inform programmes of education and to help support the needs of health and social care staff to achieve the end-of-life care learning outcomes. This strategy was paramount in providing guidance for organisations across Cornwall and Isles of Scilly. The provider had received positive feedback about the training the education team had provided to care homes and the community.

The provider engaged with stakeholders, patients and families to understand their views of the service. Feedback from patients and families was overwhelmingly positive and thankful for the support and services Mount Edgcumbe Hospice had provided.

The provider worked with other providers to deliver its strategy and improve outcomes for patients considered hard to reach such as homeless people and people with drug and alcohol addiction.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders had an inspiring and shared purpose and strived to motivate staff to succeed. All staff promoted a positive culture that was open, inclusive and empowering. The registered manager set high standards of caring for staff and told us how they nurtured staff to ensure low turnover. This also enabled them to build on the experience in the team. Staff were committed to care that placed people at the centre of the service.

Staff told us they felt supported, respected, and valued by their managers. They enjoyed coming to work and were proud to work for the service. Staff told us there was strong collaboration, team-working and support between staff and a common focus on improving the quality and sustainability of care and people's experiences. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. Staff completed equality and diversity training. Staff were encouraged to raise concerns openly and without fear of recrimination.

Staff had regular meetings where they were able to bring together staff views and raise questions. Supporting information was shared across the teams through a staff newsletter called 'All Together'.

The board of trustees and senior managers were mindful of the impact on staff of rising prices and the current economic climate and had introduced a benefit called 'early pay', where staff could access some of their salary early. The date staff received their salary was changed so they were paid earlier in the month, this was in recognition that staff paying rent needed their salary in time for these payments. The hospice had become a living wage employer for staff who had previously been employed on a minimum wage. Staff were also provided with access to counselling. The hospice was also trialling giving staff free complimentary therapy sessions twice monthly. A 'freedom to speak up' guardian had been appointed and trustees and the executive were available for staff to talk with during open door sessions. Freedom to

speak up guardians support workers to speak up when they feel that they are unable to do so by other routes and all staff knew who they were and had access. Staff were able to discuss anything that had been difficult during a weekly team talk and had access to Schwarz rounds bi-monthly. Schwartz Rounds were conversations with staff about the emotional impact of their work. Staff could also access counselling.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We found a clear line of governance to communicate information throughout the service, and to escalate and cascade information up and down lines of management and staff. Staff were clear about their roles and understood what they were accountable for and to whom. Staff could describe the governance processes for incidents and complaints and how they were investigated.

The service had a governance framework in place through which the hospice was accountable for continuously improving their clinical, corporate, staff, and financial performance. The board of trustees and the executive management team through the governance management framework oversaw governance within the hospice. The framework and supporting policies provided the structure for managing and reporting on a range of auditable metrics.

We reviewed minutes of the clinical services committee meetings

The hospice had groups where specific operational issues were discussed, such as the patient safety group, the infection prevention and control group and medicine management group. We reviewed minutes from these meetings and saw they were effective and included the set of decisions, outcomes and next steps or action items.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The board of trustees had oversight of risks. Each executive team member prepared a report for the board. For example, these included governance, clinical governance, health and safety and risk registers. This enabled the board to identify risks that were increasing or decreasing and act as necessary. The service had a risk register. The risk register was discussed and updated during clinical governance meetings. Items on the risk register included identifying the frailty of the telephone system to support the advice line; internal changes were made and talks were underway to identify an alternative option.

There was a risk to the business because medical staff did not have a service level agreement in place. A service level agreement details exactly the type of service you can expect and explains everyone's responsibilities. The provide was engaged in rectifying this.

The board of trustees had effective oversight of the quality and safety of care which enabled them to make sure decisions were in keeping with the strategy and values of the hospice and progress was delivered. Safety of the workforce was paramount. For example, the provider used a phone application for staff who were lone working which meant staff could instantly access help when needed.

End of life care

The service had a contingency plan with identified actions to be taken in the event of an incident that would impact the service. For example, extended power loss, severe weather events, short notice staff sickness and equipment failure. The contingency plan included contact details of relevant individuals or services for staff to contact.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had policies and procedures to promote the confidential and secure processing of information held about patients. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant, having been scrutinised quarterly.

We saw accurate information was effectively processed, challenged and acted upon. Key performance, audit, and patient feedback data was frequently collated and reviewed to improve service delivery.

The service had an up-to-date information governance policy and had data retention policies. These stipulated the requirements for managing patients' personal information in line with current data protection laws. The service was registered with the Information Commissioner's Office (ICO), which is in line with 'The Data Protection (Charges and Information) Regulations' (2018). The ICO is the UK's independent authority set up to uphold information rights.

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. 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.

The provider had provided staff with a lone-worker application on their phones to give them additional security. This application meant staff could be tracked if they went missing and the service could speak with the member of staff's family.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The provider's advanced nurse practitioner (ANP) worked closely with other specialists involved in setting up and delivering Cornwall's first motor neurone disease (MND) clinic. "Motor neurone disease" refers to a group of diseases that cause the motor nerves in the spine and brain to lose function over time. This clinic will be ANP and allied health professional led. Currently, patients with MND must attend multiple appointments, the MND clinic will ensure patients will have access to wider multi-disciplinary and specialist support through a single appointment. The provisional start date for the clinic will be October or November 2022.

Patients were given a patient handbook, which explained everything available to patients. Information covered information about the in-patient unit, the patient and family support available and information about services the hospice provided. Patients had information about the catering facilities and how staff would keep them safe. One person provided feedback about the patient and family support available and said, "The sessions were helpful in every way, I wish I had done it sooner."

End of life care

The provider produced a clinical newsletter every two months. The August 2022 issue contained information about CQC's new regulatory model, the safer management of controlled drugs annual report, emollient prescribing, becoming an end of life learning path champion and information about clinical note-taking accountability and delegation training. Information was also shared with staff about domestic abuse e-learning modules.

The provider produced a newsletter called 'All Together' which was widely distributed. This was used to celebrate the many achievements and successes and shared the news from activities such as the success one member of staff from the community services team had winning first prize in a competition. The provider was awarded the Bronze Award from the Armed Forces Covenant Employer Recognition Scheme in appreciation of their support for service families and ex-service personnel.

The provider engaged with stakeholders, patients and families to understand their views of the service. Feedback from patients and families was overwhelmingly positive and thankful for the support and services Mount Edgcumbe Hospice had provided.

The community team worked to signpost hard to reach groups of people with advice such as claiming benefits, bereavement teams, a helpline and putting people in touch with advocacy services.

The provider was a registered regional training provider for the Gold Standards Framework (GSF) in care home programme. The education team worked collaboratively with other providers to ensure training such as Dying Matters and End of Life Learning Path was available across the county.

The provider offered a palliative care advice line available to professionals 24 hours a day, seven days a week. This service provided access to specialist nursing and medical advice. For example, on symptom control, use of syringe drivers and drugs and management of palliative care emergencies.

The provider's website was proactive in identifying the topics people would need to ask questions about. There were links to podcasts and websites to support people managing grief and topics such as action for happiness. The service was had have been shortlisted for an excellence award for their podcast.

The education team collated and distributed the palliative and end of life care calendar of events across the county. The service also provided bespoke sessions on request. People wishing to book onto training could do so easily from a form which was accessible from the provider's website.

The provider engaged with patients, families and carers and used the feedback to develop and improve the service they provided. Between April 2021 and March 2022, 92% of respondents were very satisfied with the service, 6% were satisfied.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service demonstrated a strong commitment to professional development. Managers were proud of the work done by the education department. The service had systems to monitor staff training and development. Staff had taken advantage of the opportunities available to learn, develop and improve their skills. The provider was instrumental in establishing the countywide end of life learning path champion network which was co-facilitated by the provider and an end of life facilitator from the local NHS.

Outstanding ☆

End of life care

The provider supported medical school placements at the hospice for medical student clinical placements and palliative care taster weeks for junior doctors.

The provider offered a range of placements from a local university, including nursing students, nursing associates, allied healthcare professionals, counselling, and psychology degree students. The education department had developed clinical induction packs to support placements. The service received positive feedback about this, for example, one person said, "Just wanted to say thank you for welcoming my student onto the ward for work experience. It was an amazing opportunity for her."

The provider worked in partnership with other colleges and universities to support nursing associate's placements and a member of the education team delivered education sessions on priorities for care of the dying and advance care planning. One member of staff was a member of a placement expansion group to extend the provision of placements they offered.

The provider was affiliated with the National Gold Standards Framework Team. The service was a Gold Standards Framework (GSF) regional training centre and two members of staff were trained facilitators to deliver the programme.

The service proactively worked with commissioners to provide some funded verification of death training for designated unregistered support workers.

The provider had recently signed a national learning agreement with the Royal College of Nursing, the second of its kind for the Southwest region. Staff entered into this learning agreement with passion and enthusiasm and were looking forward to exploring different ways of supporting people on their learning and development journey.