

North Humberside Hospice Project Limited

Dove House Hospice

Inspection report

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Date of inspection visit: 7 and 8 April 2015
Date of publication: 21/05/2015

Ratings

Overall rating for this service

Good 

Is the service safe?

Requires improvement 

Is the service effective?

Outstanding 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

We undertook this unannounced inspection on the 7 and 8 April 2015. The last full inspection took place on 10 January 2014 and the registered provider was compliant in all the areas we inspected.

Dove House Hospice is situated in a residential part of Hull and provides supportive and palliative care services. The service can provide in-patient care to a maximum of 21 adults and has a day care unit providing therapy for up to 25 people, three times a week; there is also an outpatient clinic. The inpatient unit has five single bedrooms and four bays each of which accommodate

four beds and would reflect single sex occupancy. All the bedrooms and bays have doors leading directly into the gardens and patios. There is a range of bathrooms, communal rooms and therapy facilities to meet the needs of people who use the service. On the first day of the inspection there were 12 people using the service as inpatients. Other people were admitted over the two days of the inspection.

The service has recently undergone a building extension. This included the addition of two family suites, outdoor weatherproof spaces, enhanced therapy assessment and

Summary of findings

treatment areas, new rehabilitation and gym facilities and a new and improved day therapy unit. Beds were increased on the inpatient side to accommodate an additional 14 people. Two of these new bedrooms were for people living with dementia who also had need of palliative care and support. These 14 bedrooms had not been registered with the Care Quality Commission yet and were not in use at present.

The service has a registered manager. 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.

We found staff mostly managed medicines safely and encouraged people to take their medicines independently when this was possible and safe. We found some staff had not always followed the hospice's policy for recording medicines.

Risk assessments were completed and staff knew what to do to minimise risk in order to protect people and maintain their wellbeing. Some risk assessments had not been updated when people's needs changed.

We found the environment was safe and had been designed to meet the specific needs of people who used the service. Systems were in place to enhance security of the building.

Staff were recruited in a safe way and full employment checks were completed before they started work in the service. There were sufficient staff on duty to meet the range of care, support and treatment needs of people who used the service. Staff were well trained and had

supervision and support systems in place to ensure their practice was monitored and they were able to develop skills and knowledge. We saw staff had completed safeguarding training and knew what to do to keep people safe from abuse or harm. There were policies and procedures for additional information and guidance.

We found people's health care and nutritional needs were met. There were plenty of choices for meals and fluids and dietetic advice was obtained when required. The service had creative ways to alert staff when people required additional monitoring regarding their nutritional intake.

When people were assessed as lacking capacity to make decisions about their care and treatment, best interest meetings were held with relevant people to discuss options. Assessments and care plans were produced to provide staff with guidance in how to provide care and treatment which met their preferences.

We observed staff provided care and treatment to people who used the service in a kind, compassionate and professional way. People told us staff couldn't be better, were empathetic and were caring towards them. There was a range of complementary therapies and activities to stimulate people and promote their wellbeing. There were support systems in place for bereaved relatives.

We observed the culture of the organisation was one of openness and sound values based on putting the people who used the service at the centre of what they provided. There was a quality monitoring system to enable checks of the service provided to people and to ensure they were able to express their views so improvements could be made.

Summary of 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?

The service was not consistently safe.

People received their medicines as prescribed. There were arrangements in place to manage medicines safely although the recording of medicines could be improved.

Risk assessments were completed, although not all had been updated when people's needs changed. The environment was clean, safe and secure.

There were enough staff on duty to meet people's assessed needs and they were recruited in a safe way which ensured all checks were carried out prior to them starting work. Staff knew how to protect people from the risk of harm and abuse.

Requires improvement



Is the service effective?

The service was effective.

People's health care needs were met within the service by medical, nursing and complementary therapy staff. Specialist equipment had been purchased, and on other occasions hired, to meet people's health care needs and to promote their dignity and independence.

There were creative ways of ensuring people's nutritional needs were met which included a red tray system to alert staff when people needed additional support and monitoring. It also included purchasing specific high calorie meals from the local hospital trust.

There was a full training programme and network of support for staff and volunteers. This meant people were cared for and treated by staff who were knowledgeable about palliative and end of life care.

Outstanding



Is the service caring?

The service was caring.

People received care and treatment in a caring and compassionate way. We observed a very positive staff approach during their interactions with people who used the service.

Staff had developed a range of methods to include and involve people and their carers in the services provided. The service had responded positively to issues of equality and diversity; a multi-faith room had been created to allow people space to contemplate, meditate or pray.

People received end of life care that was delivered in a sensitive and compassionate way. Staff supported relatives and carers who wanted to be involved in providing end of life care to their loved one.

Outstanding



Summary of findings

Is the service responsive?

The service was responsive.

People's needs were assessed on admission and they had plans of care developed to guide staff in how to meet their needs. The care plans could contain more personalised information about preferences for care for when people were no longer able to tell staff or make choices.

There was a range of therapies and activities for people to participate in during their inpatient stay or when attending the day therapy unit.

The service had a complaints policy and procedure with leaflets on display to provide people and their relatives with information and guidance.

There were systems to ensure people had a smooth transition when they moved between services. Multi-agency discharge planning meetings ensured relevant people had up to date information about people's needs and changes in their condition.

Good



Is the service well-led?

The service was well led.

There was a well-defined structure of the organisation and management tiers. People were aware of their roles and responsibilities.

The culture of the organisation was open, transparent and inclusive, which enabled staff to feel able to express their views and raise concerns. The service had developed a sound philosophy, mission statement and set of values which we observed staff demonstrated in their interactions with people and discussions with us.

There was a quality monitoring system in place which was undergoing review at present to ensure it was delivered in a more structured way. The system involved questionnaires, audits and analysis of incidents.

The service worked in partnership with other organisations and agencies to help provide information to people and develop a local end of life strategy.

Good



Dove House Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 April 2015 and was unannounced.

The inspection was completed by an adult social care inspector, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

During the inspection we observed how staff interacted with people who used the service. We spoke with four people who were using the service. We had discussions

with the nominated individual, the registered manager, the director of human resources, two training managers, a social worker, a health and safety officer, the head cook and a service user development officer. We spoke with inpatient staff which included a consultant and two hospice doctors, two senior sisters, one junior sister, one registered nurse and one care assistant.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as nine prescription and administration sheets. We sat in on a handover meeting at which medical and nursing staff exchanged information and planned treatment for people who used the service.

We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files (one doctor and two nurses), the training record, the staff rotas, minutes of meetings with staff, newsletters, surveys, quality assurance audits and maintenance of equipment records.

We completed a tour of the building to look at how hygiene and cleanliness was maintained.

Is the service safe?

Our findings

People told us they felt safe with medical and nursing staff who provided care and treatment to them. They told us there was always staff available to support them when needed and answered call bells quickly. They also said they felt safe in their environment and they were able to keep their belongings secure. Comments included, “I feel very safe”, “They’re (staff) always there” and “They couldn’t do anything better.”

People told us they received their medicines as prescribed and on time. We found medicines were obtained, stored and administered safely to people who used the service; however, there could be improvements in the recording of medicines. For example, we found some omissions on medication charts and we were unable to check if the medicine was given but not recorded, omitted for a reason or not given by mistake. We also saw that the increase in the dose of a medicine on two people’s charts had been written in a way which was contrary to the hospice’s medicine policy. This increased the risk of nurses misreading the instructions and giving the wrong dose. These points were discussed with the medical team and registered manager to address. Training on other aspects of medicine use and learning from medicine incidents occurred at team events, but nurses did not have formal, competency assessments. This was discussed with the registered manager and training managers to review.

Medicines which required more secure storage were kept in a cupboard which complied with the law. They were checked regularly and destroyed promptly and safely when no longer needed. We saw support systems were in place via visits from pharmacy technicians and a palliative care pharmacist to check medicines and provide advice to staff. There was also a system to receive and act upon national drug safety alerts. We observed nurses administering medicines and setting up a syringe driver; these tasks were completed in a caring and safe way and were recorded accurately. Arrangements for supplying people with medicines to take home were safe; the hospice’s doctors prescribed and checked these medicines. The consultant and two hospice doctors we spoke with were very experienced in prescribing medicines for palliative care. The doctors carried out peer review and supervised trainee doctors working at the hospice to ensure safe practice and people’s safety.

Risk assessments were completed when people had individual needs that potentially posed a risk. These included: moving and handling, falls, skin integrity and the risk of pressure damage, and the use of bedrails. We saw the risk assessments had measures identified to minimise risk, for example those for pressure damage identified which pressure relieving mattress should be in place on the person’s bed. There had been occasions when risk assessments had not been updated following an incident. It was important for documents to contain accurate information about risks to help guide staff when supporting people. This was mentioned to the registered manager to address with staff.

The service had policies and procedures which covered how to safeguard vulnerable people from abuse and how to ‘whistle blow’ if necessary. We saw safeguarding training was considered mandatory by the registered provider and all staff completed this in ‘Essential Training Days’. The training records and discussions with staff confirmed this. Staff were able to describe the different types of abuse, the signs and symptoms that abuse may have occurred and how they would manage these situations in order to keep people safe. Staff said, “We would intervene, document the incident and report it to management and other agencies.” The registered manager was aware of their responsibilities to refer any allegations of abuse or harm to the local authority safeguarding team. They said, “Our family support team are available for advice and they liaise with the local safeguarding team.” The registered manager described times when medical staff had used safeguarding procedures and liaised with the local safeguarding team when people had been admitted with severe pressure sores.

The director of human resources described the recruitment process and told us it was essential staff were recruited with full knowledge of the values and expectations when working for Dove House Hospice. Records confirmed references were obtained, police checks with the disclosure and barring service (DBS) were carried out and staff were interviewed before starting employment. There were also checks made with the General Medical Council and Nursing and Midwifery Council to make sure medical and nursing staff did not have any conditions applied to their registration to practice. New staff were given job descriptions and terms and conditions of employment to ensure they were aware of expectations.

Is the service safe?

We found there were sufficient medical and nursing staff of a range of grades and skills on duty to meet people's care and treatment needs. The registered manager and nominated individual were both qualified nurses and were supernumerary to the staffing rota but were on site during the day Monday to Friday to oversee the service. The service had a bank of staff to use for short notice absences and to cover holidays. We saw there were on call arrangements for senior nursing staff, medical staff and directors for evenings and during the night. There were facilities for on call medical staff to sleep overnight on the premises, if required for close monitoring of specific medical situations.

There was a range of other staff employed by the service. These included physiotherapists, an occupational therapist, complementary therapists, a family support team consisting of social workers and bereavement counsellors, a service user development officer, a music therapist, maintenance personnel, catering staff and domestic workers.

We found the environment to be spotlessly clean. Domestic staff had cleaning schedules and nursing staff had responsibilities for ensuring specific medical equipment was clean and ready for use. Staff had completed infection prevention and control training and there were policies and procedures to guide their practices. The expert by

experience who accompanied us on the inspection reported, "The building was in excellent condition and well decorated. The cleanliness was excellent in all areas. The gardens and paved areas were well kept and clean."

We found the environment safe and secure. Environmental risk assessments had been completed which included specific areas for example, the risk of fire, flood and an outbreak of legionnaire's disease. Contingency plans were in place for failure of utilities such as gas and electricity. Moving and handling equipment such as the lifts, hoists and bath hoists used within the service were well maintained in line with manufacturer's instructions. Recorded checks were made on bedrails, the nurse call, fire safety equipment, window restrictors, shower heads and hot water outlets to make sure these were in working order and safe to use.

The reception was staffed between 9am and 9pm and there was closed circuit television (CCTV) for the exterior of the building and the reception area. The service had electronic gates which were closed at 10pm until 6am and access during these hours would be by a security code and assistance from staff. Staff carried key fobs which gave them entry into areas of the service to help maintain security. There was a system to identify an emergency duty officer each day whose responsibility it would be to coordinate any emergency situations and ensure relevant people were informed. During out of hours, this duty was passed to the nurse in charge.



Is the service effective?

Our findings

People who used the service told us they were happy with the care, support and treatment they received. They said they had access to medicines and equipment to assist them with pain and symptom control during the day and at night. They also said they felt comfortable discussing health needs with staff and received specialist advice and information to aid decisions about their care and treatment. They also told us they enjoyed the meals provided to them. Comments included, "It's a fantastic service" and "It's given me a quality of life beyond expectations." A recent questionnaire completed by people who used the service had positive comments. These included, "I was very ill on admission. The medical and nursing intervention and excellent continuing care was in this case a life saver."

We found people's health care needs were met. Medical staff were on duty each day, and on call outside of usual working hours, to provide treatment for pain and symptom control. Nursing staff provided day to day nursing care and physiotherapists, occupational therapists and complementary therapists were available as required. We saw a consultant completed 'ward rounds' twice a week to discuss people's care and treatment. Assessments were completed by medical and nursing staff on admission and there were instructions for staff to complete specific observations within set timescales. For example, baseline observations had to be completed within the first six hours of admission and a skin assessment within 24 hours. Plans of care were formulated to meet assessed needs and to decide whether specific equipment or referrals to other health professionals were required. Following research of support networks in the local area, the service had created a post of motor neurone disease (MND) community specialist nurse to liaise closely with the hospital MND specialist nurse and neurologist. We saw this worked well in practice. We saw the service had specific medical equipment which had been trialled effectively to assist in meeting people's assessed health care needs.

We found people's nutritional needs were met; menus provided choice and alternatives. The assessment on admission identified whether people had any issues which would affect their nutritional intake. For example, whether there were concerns with loss of appetite, swallowing difficulties, nausea or vomiting and whether any special

diet was required. A catering assessment form was completed which included additional information. We observed the service had been creative and used a 'red tray' system. This meant people who were at risk of inadequate nutritional intake or who required assistance to eat their meals were served them on a red tray; this alerted staff to be vigilant, provide assistance and to monitor the person's food and fluid intake. The head cook confirmed they received catering information sheets; catering staff visited each person twice a day to discuss their choices for lunch and the evening meal. We saw links had been made with the local hospital dietetic service and high calorie desserts and soups were purchased from them when required for specific people. We found good practice was followed when staff prepared pureed meals so they looked appetising for people.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people subject to a DoLS at the time of this inspection. The registered manager and medical staff were aware of DoLS criteria and knew how to submit an application to the local authority when required. We saw staff worked within the Mental Capacity Act 2005 (MCA) code of practice. Records showed us assessments of capacity were completed, and when the assessment indicated the person did not have capacity, best interest meetings were held with relevant people in attendance to assist the decision making process on the person's behalf. Staff confirmed this in discussions with them about MCA. They said, "There is a flow chart to guide us with what to do if the person has no capacity. We also have policies and procedures on the intranet; there are MCA assessment forms and we'd speak to the doctors." We saw staff had been issued with a pocket size essential guide to safeguarding, MCA and DoLS to carry on their person.

We spoke with staff about how they ensured people who used the service gave consent prior to care and treatment. Staff said, "We ask people and get verbal, non-verbal and written consent; we also have consent to share information forms that people complete" and "People mainly have capacity for day to day care and we get consent from them. If people lacked capacity or they declined care and treatment we would respect it." There were documents in care files to record whether people had completed a lasting



Is the service effective?

power of attorney (LPA), made decisions in advance to refuse treatment (ADRT) and whether they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) in place. We observed a shift handover with a range of medical and nursing staff present. We saw information regarding DNACPR status was recorded on the handover sheet to make sure all staff were aware and discussed in the meeting to check it was still valid.

We saw there was a full training programme for staff and specific training days for volunteers. The training programme for staff included set days for courses considered essential. These included, palliative care and end of life, bereavement, dementia, first aid, safeguarding, nutrition, MCA/DoLS, food hygiene, safe handling of medication, information governance, health and safety, equality and diversity, fire safety and infection prevention and control. Additional training included, care planning and person centred thinking, record keeping, enteral feeding, communication, pain management and the use of syringe drivers. There were also sessions facilitated by consultants in specific health conditions. Training records identified the courses staff had completed and there was a system to indicate when refresher training was due.

We saw staff had received an awareness session on the responsibility of the registered nurse and safety first training had been completed in March 2015 which covered, blood transfusions, medicines management, clinical incident and accident reporting, management of sharps, managing challenging and difficult behaviour and responsibilities of the emergency duty officer during out of

hours. Qualified nurses were encouraged to develop and complete post graduate training courses. Staff said, "It's a good training system", "We have personal development plans" and "We have essential in-house training every year."

There was an induction for new staff which included orientation, essential training, completion of workbooks, observation of practice, shadowing staff in a supernumerary capacity and mentoring from senior colleagues. Staff told us they received clinical supervision and described a very supportive management structure. Comments included, "This is the best place I have ever worked; they go above and beyond to support you, which because of the nature of the job is very important." Newly qualified nurses were supported by a preceptorship programme (a period of additional support and guidance) and trainee GPs completing their rotation at the service were supported by the medical team.

We found the environment had been designed to meet the needs of people who used the service. Bedrooms were spacious with en suite facilities and communal bathrooms and shower rooms had specialist equipment for bathing and moving and handling people. There were two specialist toilets purchased to promote independence and dignity during use. Other equipment, such as a specialist bed, had been hired when required. The outdoor space was well tended and wheelchair friendly. There were two bedrooms for people who were living with dementia and who required palliative/end of life care. These had en suite shower and toilet facilities, were spacious, and had a seating area with space for relatives to stay with the person if required.



Is the service caring?

Our findings

People who used the service told us staff were kind and caring and treated them with respect. They also told us they were kept informed and were involved in planning their care and making changes to it. One person described how staff had provided them with information about resuscitation. The person told us the decision not to be resuscitated was an important one for them; staff supported the person and their family in discussing the decision and completing paperwork to record it. Comments included, “Absolutely fab in every way”, “It’s a bloody, brilliant fantastic service” and “I couldn’t knock a thing.”

There was an immense amount of ‘thank you’ cards and messages from people who had used the service which indicated the kind and compassionate care people had received. A recent questionnaire feedback had very positive comments from people who used the service which included, “All the staff were very good all the time” and “The atmosphere was relaxed yet caring and nothing was too much trouble.” Bereaved relatives stated in the questionnaires, “Caring and dignified treatment of my husband and all the family and friends. My husband was truly at peace and looked so comfortable for his passing” and “Their sensitivity, care and compassion were exceptional.”

The registered manager described how the service responded to people’s diverse needs in a non-judgemental way regarding culture, religion, sexual orientation and gender. They said, “We are open to whatever people’s needs are.” They also described how they involved clergy from different faiths and the process for gaining access to interpreters. People told us they felt their cultural and spiritual needs were met. The service had access to chaplaincy support from the local hospital trust and had created a multi-faith room where people and their relatives could sit and think, meditate or pray in private. In the multi-faith room there was a ‘message tree’ and a book for people to leave messages for loved ones and facilities to light candles.

We saw care plans reminded staff to respect privacy and dignity and daily recording evidenced people made their

own choices. For example, it was written in care files, “Declined hygiene will have a bath after lunch” and “Declined a syringe driver.” The care plans were signed by people to evidence they agreed to the contents.

In discussions with us, staff were clear about how they promoted privacy, dignity, independence and choice. They said, “We have specific ways of recording private conversations on the electronic computer system and we write things in a sensitive way”, “We always knock on doors and treat people respectfully, and keep them covered up during personal care”, “It’s very important they don’t feel rushed” and “We have do not disturb signs and separate rooms for discussing private matters.” Staff described how records were held securely, computer systems were password and card protected and offices were used for confidential telephone conversations.

It was clear staff were passionate about their work at Dove House Hospice. Comments included, “It’s a privilege to work here; we have time to spend with patients”, “I love working here; it’s the best job I have ever had”, “We consider it a family here and we look after people with care compassion and dignity” and “I am proud to work here.”

We observed very positive interactions between staff and people who used the service. Staff spoke to people in a kind and respectful way, they showed compassion, they promoted independence and they supported people to make choices and their own decisions. People were encouraged to keep medicines safely in their bedside locker and self-administer them if they were able and wanted to do so. This allowed people to remain independent. We saw medical and nursing staff were very accessible to people who used the service and their relatives. They were available throughout their stay to answer any questions, spend time talking to people and explain what was happening to them.

The service provided end of life care for people. People’s preferences for their end of life care were recorded along with specific instructions when required. The service had an end of life care plan which was a generic template but personalised to the specific needs of each person. The registered manager told us they had reviewed documentation since a national review on care pathways had taken place and included key elements from it in their documentation. We looked at the care records for one person who had recently died to check how staff recorded the care provided to them. We saw staff had recorded when



Is the service caring?

personal care, catheter care, mouth care, pain management and pressure area care had been provided to the person. There were records of support for the family at the end of the person's life and following their death. Staff said, "We would never leave a person on their own when they are near the end of their life. The little things are important like pets coming in." We saw there was information about how to care for a person's body in a sensitive way following death, respecting cultural and religious needs.

Staff told us relatives were supported when they wanted to be involved in caring for people at the end of their life. A member of staff said, "We teach families how to do mouth care and some partners have wanted to do last offices which has been respected" and "We put beds in rooms or reclining chairs; often we have a room full of the person's family. The kitchen becomes a hub with relatives mingling and supporting each other." We were told people would usually be moved into a single bedroom to afford more privacy if this was their choice. We saw there were facilities to accommodate family members to stay with people at the end of their life. This could be in either specific self-contained family suites or within the person's bedroom on the inpatient unit with the provision of sofa beds.

The service had a family support team which provided a range of creative services such as psychological, practical,

financial and social support in people's own homes, the inpatient unit, day unit and outpatient clinics. They liaised with and made referrals to other agencies when required. The staff from the team ran carers support groups and bereavement groups. One member of staff told us, "Our team is a bridge between the unit and the community."

There were a selection of leaflets to provide information to people about the services provided and decisions they could make. For example, on advanced care planning, preferred priority of care decisions, therapies and support groups. There were leaflets for family and carers to provide them with information about what to expect when a person approaches the end of their life. There were also leaflets for staff to provide people who used the service with guidance on important issues such as body and tissue donation when they requested this information. People who used the service were provided with information about their medicines. We saw people were given reminder charts to help them take their medicines at the right times at home. The leaflets were written in a sensitive and caring way.

We saw there was a large contingency of volunteers who supported the service by providing direct support to people who used the service, assisting in the day care unit, helping to maintain the grounds, working in reception, fund raising and serving in Dove House charity shops.

Is the service responsive?

Our findings

People who used the service told us they received personalised care and felt it was focussed on their individual needs. They also told us staff supported them to keep in contact with their families and they felt confident and comfortable to raise concerns if required. Comments included, “It’s personal service”, “It’s better than private hospitals” and “They don’t get the recognition and funding they deserve.”

The care files of people who used the service showed that an assessment of their needs was completed by medical and nursing staff on admission; this included risk assessments. The assessment was completed in a person-centred way with full involvement of the person when able. The admission information included a discussion with the person to ensure they understood their diagnosis and had awareness of the reason for the admission. There was also scope to check the person’s expectations of the admission and those of their relatives. Staff recorded advanced planning decisions about lasting powers of attorney, advanced decisions to refuse treatment and do not attempt cardiopulmonary resuscitation. We saw staff completed an initial checklist, for example of basic observations, whether the person was nauseous and what their appetite was like. A member of staff told us, “We have ‘living well’ documentation which provides a holistic view of people’s needs.” We saw this worked in practice; the specialist palliative care inpatient unit assessment was holistic and included physical and psychological symptoms, religious and spiritual needs, personal care, independence and activity levels, and family and social concerns. People who used the service were involved in completing documentation about what was important to them, how best to support them and their carers and what would constitute a good and bad day for them.

Plans of care were produced from assessments and risk assessments. The templates for the care plans were generic and personalised with specific information. We found these could provide more detail about people’s preferences for how they wished care to be provided to them. For example, one person’s care plan for personal hygiene stated they ‘will need assistance’. However, it did not indicate how much assistance was required and what the person was able to do for themselves. People who were currently using the service were able to tell staff how they wished to be

cared for and the amount of support they required, however this would not always be the case and care plans would require more personalised detail to guide staff. Staff told us they had time to read care plans. Comments included, “We have recently been improving care plans to make them more person-centred. We discuss patients at handovers, for example their mobility and I’ll go and look at how people move and check care plans for information.” Despite the shortfall in some care plans it was clear staff knew people’s needs very well.

People had reviews of their care undertaken in multi-disciplinary meetings. These were held weekly to discuss the care, treatment and discharge planning arrangements of people who used the service. This enabled a range of health and social care professionals to review people’s needs, plan care and treatment in an integrated way and manage transition between services and agencies involved with the care package. The service used an electronic record system which enabled information to be shared amongst health professionals in different agencies when the person provided consent to this. The system meant there was less need to duplicate assessment information and health professionals would be able to access the information when planning care and treatment. GPs who were linked to the system were able to access the information regarding their patient’s stay at the service. Medical and nursing staff provided information for a discharge record when people went home or moved to another service. This provided an up to date account of the person’s reason for admission and changes of note to their condition and to their medicines.

We saw the service worked closely with Hull and East Yorkshire Hospitals Trust and community services such as district nurses, GPs, specialist nurses and the MacMillan nursing service regarding the referral system for people to access Dove House Hospice.

We saw there was a checklist of people staff contacted following the death of a person on the inpatient unit. This made sure all people who were involved in their care were provided with accurate and relevant information.

The service provided a range of therapies such as Reiki, massage, reflexology, relaxation, physiotherapy, pet therapy and aromatherapy. People were referred to the complementary therapy team and signed their consent to the treatment. There was an active music therapy group for people who used the service, their relatives including

Is the service responsive?

children, carers and staff. The bathrooms had sensory equipment such as soft lights, Jacuzzi baths and a facility to insert memory sticks of favourite music. There was a gym on the first floor which included exercise and rehabilitation equipment.

The service had a day therapy unit and people who used the inpatient unit could access activities there if required. The activities included staff sitting and talking to people, social events, craft work, a pool table, developing photograph albums and making CDs of people talking about their life in words and music for them to give to their relatives. The day service unit also gave people access to nursing and medical staff for advice and treatment. As well as day therapy, the service held support and wellbeing groups including one for people living with motor neurone disease and another for bereaved relatives.

There was an accessible outside area that consisted of well-tended gardens, a fish pond, water feature, patio areas and seating. There was space for people to sit with their relatives or on their own if they chose. We saw the service had a designated room for people who wished to smoke. There was also a café on site for visitors to access. The service had holiday facilities, which consisted of a lodge and a caravan at local areas for people who used the service to access free of charge.

The service had a seasonal newsletter which gave information to people about issues such as upcoming social and fundraising events, a values exercise the staff team completed, people's stories and experiences of the service and what support staff can offer bereaved relatives. The newsletter provided information and helped people to feel less isolated.

The service had a complaints policy and procedure and staff knew how to deal with complaints. There were leaflets on how to make a complaint on display in the service which told people that feedback was welcomed and important to ensure high standards. The leaflet provided information on how to make verbal or written complaints and included timescales for acknowledging the complaint, investigating them and responding to people with the outcome. There was also information on how to escalate the complaint if required. The registered manager said, "Concerns are not trivial; patients and relatives are listened to." We saw the service received very few complaints and those that were received were managed appropriately and quickly.

Is the service well-led?

Our findings

We observed the registered manager and nominated individual made themselves available to patients and staff on the inpatient unit and in the day therapy unit.

The service had a well-defined organisational structure. This consisted of a Board of Trustees who delegated the operational management of the organisation to a Chief Executive Officer (CEO) and Executive Management Team (EMT). There were heads of service such as the registered manager and a consultant in palliative medicine, tiers of managers, medical and nursing staff and support services. Staff told us they felt able to raise concerns and voice their opinions to management. Comments included, “We want to create an atmosphere where people do report issues”, “Yes, I would feel able to raise concerns with senior managers”, “I feel included and involved in decisions; there is always someone to talk to and management are supportive.”

We spoke with the registered manager about the culture of the organisation and how they ensured the vision and values were embraced by all staff. They told us the organisation had an open culture and although there had to be a hierarchy for roles and responsibilities, no one person was more important than others. We saw there had been team days to analyse strengths and areas to improve. The registered manager said, “Managers set the tone of the support; our CEO is open and honest and leads the organisation well.” They also said, “It’s important to be supportive, to develop and educate staff and have a reflecting and learning culture; we have to trust people and not always look over their shoulder” and “We expect staff to know their roles and to be passionate and caring.”

The registered provider had printed information about its philosophy and mission statement. These stressed the importance of caring for people and putting them at the centre of what they do, enhancing quality of life, promoting privacy, dignity and respect, striving for improvement, investing in staff and acknowledging people’s contributions. The staff team had completed an exercise to explore the values they felt were important to them in their workplace. The values exercise enabled staff to take ownership of them and we saw they were established in the day to day practice we observed during the inspection.

The director of human resources said, “We recruit staff to the values and ensure they fit in with our culture” and “The new appraisal system developed last year is tied in with the values exercise.”

We saw there was a quality monitoring system in place which consisted of checks, audits and seeking the views of people who used the service and staff. We looked at a selection of audits, which included two on infection prevention and control regarding care of deceased patients and hand hygiene. There were also clinical audits such as pain score recording, do not attempt cardiopulmonary resuscitation records, documentation of people’s preferred priority of care, the motor neurone disease community service, breathlessness outpatient service and nursing care plans. In all cases we saw results were analysed and actions plans produced with recommendations for the improvement of practice. We saw currently the audit system was more ad hoc with different departments completing audits rather than via a planned programme. We also found there had been a shortfall in medicines audits and a risk assessment update following an incident. However, we saw there was a multi-disciplinary team responsible for the audits and ensuring information was collated into reports and cascaded to staff for action. They had also met to discuss how to develop the audit programme to ensure it was more structured. Minutes of an audit meeting described how staff had researched national guidance on hospice audits and distributed examples of good practice and links to tools for measuring quality to the team so they could be incorporated into the audit programme. The minutes also showed staff had planned to attend the Hospice UK Conference, had contacted another hospice for information about a regional hospice audit group and set up a communication email group for the audit team.

We saw checks were carried out on issues such as referral to admission times and the environment for cleanliness and health and safety issues. A range of meetings were held to discuss clinical practice, check health and safety, analyse incidents and accidents, discuss any complaints, share information and to prepare reports for monthly board meetings. An annual review was produced which included information about the service and statistics such as how well used it was and the financial position.

People who used the service and bereaved relatives and carers completed questionnaires about their experience of

Is the service well-led?

Dove House Hospice. We saw the survey for April to September 2014; this had an analysis of the scores and an action plan to indicate where managers felt improvements could be made. The registered manager told us there had been a low return of some of the questionnaires and they were to review this to see if it could be improved. There was a suggestion box in reception and a member of staff had a 'service user involvement post' to develop how people's views could be captured.

Staff told us they felt included and enjoyed working at the service; there were some incentives provided for staff. These included twice yearly 'staff wellbeing days' where they could access complementary therapies to relax and unwind, an employee Christmas savings club, a scheme for buying additional annual leave, competitions such as, 'win a week off work' and volunteer awards. Staff had team meetings, a staff forum, supervision sessions, appraisals, shift handovers and a newsletter which ensured they received information and enabled them to express their views. We read some of the newsletters and they described a staff team that were involved and committed to the service. Staff had the opportunity to voice their opinions in an annual staff survey which was run by an external organisation.

The audits, checks, questionnaires and meetings showed us the service had systems in place to learn from incidents, complaints, and people's views in order to improve the service. The registered manager described how changes had been made as a result of analysis and feedback. For example, changes in how the service responded to

admissions meant people could now be admitted to the service 24 hours a day, seven days a week. An analysis of people's skin reactions to syringe driver sites resulted in the use of Teflon cannulas rather than metal needles. Medication errors had been discussed in meetings and additional training sessions arranged.

We saw the service worked in partnership with other agencies to provide training and information, to improve the perception about hospices and to assist in the development of a local end of life care strategy. For example, the training section worked with the local authority and, at their request, developed a training package for staff working in domiciliary care agencies. This was to enable them to recognise the possible early signs of cancer and to develop their communication skills and what they could do if they had any concerns. The service also provided training for teachers to enable them to support bereaved children more effectively. The service took part in 'Dying Matters Week' with the local authority to provide information and advice to people. They also meet and take part in care pathway audits via meetings with partnership agencies. There were palliative care training packages for staff working in residential and nursing homes and educational events for a range of health and social care staff. There was also a range of partnership working with community services such as GPs, MacMillan nursing services, district nurses, intermediate care services, the long term conditions team, the Motor Neurone Disease society, local dementia working groups, Hull University, local hospital trusts and clinical commissioning groups.