Prospect Hospice Limited

Prospect Hospice

Inspection report

Moormead Road
Wroughton
Swindon
Wiltshire
SN4 9BY

Tel: 01793813355
Website: www.prospect-hospice.net

Date of inspection visit:
08 November 2016
09 November 2016

Date of publication:
20 January 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 8 and 9 November 2016 and was announced. We gave the registered manager 48 hours' notice of the inspection because we wanted key people to be available.

Prospect Hospice's principal activities were to provide timely and responsive care and support for people living with and dying from advanced and progressive life limiting illnesses. The 16-bed in-patient facility provided respite care, symptom control and care at the very end of life. There was a range of day services offering therapeutic and social opportunities for out-patients, including complementary and creative therapies. The Prospect at Home service provided practical support and nursing care up to 24 hours a day, in people's own home. Their clinical nurse specialist service provided advice, support and information for people at home and in local care homes, plus supported end of care life at the local hospital in Swindon.

A consultant-led medical team provided care across the range of the hospice services. Rehabilitation services included physiotherapy, occupational therapy and dietary advice through a dietician employed by the local hospital. The family support team worked with people and their families and offered bereavement services including welfare advice, drop-in sessions, carer's cafes and a carers' course.

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

People who used the hospice services were safe. All staff received safeguarding adults and children training and would know what to do if there were any concerns about a person's welfare. Nurses and health care assistants were trained how to use moving and handling equipment safely. All risks to people's health and welfare were assessed and then well managed, in order to reduce or eliminate, that risk. Safe recruitment procedures were used to ensure that only suitable staff were employed. Medicines were well managed. This meant the service had the appropriate steps in place to protect people from being harmed and to keep them safe.

People were safe because the staffing levels were sufficient to meet their needs. The staffing levels in the in-patient unit and the day hospice were determined by the number of people being looked after and their care and support needs. The Prospect at Home service had a flexible workforce in order to be able to accommodate demand. This part of the service was already recruiting additional staff because of the increase in referrals from people who wanted to be supported to die in their own home.

All staff had a programme of mandatory training to complete. This enabled them to carry out their roles and responsibilities. New staff completed a robust induction training programme and there was a programme of refresher training for the rest of the staff. Staff received palliative and end of life training and had the necessary skills and qualities to provide compassionate and caring support to people and their relatives.

People were supported to make their own choices and decisions where possible. Staff understood the principles of the Mental Capacity Act (2005) and key staff understood the Deprivation of Liberty Safeguards and how this affected their service. Where people lacked the capacity to make decisions because of their condition or were unconscious staff worked within assumed consent but checked with healthcare professionals and relatives before providing care and support.

People were provided with a nutritious meal or food they liked or were able to eat, when they were an in-patient or attending the day hospice. They were provided with the assistance they needed to eat and drink where this was required. Those people supported by the prospect at home service were assisted with eating and drinking but staff were not expected to prepare meals. The staff from each of the hospice services worked collaboratively with hospital staff, district nurses and the person's GP when needed.

People said staff were very kind and caring towards them and respectful of their views. People were involved in having a say about how they were looked after, listened to and assisted promptly when they needed help. End of life care wishes were documented and staff were passionate about supporting people to die in their preferred place of care. Relatives were also well looked after and all feedback we received before and after the inspection was overwhelmingly positive. Families were provided with post-bereavement support where this was identified as needed.

People were provided with a service where their specific needs were at the heart of how this was delivered. People were included in decision making about the support they, and their relatives needed. The Prospect at Home team worked in partnership with the district nurses and had good channels of communication to ensure significant information was reported and changes in people's health was reported.

The service was well led with a strong senior management team. All staff had a passion for providing a quality service and ensured people received a good and safe service. For those people who were at the end of their life they strived to ensure that person had a good death. Where things did not go as well as expected, they looked at the reasons why and made adjustments accordingly. There was a continual programme of review to drive forward improvements.

People's views and opinions were at the heart of the service provision. Feedback was gathered from people using the in-patient unit, the day hospice and the Prospect at Home service. All feedback that the service received was used to drive improvements and took account of the fact there was an increasing trend for people to be looked after in their own homes.

The service worked with other care service providers to educate and teach their care workers to provide good end of life care, sharing their expertise with others. This meant people could then remain with the care and support services they were used to but still receive good end of life support.

The service had systems in place to ensure it remained safe, effective, caring, responsive and well-led.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff looked after people safely and were aware of their responsibilities to safeguard them from harm. Recruitment procedures for new staff were safe and ensured suitable staff were employed.

Risks to people's health and welfare were well managed. People were assisted with their medicines by qualified and competent nurses.

The service had sufficient staff to meet people's needs and a flexible workforce for the Prospect at Home team. This enabled the service to be able to respond to referrals promptly and to expand to meet any increasing demand for support.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were well trained and supported to do their jobs effectively. They had the right qualities and skills, to provide compassionate care and support.

Staff understood the importance of obtaining consent from people before helping them. Staff were aware of the principles of the Mental Capacity Act (2005).

People were assisted to eat and drink safely and there was good communication with the GP's, district nurses and other healthcare professionals.

Is the service caring?

Good

The service was caring.

People using each of the services were treated with respect and kindness. People were supported to express their views about their care. They were involved in making decisions about their care, support and treatment. The service also cared for relatives and family members.

The staff team had good relationships with people and talked respectfully about the people they looked after.

Is the service responsive?

Good

The service was responsive.

People received the care and support that met their specific needs and relatives were supported. The service was adjusted to take account of any changes in people's needs.

People were listened too and their views were seen as important. Feedback was used to drive forwards improvements.

Is the service well-led?

Good

The service was well led.

The service promoted a positive culture that was open, inclusive and empowering. People and families remained at the heart of their work.

Feedback from people who used the service and their relatives was regularly gathered and used to make improvements to make the service better.

There was a clear management structure in place. There was a programme of checks and audits in place to ensure that the quality of the service was monitored. Any accidents, incidents or complaints were analysed to see if there were any lessons to be learnt.

Prospect Hospice

Detailed findings

Background to this inspection

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

The inspection was announced and was undertaken by two inspectors, one a pharmacy inspector. There were two other members of the inspection team; a specialist advisor and an expert by experience. The specialist advisor was a qualified nurse who had experience of working in palliative and end of life care. The expert by experience had experience in using this type of service. Prospect Hospice was last inspected in February 2014 and we found no concerns.

Prior to the inspection we looked at the information we had about the service. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We contacted health or social care professionals and asked them to tell us about their views of the service. Their comments have been included in the body of the report.

During our inspection we spoke with five people on the in-patient unit and nine people attending the day hospice. We also spoke with five relatives of people in the in-patient unit and two relatives of people who had recently used the Prospect at Home service. We spoke with two directors one of which was the registered manager (director of patient services). We spoke with 30 members of staff including nurses, doctors, health care assistants, the chef, therapists and volunteers.

We looked at six people's care records and nine staff recruitment files. We also looked at training records, policies and procedures, audits, quality assurance reports and minutes of meetings.

Good

Is the service safe?

Our findings

In our discussions with people, their relatives and hospice staff it was evident they all thought the service was safe. People said, "I have nothing to worry about. I feel safe here", "At home I was always worried about falling. The staff help me so I don't have to struggle" and "All the staff are so kind and caring towards me". One relative said, "The staff are just so wonderful. When I nip home for a short break I know he will be well looked after".

The service had policies and practice guidelines in place regarding safeguarding adults and safeguarding children. The policies were last reviewed in August 2015 and contained all the necessary contact details and telephone numbers so staff would know how to contact the local authority, the police and the Care Quality Commission with their concerns. Although the service was not provided to children, the nurses were made aware of child protection procedures because children could be present in the home when nurses supported a parent. There was also a whistleblowing policy in place to protect staff if they raised concerns about misconduct of their colleagues or other wrongdoings. The registered manager and the designated safeguarding officer were the leads for safeguarding and responsible for ensuring the policies were implemented and fully upheld. All staff completed safeguarding adults and children training. Safeguarding alerts had been raised with the relevant authorities, the local authority, CQC and the CCG. For example when a person had been admitted with a grade three pressure ulcer or there was an allegation of abuse by a relative.

Staff files were checked to ensure safe recruitment procedures were followed. Each file evidenced appropriate pre-employment checks had been completed. Disclosure and Barring Service (DBS) checks had been carried out. A DBS check allowed employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. The measures in place prevented unsuitable staff being employed.

Staff received moving and handling training in order to assist people to transfer from one place to another or to change positions to aid comfort. The training included demonstrations of how to use the various types of equipment including hoists. The in-patient unit had a plentiful supply of moving and handling equipment. The community nursing services were responsible for ensuring the appropriate moving and handling equipment was in place for those people who received Prospect at Home support. The measures in place ensured people were assisted properly and were not harmed by being moved incorrectly.

People received a safe service because risks to their health and safety were being well managed. Risk assessments were completed in respect of moving and handling and care plans written to show what equipment was to be used. For each person in the in-patient unit a personal emergency evacuation plan (PEEP) was prepared. These set out the level of support each person would need in the event that premises needed to be evacuated. Other risk assessments were completed in respect of falls risk, the likelihood of pressure damage to skin and nutrition. For those people in the in-patient unit, these assessments were kept under continual review.

In addition, the Prospect at Home staff undertook a risk assessment of the person's home. This was because the home was also the 'place of work' for the Prospect at Home staff. The assessment covered both the external and internal hazards of the home. The nurses and health care assistants were expected to be responsible for their health and safety at all times and to report any concerns they had about their own safety and that of the people they supported.

The service had a disaster management plan in place. This was currently under review by the new health and safety advisor. The service had a reciprocal arrangement with a health care provider next door that their facilities could be used if Prospect Hospice became uninhabitable. The service also had emergency plans in place covering adverse weather conditions, staff sickness and if failure in their IT services occurred.

The service had sufficient staff for the in-patient unit, the Prospect at Home team and the day hospice. Staffing levels for the in-patient unit related to the number of people occupying beds and the complexity of their care and support needs. The in-patient unit used a 'patient dependency tool' which identified the staffing requirements as led by patient need. The number of staff on each shift was adjusted in accordance with people's needs. There were always several qualified nurses on duty at all times. People were looked after by qualified nurses and health care assistants and supported by volunteers. Additional resources were made available as determined by the shift nurse coordinator. The nurse call bell system was audited to ensure people were responded to in timely manner.

The Prospect at Home service had eight contracted full time staff, one nurse and seven health care assistants plus additional bank staff and companions. By having a flexible workforce, the service was able to respond to referrals promptly and to expand to meet demand for support. The day hospice was staffed with qualified nurses, health care assistants, physiotherapists and occupational therapists and trained volunteers.

Effective systems were in place for obtaining medicines. Policy and practice guidelines were in place for all aspects of medicines management. People brought their own medicines to the hospice for continued use. Staff were able to use the local hospital's out of hours pharmacy service if needed which meant people could be confident their medicines would be available for them.

A pharmacist from the supplying hospital visited the hospice twice a week and checked the prescription and administration charts. The doctors prescribed medicines on specifically designed prescription and administration charts. These included a list of discretionary medicines staff were able to administer. People told us they were able to ask for pain relief when they needed it and were happy with how staff looked after their medicines. People were able to self-administer their medicines if they wished to after staff had assessed they were able to do so safely. No-one was doing this at the time of our inspection.

People were given a two week supply of medicines if they went home from the hospice. The nurses completed a 'Going home, a guide to your medicines' booklet. These explained the purpose of all the medicines and the times of day they should be taken.

Stocks of medicines were stored safely, either within a secure treatment room or locked cupboards by people's bedside. Medicines were all stored at the correct temperature and this included those that had to be kept in the refrigerator. We noted that staff had taken some stock medicines from their boxes and stored the sealed medicine strips in the bedside cupboards. Although the strips were labelled with the name and strength of the medicine this was not as clear as the labelling on the outer pack. This could increase the risk of mistakes being made. Immediate action was taken to rectify this.

Staff attended medicines training, had an annual competency assessment and there were comprehensive policies and procedures in place for them to refer to. The supply of emergency drugs and equipment were checked on a weekly basis. Staff had carried out medicine audits to check the quality of their practice and had identified where actions were needed.

Good

Is the service effective?

Our findings

People were involved in making decisions about the care and support they needed where this was possible. Information was also gathered from their relatives and where involved, clinical nurse specialists, district nurses and the person's GP. The following comments were made when we asked if the service was effective. "I could not be better looked after", "The staff are angels and full of compassion and empathy" and "I cannot thank the hospice staff enough for making my husband's wish to die in his own bed come true. Without them I would not have managed to achieve that".

Feedback we received from health and social care professionals was in support of the service being effective. The district nurses talked about working effectively in partnership with the hospice staff.

The Prospect at Home service ensured people could receive care and support at home when needed, thereby avoiding admissions to hospital. They ensured they supported people to remain where they most wanted to be. The Prospect at Home team previously provided a rapid response service for people living in Wiltshire. However funding was withdrawn by the CCG in April 2016. The hospice had continued to fund and provide a seven day a week service to people, responding wherever possible to requests.

All staff we spoke with felt they provided an effective service and were highly motivated to support people, whether this be in the in-patient unit, the day hospice or their own home. Each member of staff had a passion to support people who had life limiting illnesses or were at the very end of their life and felt valued and appreciated by their colleagues and line managers. All the nurses, doctors, health care assistants and therapy staff who worked for Prospect Hospice had the necessary skills competencies and personal qualities to meet the needs of people.

Staff received training in a variety of areas to ensure they were able to effectively support patients and their families. The staff training matrix evidenced that staff had received extensive training to underpin their skills in supporting people. Some of the training was mandatory all staff had to complete, other training was role specific or bespoke training. Examples of training included first aid, food hygiene, fire safety, moving and handling and safeguarding. Care staff (nurse and health care assistants) completed Mental Capacity Act 2005 (MCA) training. There had been discussions with the staff in the in-patient unit in respect of the Deprivation of Liberty Safeguards (DoLS) legislation.

New staff received a comprehensive induction training programme including the Care Certificate. The Care Certificate is a set of standards that all new social care and health staff need to cover as part of their induction. Staff must evidence they were aware of and understood these and were able to put them into their day to day care practice. New staff were assessed by the completion of workbooks, observation of practice and face-to-face learning.

Staff were able to complete the National College of further Dducation accredited course at level three, in the principles of end of life care. In order to achieve this qualification, five modules had to be completed. This course was also made available to healthcare professionals working within other health and social care

organisations in order that people who were not using the Prospect Hospice services could still benefit from receiving good end of life care. Examples of other training the service organised included care in the last days of life, communication skills to support advanced care planning, managing breathless, syringe driver training and supporting children and families in coping with serious illness, dying and bereavement.

A staff appraisal programme was in place where work performance and training and development needs were discussed. All staff received a regular supervision session with their line manager and enabled them to discuss how they were doing and their own emotional and development needs. Staff were supported to do their jobs effectively. For the Prospect at Home team there was also a senior member of staff on-call for out of hours advice or provide practical support. Team meetings were held on a regular basis with the nurses and the four co-ordinators had a monthly meeting to discuss what had worked well and what had not worked well.

We assessed the service to see whether they were acting in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Policy and practice guidelines were in place for the staff to refer to. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty of people who lacked the capacity to consent to the treatment or care they needed.

People were encouraged to make their own choices and decisions and were always involved when discussions were held about their care and treatment options. As part of the assessment of each person who received support, their ability to make decisions for themselves was determined. Consent for care and treatment the person had agreed to was recorded on admission to the in-patient unit This helped the staff be clear about the possible need for a DoLS authorisation occurring at a later date should there be an element of care not originally agreed to where the person now lacked capacity. Staff knew the importance of gaining consent before they provided any care, support and treatment and reviewed this each time they were going to support the person. In August 2016 the mental capacity act programme manager from the local council had attended a staff meeting to discuss key points in respect of DoLS to support staff to better understand their responsibilities under the MCA.

People in the in-patient unit were served with nutritious meals and drinks. They were assisted to eat and drink, where required. We saw several people being helped to cut up their food so they could then eat their meal independently. All meals were fortified and there was a choice of menu options every day. People made choices from the menu. Alternatives were prepared if the options were not suitable and the chef would visit people in the in-patient unit and the day hospice to talk about their preferences. The chef told us "If someone wanted a specific meal or food item it would be prepared for them". People said they did not feel guilty if they requested something different to eat. Nutritional needs were considered as part of the overall assessment process and this included any food allergies. The staff would assess the person's ability to swallow safely and would ensure it was safe for people to eat and drink. Where people were unable to eat and drink, mouth care and oral hygiene were provided in order to keep their mouth comfortable. The Prospect at Home staff were not involved in meal preparation for the people they supported however they could support a person to eat and drink.

The district nurses were the lead healthcare professionals for people receiving care at home and the Prospect at Home team worked collaboratively with them, the GP and other relevant health and social care professionals. There were good systems in place for the passing of information from one care provider to another.

Healthcare professional feedback was extremely positive about the Prospect Hospice services. They said,

"The clinical nurse specialists are expert and my go-to-people if I need some advice", "The Prospect at Home team is a valuable community resource", "The in-patient unit often admit people for symptom control and then they can return home" and "The staff in the day hospice improve the quality of life for those who are living will serious illnesses".

Prospect Hospice was purpose built with all care facilities based upon the ground floor. There was level access into the building from the large car parking area into the reception area. During office hours the reception area was manned with welcoming staff. Behind the reception area there was a café, used by visitors to the hospice, people using either the in-patient unit or the day hospice and the staff team. The premises were bright and airy and staff told us visitors had commented that contrary to their expectations, Prospect Hospice was not a gloomy place at all.

The in-patient unit had eight single bedrooms with en-suite facilities and two spacious four-bedded bays. Curtain screening was in position surrounding each of the beds and enabled the staff to provide support with personal care tasks in privacy. There were private rooms available for people to have quiet time or to talk with their visitors. There was also accommodation available so family could stay at the hospice when the person's death was imminent. All facilities were well decorated, clean, tastefully decorated and comfortable.

Good

Is the service caring?

Our findings

People and their relatives were extremely positive about the service they received from Prospect Hospice. They told us, "I have been so impressed with how they look after both the patient and their relatives here and nothing is too much trouble", "If I just feel like having a cry or a shoulder to lean on, someone will appear to support you", "Nothing is too much trouble" and "I have been so impressed with how they have looked after my husband and myself and the family. In fact, words really can't convey what that means to us at this really difficult time".

Those relatives we spoke with who used the Prospect at Home service were very complimentary about the nurses and the health care assistants who supported their loved one's wish to die in their own home. Examples of the comments included, "They are all angels", "They even gave their time to comfort me" and, "Such kind, caring and compassionate staff".

Since the start of 2016 the service had received 60 complimentary letters from people, or the families who had been supported by Prospect Hospice. The comments received were overwhelmingly positive. They said, "Thank you. The sadness and loss I felt wasn't something I was prepared for but the staff helped me as well as looking after the patient so well", "I must express my appreciation of the warmth, kindness and exceptional care given to (loved one) and the family", "Heartfelt thanks for all the care and consideration given to the patient and family. We felt surrounded by love and because of this the family were able to fulfil her wish they could stay with her until the end" and "Her final weeks were made so comfortable due to the unstinting care received".

The service had policies in place to ensure staff maintained and promoted people's privacy and dignity. We spoke with staff to check their understanding of how to treat people with dignity and respect. They told us that a person's care was always provided in privacy and in the four bedded bays, they would make sure the screens were fully pulled around the bed space. The registered manager told us people would be nursed in the single bedrooms if they had distressing visible signs of their illness (for example a facial disfigurement) or were at very end of life, in order to preserve that person's dignity. The staff however did keep the movement of beds between the shared space and the single rooms to a minimum.

The staff who worked for each of the Prospect Hospice services were passionate about getting the support they provided to people with life limiting diseases and end of life care right. Staff spoke about the people they looked after in a respectful manner and genuinely cared for the relatives as well. All staff had chosen to go into this field of work because they were highly motivated to get the one chance to provide compassionate, end of life care right for people. Volunteers had chosen to give their time to the hospice because they "wanted to give something back" and had "valued the way their relative had been looked after previously". Staff believed the service they provided was "the best possible" and would recommend the service to family and friends.

The feedback we received from healthcare professionals was also very complimentary about the services provided by Prospect Hospice. It included, "The staff are so helpful and always willing to help my patients

(from a GP)" and "The relatives of people who have been supported by the prospect at home team are always so thankful for the kindness and care given".

We saw throughout the inspection that all staff and volunteers were caring, considerate and compassionate towards the people they were looking after. They talked to us about the care and support they provided to people and their relatives, not only personal care but practical support, emotional and spiritual care and companionship. We saw staff and volunteers sitting with people in the day hospice, chatting about what was happening in each of their lives that week. During one of the group activities in the day hospice we heard people talking about their treatments and how they were coping at home whilst being able to relax and do something they clearly enjoyed doing. Staff understood the need to spend sufficient time with people and their relatives, taking time to listen to them and respond to their needs without rushing. One relative made a comment that the nurses had taken time to explain things to them in "plain English" and did not mind how many silly questions they asked.

Staff received equality and diversity training and ensured each person was provided with person-centred care. Each person's age, gender, race and religious beliefs were respected. The registered manager talked about one person they had previously supported from the travelling community and the challenges this had presented to the hospice (around the large number of visitors to the person who was at the end of their life). The staff had risen to the challenges, had enabled the whole 'extended family' to visit, and park up their cars, without causing a disruption to the service for other people.

All hospice staff had the required skills in communication which enabled them to talk to people in a sensitive, respectful and caring way. They gave people the information they needed about their health condition in a sensitive manner but were also open and honest in the discussions. They gave people time to understand and to ask questions either at the time of any discussion or later. The hospice service provided people and their families with various leaflets about specific conditions and life-limiting illnesses to help them gain an understanding before making any decisions. They provided as many further opportunities for discussion as the person needed. In the in-patient unit, the staff made sure these conversations were held in private and were confidential. Staff would always ensure that the person was happy for other family members to be involved in these discussions but would keep the person at the centre of decisions being made. The service always ensured people were involved in decisions about their care and treatment options.

Bereavement support services were offered and made available to people and their relatives as appropriate. This service provided emotional support to those who required it. Monthly bereavement groups were held. Six to eight weeks after the death of a person the relatives were contacted by letter or telephone, to check how they were doing. The hospice did this because the withdrawal of what was usually an intense period of support ends with the death of the person and can feel like another bereavement. In addition the service had a welfare benefits advisor for those who needed financial guidance pre or post-death. The hospice would refer families with children who were bereaved to a local children's bereavement charity in order to ensure they received the specialist support they needed. The care support lead told us they would gain the consent of a parent and speak to the children's school if required.

Remembrance events for children who had lost a parent were held at the hospice twice a year. Arts and crafts featured in the events and the children were able to make things in memory of their mum or their dad. The staff told us about the advent calendars made in the previous event, with photos and reminders of their parent for each day. For adults, there was an 'Evening of Reflection' held every other month. At the last meeting 60 people had attended. There was music and poetry, the names of those who had died were read out and a candle was lit for each person. The hospice had an 'Annual light up a life' event each December

attended by bereaved relatives and supporters of the hospice. In December 2015 several hundred people had attended.

There was a chaplaincy service available in the in-patient unit and the day hospice to offer support if required. It aimed to meet multi-denominational spiritual needs of people using either of the services and their family members. Each Friday there a short 15 minute 'Christian service' held at the hospice but they catered for other faiths as and when needed.

Good

Is the service responsive?

Our findings

People told us they received the care and support that met their needs and the service was responsive to any changes in their needs. Those in the in-patient unit told us, "I am always asked if there is anything I need help with", "I have only got praise for the hospice" and "All is so calm here and this helps me relax. I get all the help I need and more on top". Day hospice users said, "If I was unhappy I would certainly talk to one of the staff. Although to be honest I cannot begin to imagine what anyone would complain about".

One person who had used the day hospice service in the past posted comments on our website because they knew we were in the process of inspecting the service. They told, "I have used the day services. I feel like they have enabled me to cope with health issues, pain control, liaising with my GP for me, support when feeling low, reiki (complementary therapy) and exercise – the support I have had turned my life around".

The service provided to each person, whether in the in-patient unit, the day hospice or those using the Prospect at Home service was person-led and based on their own individual care and support needs. Their care and support needs were fully assessed. Day hospice services were provided for a 16 week period but there was some flexibility in these arrangements. The registered manager told us that nearly half of the in-patients would return home after a period of in-patient stay for symptom control, pain management, or to give relatives a break. The Prospect at Home service was provided to people living with life limiting illnesses or at the end of their life. The service provided was based upon the person's specific needs and the support required by the relatives. The aim of the service was to look after the person, enable the family to take a break and have a rest, and to support their wish to die at home. Visits by Prospect at Home staff were provided during the day or overnight if needed which enabled people to be cared for and die at home. The service had recognised the increased demand for the service so it was expanding in order to be able to respond to referrals for help.

Each person had their care and support reviewed on a continual basis. The nurses, healthcare assistants and clinical nurse specialists discussed with people how their personal and health care needs were best met. Service provision was completely person-led. People were encouraged to have input into their own care plans and where this was not possible the views of the relatives and other supporting carers were taken into consideration. This ensured that service provision always remained appropriate and remained responsive to people's changing needs. The therapy and family support teams were available to people who used the hospice, day hospice or hospice at home services.

The Prospect at Home were able to adapt to any sudden changes in people's condition because the nurses instigated changes to service delivery promptly. After every visit the Prospect at Home staff used a secure email and text messaging service to relay information to the team leader who would then be able to liaise with other health care professionals. For people this meant the service remained appropriate for their needs at that time.

In order to be a responsive service, the clinical nurse specialist team and the therapy service worked a seven day week. The therapy team now had access to the community equipment stores to ensure people could

be provided with any required equipment promptly.

Multi-disciplinary team (MDT) meetings were held weekly and we were able to observe one of these. Senior representatives from each department attended these plus staff from the palliative care team and discharge nurses from the local hospital. Clinical nurse specialists discussed their concerns regarding people and took advice on possible solutions to try. The outcomes of the discussions were recorded in the person's electronic care notes. These meetings also looked at the referrals, the people currently supported by the hospice and those who had recently been supported through post-death analysis. This process allowed the team to look at how things had gone and identify where things could have been done differently or better.

The Prospect at Home team had previously partnered with another hospice service to ensure that those patients who wished to stay at home could access both services through one phone call to their service. This was the Wiltshire Rapid Response service pilot which ran for 18 months until April 2016. However the hospice has since continued to maintain a 7 day service to provide a timely response to patients needs. Other healthcare professionals can also refer to both services through a single call to the hospice. A single-point-of-access telephone centre was being introduced at the end of January 2017 to take referrals for all services enquiries. This will be managed by the clinical lead for the clinical nurse specialist team. They will liaise closely with all hospice services. To enable closer alignment between the community nursing services and the hospice's clinical nurse specialist service, team leaders from both services attended each other's weekly MDT meetings. These improvements had been instigated in recognition that both services needed to maintain good communication and to ensure coordinated delivery of care. The electronic patient record system across all clinical services meant there was improved access to information about people for all clinicians. The system also allowed for better and consistent data collection across the organisation.

People we spoke with felt able to raise any concerns or complaints they had with the staff and said they were listened to. One person in the in-patient unit told us they were unhappy because they were being discharged home. However after talking with nursing staff, it was evident that discussions were taking place with the person's family and other care providers regarding their on-going care. It was evident the person was involved in these discussions but had expressed a preference to remain in the in-patient unit. Prospect Hospice welcomed feedback in order that they could better understand what they did well and more importantly where improvements were needed. The service had a complaints coordinator whose role it was to ensure the complaints procedure was well managed and that decisions were clearly communicated and things were put right. 'We value your feedback' leaflets and 'have your say' cards were displayed in the day service, the reception area and the in-patient unit. The leaflets explained what to do if people had concerns or a complaint about the service they were provided with. It stated any complaints would be acknowledged within two working days with a response or an update provided within 10 working days.

People and their relatives and health and social care professionals were asked to share their views about the service provided. People's views were gathered during their care visits, their attendance in the in-patient unit and in the day hospice. One staff member said, "The person is at the heart of everything we do". Questionnaires were given to people and their relatives after admission to the in-patient unit and analysis of the results was made on a three monthly basis. People were asked to make comments about the day hospice service and suggestions that may improve the service. Feedback reports were discussed in the 'patient services committee'. The meeting notes of the end of September 2016 meeting identified highlights and lowlights, action and future plans developed. The biggest challenge to the service was one of increased demand and steps were already being taken to recruit additional hospice at home staff and carer's support services (carer's cafes and death cafe's). This enabled the service to be responsive and make changes based upon how people felt and the service they said they wanted.

Good

Is the service well-led?

Our findings

Prospect Hospice's vision was for excellence and choice in end of life care for everyone living in the local community. Their mission was to work within the community in partnership with people, their families and organisations to provide and influence excellent care, support and understanding at the end of life. Prospect Hospice was increasingly working in close partnership with other care-focused organisations, specifically with local services, with the shared aim of bringing the best possible care to people in their last months of life.

The service promoted a positive culture that was open, inclusive and empowering. Staff in both the in-patient unit, the Prospect at Home service and the clinical nurse specialists were committed to providing person-centred care which placed people at the centre of the service. Feedback, both positive and negative was discussed in the weekly multi-disciplinary meetings and also at senior management meetings. People's stories were included on the hospice website in order to tell the public about the range of services available to help people and their families and to advertise new initiatives. These measures ensured people and families remained at the heart of their work.

Although people using the service and their relatives stated the service met their needs, they did not make any direct comments about whether Prospect Hospice was a well led service. It was evident the service was well organised and was focused on meeting peoples' needs.

All hospice staff and volunteers were supported to do their jobs and had access to forums and informal support. They were able to turn to management for support and guidance if they had either a professional or personal problem. All staff we spoke with said the job was hard, very emotional and difficult at times but they were passionate about what they were doing and the impact their role had on people who were either very ill or were dying. Staff were able to access the family support and bereavement service, attend reflective group sessions and said this support meant they were able to continue in their role.

There was a clear management structure in place. The registered manager took up post in June 2016 but had previously been a CQC registered manager and a head of governance at other hospice services. They were supported by a senior management team, the chief executive officer, directors, heads of departments and a board of trustees.

We were told that members of the senior management team (SMT) would often spend time within a different part of the service in order to "understand the whole organisation". This enabled them to be a critical eye and see things that those who regularly worked in that area may have overlooked. One of the SMT said they had previously served hot drinks and meals in the day hospice whereas their day to day role was purely office-based.

The registered manager and senior managers had measures in place to ensure the quality and safety of the service was assessed and evaluated. They placed great emphasis on these systems to ensure excellence in care and quality assurance. They used the CQC's five domains of safe, effective, caring, responsive and well

led as a basis for auditing the service. The systems they had involved checking various aspects of the service at frequent intervals. They used their findings and 'benchmarked' them against Hospice UK quality standards. They told us their service was consistently scoring well. The board of trustees were kept fully informed about how the service was doing. Board reports were prepared on a quarterly basis and board meetings were held every three months. The arrangements in place ensured there was good oversight of the care provision and safety, staffing and service quality.

Audits were completed in respect of infection control and prevention, the prevalence of falls, planning for death, and treatment escalation plans, information governance and medicines for example. We saw that one audit had been completed in January 2016 regarding data entry in people's care notes, where the findings were not acceptable. The service had been re-audited in the August and the action points had been addressed. These checks ensured people's care notes were complete and provided an accurate account of their care needs and the care delivered.

The service is linked with Hospice UK and staff regularly attend conferences. One member of staff told us they had just returned from a conference where they had been looking at a national project to drive improvements in carer support services. The registered manager said this enabled the service to share, and learn about, good practices with other hospice servicse, use national documentation and look at effective governance measures.

A new role within hospice services was that of a community engagement team. The aim of this team was to engage with stakeholders in order that they were aware of the changing role of hospices, to relay what the service can offer and to find out what services were needed. The lead for the team told us their training programme was not only for hospice staff but also other care providers. In two years the education team had delivered about 2,000 sessions of end of life training to care workers and had engaged with 55 care homes in the local area. The five day modular bespoke training course was accredited with the NCfE (National College of further Education). The team also told us about the work they were currently doing with homeless people charities to improve end of life for people who lived on the streets. This work enhanced the ability of other care services to provide good end of life care.

Any accidents, incidents, falls, complaints, safeguarding concerns and staffing issues were reported electronically and then follow up action was recorded. An analysis of the prevalence of people admitted to the in-patient unit with pressure ulcer damage had been completed for the six month period ending 30 September 2016. Because of this, the service provided every person with pressure relieving mattresses. During the same period of time there had been an analysis of the numbers of falls and near misses. These measures enabled the staff to identify any trends so that further occurrences could be prevented or reduced.

The Prospect Hospice complaints policy had been issued in 2013 and was due to be reviewed in 2017. We only looked at the log of complaints that had been implemented since the registered manager took up post at the hospice. Four complaints had been logged. It was clear to see that each of the complaints had been handled correctly but it was not obvious what the outcome was. This was because the outcome was recorded on a separate spread-sheet. Two of the complaints were as a result of negative feedback but had been handled as if it was a complaint. It was evident the service took complaints and negative feedback seriously and used this to make improvements. The registered manager gave assurances that the records would be linked together and agreed this would make identifying any trends easier.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the service and which the service is required

by law to tell us about. This meant we were able to monitor how the service managed these events and would be able to take any action where necessary.