

The Heart of Kent Hospice

The Heart of Kent Hospice

Inspection report

Preston Hall
Royal British Legion Village
Aylesford
Kent
ME20 7PU

Tel: 01622792200
Website: www.hokh.org

Date of inspection visit:
20 February 2017
21 February 2017

Date of publication:
25 April 2017

Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Good 

Summary of findings

Overall summary

The Heart of Kent Hospice is a local charity that provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families in the Maidstone, Aylesford, Tonbridge and Malling area. They deliver physical, emotional and holistic care through a multi-disciplinary team that includes doctors, nurses, physiotherapist, occupational therapist, volunteer complementary therapist, counsellors, a welfare advisor and administrative, catering and housekeeping staff. The service is supported by approximately 600 volunteers. Services are free to people and the Heart of Kent Hospice is largely dependent on donations and fund-raising by volunteers in the community.

The service cares for people in two types of settings: at the hospice in a 10 beds 'Inpatient Unit', or in their own home with the support of a community palliative care team. In addition, the Heart of Kent Hospice provides an Outpatient Centre, 'Magnolia Place', which is open three days a week, where people can access advice, support, and take part in individual and group therapeutic activities. A weekly Drop-in Centre and a dementia café provide an environment where people and their families can receive support from the team as well as talk to others facing a similar situation.

At our last inspection on February 2016, we issued three requirement notices in relation to three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that care and treatment was not provided in a safe way for people; medicines were not properly and safely managed; documentation regarding staff training, advance care planning, people's individual likes and dislikes, complaints logs and recruitment was not appropriately completed; systems and processes were not established and operating effectively to ensure compliance; there was a lack of staff competency checks; and staff did not receive appropriate support, training, supervision as is necessary to enable them to carry out their duties. The registered provider sent an action plan to us detailing the improvements they would make. They confirmed they would be meeting the requirements of the regulations by February 2017 and that new systems would be embedded and sustained over time. They kept us informed of their progress.

This inspection was carried out on 20 and 21 February 2017 to follow up on compliance with these notices. At this inspection we found that the registered provider had met the requirements detailed in the requirement notices and had made significant improvements to the culture of the service and the care people received. At the time of our inspection, six people resided in the Inpatient Unit and 575 people were open to the community palliative care team, 170 of whom lived with dementia.

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

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns in regard to people's safety. Risk assessments were centred on the needs of the individual. Each risk assessment

included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

There were sufficient staff on duty to meet people's needs across the service. New recruitment systems were embedded in practice and ensured relevant checks and records were appropriately completed.

Improvements had been made in regard to the secure storage of medicine, competency checks for nursing staff and records of administration of medicine. People received medicines that were appropriately stored, documented and administered by competent staff.

People could be confident that staff had been appropriately trained. Essential mandatory training was provided and the monitoring of staff training had been improved. A new system to monitor all staff training had been implemented and embedded in practice. All members of care staff received regular one to one supervision sessions to support them in their role. There were members of staff who took the lead in a speciality, offering guidance to other staff so people could be confident about staff particular expertise.

People were fully involved in the planning and review of their care, treatment and support while in the Inpatient Unit (IPU) and while receiving support in the community. Staff delivered care and support to people according to their individual plans.

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

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

Staff knew each person well and understood how people may feel when they were unwell or approached the end of their life. They responded to people's individual communication needs and treated them with genuine kindness and respect.

Staff were outstandingly caring. Staff approach was kind, compassionate and pro-active; they were skilled at giving people the information and explanations they needed in a sensitive manner. They often went beyond the scope of their duties to meet people and their families' needs.

Clear information about the service, the facilities, and how to complain was provided to people and visitors. People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent or refusal before they supported them.

People and relatives told us they were extremely satisfied about the staff approach and about how care and treatment was delivered. They described the way staff responded to their needs in emphatic terms. Dementia care was provided by the service as an innovative response to the increase of dementia in the community.

The service responded to the community's need for information on palliative care, aiming to take the stigma out of hospice care. People's feedback was sought, valued and acted on.

A new robust quality assurance system was implemented and embedded in practice. A range of audits and

checks were carried out throughout the service to identify how the service could improve and action was planned and taken as a result.

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.

Practices regarding the storage, administration of medicines and regarding staff competency checks were in accordance with current legal requirements..

Consistent and robust recruitment procedures were followed in practice.

Staff knew how to recognise signs of abuse and how to raise an alert with the local authority if they had any concerns in regard to people's safety.

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

Is the service effective?

Good ●

The service was effective.

The system for the monitoring of staff training was effective. Essential mandatory training was provided consistently. All staff received one to one supervision to be supported in their role. All care staff were subject to competency checks to ensure they were competent to carry out their role.

Staff had a good knowledge of each person and of how to meet their specific support needs.

The registered manager understood when an application for Deprivation of Liberty Safeguards (DoLS) should be made and how to submit one. Staff were trained in the principles of the Mental Capacity Act (MCA) and the DoLS and were knowledgeable about the requirements of the legislation.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were complimentary about the quality of the food.

Is the service caring?

Outstanding ☆

The service was outstandingly caring.

People's feedback about the caring approach of the staff was overwhelmingly positive and emphatic terms such as, "exceptional", "remarkable", "amazing" and "outstanding" were used to describe them.

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. They were skilled at giving people the information and explanations they needed in a sensitive manner. People valued their relationship with the staff team who often performed beyond the scope of their duties and pre-empted people's emotional needs.

Staff communicated effectively with people and treated them with utmost kindness, compassion and respect.

People were consulted about and fully involved in their care and treatment. The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

Is the service responsive?

The service was outstandingly responsive to people's individual needs.

People were routinely invited to take part in 'advance care plans' (ACP) in the community and the hospice, and were supported during the process.

People's needs were assessed before support was provided in the community, in the Outpatient centre and as soon as they came into the Inpatient Unit. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in accordance with people's care plans and was very responsive to people's individual needs.

Specialist dementia care was provided by the service as an innovative response to the increase of dementia in the community.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to, valued and acted on. People and relatives's comments were overwhelmingly positive about how staff responded to their needs.

Outstanding 

Is the service well-led?

Good 

The service was well-led.

The service demonstrated considerable improvement. New systems and projects had been implemented and embedded in practice.

The staff told us they had confidence in the current management team and were complimentary about the managers, the registered manager and the CEO's leadership style.

There was a culture that focused on people and people were placed at the heart of the service.

The Heart of Kent Hospice

Detailed findings

Background to this inspection

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

This inspection was carried out on 20 and 21 February 2017 and was unannounced. The inspection team consisted of three inspectors, one pharmacist inspectors and an expert by experience. The expert by experience who supported this inspection had experience in palliative care.

The registered manager had completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before our inspection we looked at the information provided in the PIR; records that were sent to us by the provider, the registered manager and the local authority to inform us of significant changes and events; the provider's action plan; and our previous inspection reports.

We made a tour of the premises and equipment. We looked at ten sets of records that related to people's care and examined people's medicines charts. This included people's assessments of needs and care plans and observations to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff recruitment, training and management, maintenance and safety of the premises, and records relevant to the storage, ordering and administration of medicines. We looked at checks that were carried out concerning the monitoring of the safety and quality of the service. We observed a multi-disciplinary meeting and the administration of medicines. We sampled the services' policies and procedures.

We spoke with the chief executive officer (CEO), the registered manager, the head of the Inpatient Unit (IPU), the palliative care consultant, the human resource manager, the head of the Outpatient Centre, the head of Community Outreach Team, the family support manager, and the head of retail. We spoke with a dementia nurse specialist, three nurses, three healthcare assistants (HCAs), the maintenance manager, the chef, and a member of the housekeeping team.

We consulted three people who stayed in the IPU, four of their relatives, two visitors including a member of the 'patient and carer engagement group' and five volunteers. We also spoke with three people who attended Outpatient Centre, and three people who received support in their own home from the community team. We contacted two GPs who referred people to the service, three external specialist nurses, and a lead specialist who visited the service regularly to help staff manage acute and chronic conditions associated with Cancer. We obtained their feedback.

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "It feels very safe here; I always have two people to hoist me in and out of bed and into the chair. The staff always tell me what they are doing", "I have seen the staff wipe the floor when there was a drop of water on it to ensure no one slips" and, "I feel totally safe here, I don't want to leave, I want to stay here". Relatives and visitors' comments included, "This place is 100% safe, no issues at all" and, "All the procedures are very safe, we have a huge amount of trust in the staff care, when [relative] needs moving there are always two staff; very gentle", A relative told us how they had been staying overnight and had observed that "The person 'next door' had been getting out of bed at night; the staff have now placed a sensor mat on the floor so that they are immediately aware; they are constantly thinking of things to make sure people are safe."

At our last inspection in February 2016, we had found that only clinical and medical staff had received training in the safeguarding of adults and children. There were plans to provide this training for all staff in all departments of the service from April 2016. At this inspection, we found that improvements had been implemented.

There was a comprehensive safeguarding policy in place which included relevant guidance from the local authority multi-agency policy and protocol. Safeguarding training was mandatory for all staff and volunteers within the hospice and checks were maintained concerning the level of compliance for different staff groups. The safeguarding policy reflected relevant legislation. Staff we spoke with were knowledgeable concerning how to identify abuse and potential abuse and they were clear about the need to take steps to report any concerns they may have. Staff were also aware of the whistle blowing procedures that were in place in case it was necessary to raise concerns about professional practice. Staff we spoke with were confident that concerns would be raised if they were noted. One staff member told us "We're all very aware of the need to report abuse. Any of us would say something if they had any concerns."

At our last inspection in February 2016, we found that new recruitment systems were not yet embedded and that documentation in personnel files was not appropriately completed. At this inspection, we saw that improvements had been carried out.

A system was in place to ensure that when staff were employed, all relevant checks were completed prior to them commencing work at the hospice. Staff had provided evidence that were eligible to work in the UK and a full employment history was provided as part of the application process. Staff completed Disclosure and Barring Service (DBS) checks before they started work at the hospice. These checks indicated whether staff had any criminal history. Checks were made concerning the current registration status of clinical staff. For example, systems were in place to ensure that nurses employed by the hospice were registered with the Nursing and Midwifery Council (NMC). Staff had completed questionnaires about their medical history that showed that they were fit to work and able to fulfil their roles.

There was a detailed disciplinary process in place that clearly outlined the steps that would need to be taken if it was necessary to address staff performance issues. Appropriate steps had been taken by the

provider to keep people safe and ensure good standards of practice were maintained. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

There were sufficient numbers of staff deployed to ensure that people's needs were met. People and relatives told us that there were enough staff around to meet their or their relatives' needs "day and night." Comments included, "I have never been in a situation where I could not find someone to help", "Staff are consistently present up and down the corridors, [relative] has always had someone to help" and, "Response to the buzzer is very fast, even at 5am in the morning." The hospice employed a number of bank staff who would support should additional staff be required to cover short-term sickness or holidays. Within the IPU, three qualified nurses were on duty during the day with two or three healthcare assistants (HCAs) on shift depending on the needs of the people being cared for within the unit. Overnight, two qualified nurses were deployed with one or two HCAs. Staff confirmed that they were able to request additional staffing if a need was identified. A staff member told us, "We've got the resources, we've got the staffing levels and we will pull together when we need to support each other".

The community team employed a total of eleven care staff and supported over 500 people in the community. This included seven general palliative care clinical nurse specialists, two dementia nurses and one clinical nurse specialist who was jointly employed with the local NHS Trust and worked within their Accident and Emergency (A & E) department, to support people who presented to the A & E with end of life or palliative care needs. In the IPU, the manager oversaw eleven nurses and ten bank registered nurses. A palliative care consultant and two speciality doctors provided medical guidance and treatment; a new post had been created for a practice development nurse, who would work with students, inductees, and 'return to practice' nurses.

At our last inspection in February 2016, we found that there was no system to track and monitor how repairs were carried out within the hospice. At this inspection, we saw that improvements had been carried out.

A new monitoring system for repairs and maintenance had been implemented and was embedded in practice. Repairs were logged and information was appropriately recorded showing how and when issues had been resolved. Staff told us that they were always able to get repairs completed in a timely manner if there were concerns about the premises or equipment. One member of the housekeeping team told us that they had reported a concern about equipment on the morning of our inspection. The issue has been dealt with straight away by a member of the maintenance team. Contracts were in place for the regular servicing of equipment such as hoists and lifts.

Individual risk assessments were carried out for people in the community and in the IPU to identify how risks could be minimised. They included clear control measures for staff to follow in practice. Staff were aware of the risks that related to each person. For example, two people who were at risk of falls were provided with bed rails and a specialised floor mat to alert staff when they got out of bed in the night and may need assistance. Another person whose skin was at risk was provided with a pressure relieving mattress; staff implemented a skin damage prevention management plan. A person whose bones were fragile had specific instructions in their care plan for staff to follow when supporting them to move or change their body position. Staff ensured that people had their call bells within easy reach so that staff could respond when they needed help.

There was an effective system in place for reporting, monitoring and analysing accidents and incidents. This ensured that where preventative measures were identified, these were implemented. A new reporting system had been introduced to improve the way staff reported and logged accidents and incidents. The

registered manager maintained an overview of these logs and analysed the data to ensure that trends and concerns were identified. For example, they had completed an analysis concerning the reporting of pressure ulcers to look at trends and identify how reporting practices may influence the data. The manager had introduced bench-marking against other hospices in order to gain a better understanding of where potential improvements were needed. There had been an 82% reduction in errors related to medicines which indicated medicines administration was safely monitored.

Environmental risks had been given due consideration and steps were outlined concerning how they would be managed. There was a detailed business continuity plan in place that provided comprehensive guidance concerning how the hospice would operate if there was damage to the premises. This plan also outlined how the potential loss of utilities such as power would be managed and how the hospice would operate in case of the loss of IT systems.

There was a comprehensive fire risk assessment in place and actions had been completed following a recent review of arrangements. For example, improvements had been made to the signage in some parts of the premises. Patients had individual personal emergency evacuation plans and there were detailed evacuation plans for the building. Designated fire marshals had specific duties during fire drills and in case of an emergency. For example, fire marshals were responsible for reporting any difficulties encountered during a fire drill. The premises were secure and visitors signed in on entry to ensure that only people who were authorised to be within the hospice were allowed into the building.

Peoples' own medicines were kept securely in lockers in their own rooms. Appropriate arrangements were in place for ensuring medicines were not used past their expiry date. There were detailed, clear records of medicines which had been ordered and received by the hospice. Emergency medicines and oxygen cylinders were available, in date and stored appropriately. Waste medicines were stored securely and disposed of appropriately.

Controlled drugs (CDs - medicines which are at higher risk of misuse and therefore need closer monitoring) were kept in locked cabinets. Staff conducted balance checks of controlled drugs and ordering processes and records were appropriate. High strength preparations of CDs were kept separately from other strengths to help prevent incorrect selection. Disposal of expired medicines and patients' own CDs was undertaken appropriately. The registered manager had implemented a new procedure to ensure CDs were destroyed on the premises in line with current legislation.

Blank prescription forms (FP10s) were stored securely although there were no processes in place to allow their use to be tracked in the hospice. This is important in preventing misuse of prescriptions. We discussed this with the registered manager who remedied this on the day, and who implemented a tracking system. Prescribing was undertaken by in-house doctors along with an in house consultant. A range of medicines were prescribed for people on admission to the hospice to ensure they always had access to appropriate medicines whenever they needed. Prescribed medicines were also screened by a pharmacist twice a week. On two occasions, we saw trained nurses safely prepare a syringe driver for a patient (a portable pump which allows medicine to be administered by slow release over a period of 24 hours). Staff also had good access to up to date resources which they may need for medicines administration, including guidance on the use of syringe drivers. Staff were assessed to ensure they were competent in the use of syringe drivers.

Staff were able to clearly explain information patients are given about unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms). The provider had effective processes in place to enable patients to take out medicines when on day leave and provided oral syringes for liquid medicines. A full audit on medicines management had been undertaken in January 2016

and we were able to view an action plan made to address issues which had been highlighted by the audit. Alerts issued by the Medicines & Healthcare products Regulatory Agency (MHRA) were acted on.

A detailed infection control policy was in place and an infection control lead took responsibility for ensuring that staff received the training and support they needed to maintain good standards in relation to infection control procedures. Audits were regularly carried out and they were used to identify good practice as well as any areas that were in need of improvement. These were specialist audits that had been developed by Hospice UK specifically to assess risks within a hospice environment. They included checks on facilities as well as staff practice. For example, checks were undertaken concerning hand washing practices.

High standards of cleanliness were maintained throughout the premises and it was evident that the housekeeping team took pride in their work. One member of the housekeeping team told us 'We're not just cleaners, we're valued, we're part of the team'. Staff had completed infection control training and they knew who the infection control lead was in case they needed further guidance. There was a plentiful supply of personal protective equipment available within the premises and staff were observed using this equipment appropriately throughout the inspection.

Is the service effective?

Our findings

People told us the staff gave them the care they needed. Two people who stayed in the In-Patient Unit said, "This is my third stay, I am very satisfied. If I am in pain I discuss it with the nurse and they get the doctor to come and see me; they must be well-trained to be as good as they are", "Best thing has been the continuity of care with the same nurse so I don't have to keep retelling my story" and, "The staff are well trained, so professional in what they do; they always answer my questions and are able to confidently explain what treatment I am on and the possible side effects." A relative told us, "The staff are very thorough and seem very well trained in everything, not just dealing with the patient but also keeping the family informed." An external clinical specialist in terminal illness told us, "The initial administrative triage is excellent at the Hospice and offers reassurance that electronic communications will be forwarded to the correct person. Regular updates on complex care provision or changes in patient well-being offer a quality service and reassure the patient that their health care team are "singing from the same song sheet" so to speak, delivering continuity of care."

At our last inspection in February 2016, we found checks of staff competency during induction were not appropriately carried out, including checks for staff who administered medicine to people; a system of regular supervision across the service had not been implemented. At this inspection, we found that improvements had been implemented and that new relevant monitoring systems had been embedded in practice.

Staff completed a detailed and comprehensive induction process when they began working at the hospice. This included orientation and relevant information they needed to be effective in their roles. Staff were signposted to key policies that they needed to be aware of such as whistle blowing and confidentiality. Volunteers also received induction training and orientation when they started at the hospice. One volunteer we spoke with told us they had been given opportunities for shadowing and they were well supported by colleagues. They told us, "We get a lot of support from the ward and from the community nurses. All the staff have a lot of passion for what they do and they share this with us."

Staff at all levels of seniority had received regular supervisions and appraisals. Staff we spoke with confirmed that they received support and guidance they needed. The heads of department were being supervised and appraised by the registered manager to ensure they were appropriately supported. Staff were given opportunities to pursue additional qualifications that were relevant to their role. For example, three HCAs had been encouraged to undertake qualifications that would develop their knowledge and understanding of leadership. The registered manager had plans to introduce an associate nurse position in the future that would allow HCAs to develop their skills and take on additional clinical tasks.

There was a range of training courses that the hospice had identified as mandatory for staff to complete. This included end of life care, infection control, equality and diversity, safeguarding, moving and handling and data protection. Effective systems were in place to ensure that training was monitored and any priorities for training were identified. An on-going programme of training was scheduled and staff were positive about the opportunities they received to complete the training they needed to be effective in their

roles. One staff member told us 'We get excellent support from the management team and this allows us to move up'. They told us 'It's not just about the financial help to undertake further training, they advocate for us and they know my skill base and how I need to develop'. Clinical staff received appropriate training in accordance with their role. For example, nurses had completed specialist training on the use of syringe drivers.

A range of checks had been carried out concerning staff competence to carry out important functions within their roles. This included a personal, interpersonal and clinical competency review. Staff were assessed in relation to a range of skills, attitudes and competencies such as their ability to embrace change, their passion for results and their communication skills. Staff were asked to complete self-evaluation and meet with their supervisor to agree on any further action that was required to support their development. Staff competency was also assessed in relation to their understanding of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) directives and how they should be completed appropriately. For example, staff were assessed concerning their understanding of national and local guidelines and policies in relation to DNACPR directives.

The hospice had worked to develop the role of volunteers and they were given additional training and guidance to allow them to provide more practical support for people accessing the IPU, such as in moving and handling techniques. Volunteers had been given uniforms and were identifiable as part of the team. The nurse educator for the hospice had been involved in developing training for volunteers. They had identified that besides practical skills, volunteers needed to develop their understanding of end of life care. They told us 'We need to develop them into that role and make sure they are equipped with the philosophy of end of life care'.

There was an emphasis within the hospice on learning and development for staff at all levels. Staff participated in a journal club and this was used to ensure that they were given opportunities to develop their knowledge and understanding. Staff were enthusiastic about the journal club as it gave them opportunities to request input and learn more about pertinent topics they had identified during their day to day practice. For example, staff could ask the consultants who worked at the hospice to present on specific topics if they wished to have further input and develop their understanding. Recent topics included nutrition and hydration for end of life care, managing opiates and leadership in palliative care. The hospice had introduced Schwartz Rounds for staff (forums where all staff come together regularly to discuss the emotional and social aspects of their work). The service was considerate about staff wellbeing. 'Staff Wellbeing Days' had been held in June 2016, with NHS health checks and a weight loss programme with weekly classes offered to staff. A 'Rest and Restore' programme had been introduced with activities such as mindfulness (ways to manage stress).

There was a system of frequent and scheduled staff handovers throughout the day to ensure continuity of care between staff shifts. There were daily 'Referrals meeting' and weekly multi-disciplinary meetings to review each person's care and treatment to ensure it remained appropriate and discuss how to support people in the community who might be admitted to the hospice. We observed a multi-disciplinary meeting. A comprehensive team attended including the registered manager, the IPU manager, the chaplain, the palliative care consultant, a doctor, clinical nurse specialist, nurses, occupational therapist and healthcare assistants. A range of options to present people, such as referrals to external healthcare services was discussed with the team's active participation. A person was being referred to a psychiatrist. The doctor was updating people's care plans on a laptop during the meeting. This system ensured staff responded effectively when people's health needs changed and that effective continuity of care was assured.

There were members of staff who took the lead in a speciality such as dementia, mental capacity and

safeguarding, equality and diversity, and dignity. These members of staff could offer specialist guidance to other staff. This meant that people could be confident that staff had access to expertise that could enhance their knowledge and delivery of care. The registered manager was a Caldicott guardian (a senior person responsible for protecting the confidentiality of people's information and enabling appropriate information-sharing).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had completed training on the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards. Staff we spoke with were aware of the need to assess people's capacity in relation to decisions and involve families and also other professionals when necessary to help make decisions in the person's best interests. For example, staff were aware that people they cared for may not always have the capacity to express their wishes. A staff member told us 'We work with the families and we take our lead from them but we use our professional judgement as well'. Another staff member told us that staff were always noticing and assessing changes in capacity. There had been one occasion recently when it had been necessary for the hospice to complete an application to deprive a person of their liberty. Staff of all levels of seniority we spoke with were aware that this application had been made and they understood the rationale concerning why it had been made. Assessments of people's mental capacity, relevant meetings and their outcome were appropriately documented.

People told us they were very satisfied with the quality of the food. Their comments included, "The food is hotel quality; all freshly cooked on the premises; I can choose what I want if I don't like what is on the menu and they will go and get it for me" and, "The food is lovely and piping hot; they'll chop the meat for me if I ask; today my knife is just falling through this meat." Each person in the IPU had a copy of the menu and staff helped them make their choice when needed. People could choose any alternatives. The chef told us, "We will always accommodate any wish." At tea time there were choices of cooked snacks as well as sandwiches along with soft food alternatives. Visiting out-patients and their carers were able to choose from the displayed salad bar and menu. People in the IPU, in the Outpatient Centre and in the Café were served their preferred options. Staff in the IPU took time to explain what each dish was and offered assistance when needed. They made sure that people were sitting comfortably and able to reach their meal. Hot and cold refreshments were offered throughout the day.

The chef was aware of the need to cater for changing needs and preferences. They confirmed that records were maintained concerning people's likes and dislikes as well as important information about dietary needs such as allergies, and whether people required soft diet. A relative told us how their loved one was having difficulty swallowing their food. Each individual part of the dish was pureed separately to prevent them from choking and staff consistently checked that their milk shakes were of the correct consistency. The chef told us "We don't assume that because someone doesn't want to eat one day they will not want to eat the next, we will always offer; we will investigate if meals aren't eaten and see if we can offer something different or something special." Special occasions such as birthdays and anniversaries were marked with a cake made by the catering team. They had also provided catering for special events held at the hospice such

as weddings and christenings.

The premises included a number of comfortable private spaces where people and their friends and families could spend time. For example, there were counselling rooms available and these included spaces for children where games, toys and art supplies were provided. There was a chapel where people could reflect or pray and this space was also used for ceremonies. The gardens were well maintained by volunteers and it was evident that considerable effort had been taken to ensure that the garden was attractive and welcoming. A conservatory opened onto the garden.

Is the service caring?

Our findings

The service continued to be outstandingly caring. All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were overwhelmingly positive and emphatic terms such as, "exceptional", "remarkable", "amazing" and "outstanding" were used to describe staff and the service. A relative told us, "The staff are like members of our family, they give absolutely fantastic care." There was an array of examples that demonstrated how staff went 'the extra mile' and met people's individual needs with kindness, empathy and dedication. One staff member told us, "We go that extra mile – that extra mile is celebrated and encouraged". Another staff member told us of their team, "We are privileged because we get to give the care that we want to give."

A person in the IPU told us, "I am extremely satisfied, cannot talk highly enough of the hospice, absolutely amazing place at every level of care, cleanliness, friendliness, professional and so supportive to me and my family." A lead specialist who visited the service regularly to help staff manage acute and chronic conditions associated with Cancer told us, "Many of my patients have been admitted for respite or end of life care in the IPU. The staff have been very welcoming for me to visit to see them, and have been more than amenable to discuss and share care options which has been beneficial for so many patients, especially during a difficult transition between oncology and palliative care alone when nearing end of life. They have shown compassion for the patient and family". A GP who referred people to the service told us, "I know patients are receiving excellent care in The Heart of Kent; the staff are very professional and extremely compassionate, they provide outstanding care and I would be hard pushed to identify how the hospice could improve what they already deliver."

There was a homely atmosphere throughout the service and a social atmosphere where people were encouraged to chat if they wished, and were listened to. Staff were smiling and engaging; they looked neither rushed nor under pressure and always spoke to people and visitors they met in the corridors. Staff responded to them with apparent genuine interest. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they conversed with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names. Staff used appropriate touch when needed such as gently stroking a person's arm while they experienced some discomfort when such gestures of empathy were welcomed by people. They offered companionship to people who stayed in their bedrooms when they considered that people may not wish to be on their own.

The staff responded quickly to people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected and staff communicated the updates with each other during handovers. People told us that their families, grand children and family pets were all made welcome by staff who made "a special effort." Staff greeted them warmly and ensured all felt welcome and at ease in the hospice. Visiting children appeared at ease talking with staff and to enjoy being at the hospice. A nurse told us, "This place should be a positive place, free of any anxiety or apprehension."

People valued their relationships with the staff team and told us that they often went 'the extra mile' for them when providing care and support. As a result people felt cared for in an outstanding way and that they mattered.

The culture of going 'above and beyond' for people was promoted throughout the service. A consultant had carried out an ultrasound on a person's relative so the person could see their unborn grandchild; staff arranged for pets to come into the hospice, and a pet dog was staying with a person in their room; staff had completed a care plan for the pet, ensuring their owner had peace of mind. Families were able to stay with their loved ones in 'Z' beds and reclining chairs. A person told us, "I felt very anxious one night, the nurse sat with me most of the night helping me to relax using deep breathing technique". A relative told us, "One day when I was not there the staff had prepared my dad an ice cream sundae and he said he wished the family could see him; the nurse suggested they took a photo of him with the ice cream sundae; he had a lovely smile on their face; seeing him happy made me really happy."

Staff told us they were encouraged to identify any special wishes that could be fulfilled and make them a reality. When a person who approached the end of their life had wishes to be at the seaside, staff had decorated their room in a beach theme, produced fish and chips and sea-salt water spray to recreate the right atmosphere. A person who was a flying enthusiast had been successfully nominated by the hospice staff for a helicopter trip at a local aerodrome. There were blessings and weddings held at the hospice for people who were too unwell to return home. Staff had accommodated a Halloween wedding with a Gothic theme for a person who spent their last days in the hospice, dressing up for the occasion. One care worker told us they had seen how holding hands was particularly important for a person. They had arranged for handprints of all of the members of the family to be captured and arranged in a frame for the person to keep.

Staff had exceptional communication skills. They knew how to communicate with each person, pre-empted their mood and understood their individual needs. People in the IPU told us, "They(the staff) are very patient, sometime I have trouble getting the words out, they wait and let me finish what I want to say", "Communication is brilliant. If I have had an anxious sleepless night, I can ring up and speak to someone. Sometimes I just need to offload, they listen." Staff provided explanations before undergoing any tasks to ensure people knew what to expect next, such as, "(First name), we are going to wash you, if that is OK with you?; or (first name) we are going to speak to your daughter and get back to you straight after that." A relative told us that although their relative was now in a semi-coma staff were talking to him "all the time", announcing what they are doing and asking him if he was comfortable."

Staff were transparent with people and did not shy away from difficult conversations. People were given support when making decisions about their care and treatment and were fully involved with all relevant planning, from symptom and pain management to their end of life care. They were proactively supported to express their views and staff were skilled at giving people face to face information and explanations they needed and the time to make decisions. Relatives told us how staff had taken time to explain exactly what they could expect when their loved one's condition had worsened and understood how they felt, saying, "They are always proactive, explained in such a way that we understood, I wasn't scared when the changes happened", "No-one has walked away without giving me a response to my questions. I had so many questions. The staff dealt with everything in a very professional way" and, "The staff seem to know our needs, they sit and explain everything in great detail in layman's terms." Following a family meeting with the doctors, nurses and relative, a nurse had discreetly pulled the relative aside to make sure that they were coping with what they had been told.

Staff showed great empathy in the way they treated people and their families. All members of staff used a

gentle tone when they spoke with people and used appropriate touch to communicate their empathy. Relatives told us of the staff willingness to engage with them. They told us, "All staff and volunteers cannot do enough for you, they pick up on the fact you are worried and any little thing that is troubling you, you can sit and chat it over, everyone is always available to listen and reassure you." A nurse had taken time to sit with a person's son when he preferred not to say goodbye to their parent in the IPU and explained it was "okay to feel that way." A relative told us that they felt able to ask one of the staff whether their relative was waiting for 'approval to die' and the staff member had suggested letting their relative know that "I was going to be okay and I would be fine if you go." They told us that approach had been "extremely helpful" in helping them cope.

People and their relatives told us that the staff were very polite and respected their or their family's need for privacy and dignity. Staff always knocked on the doors before they entered, were discreet and always entered with a cheery greeting directed at the person and then to their family members. They placed a sign 'do not enter' on the door and drew blinds down when people received personal care or expressed the wish to have time to themselves. A person recalled the first time staff helped them shower, saying, "The curtains were closed and the blind pulled down on the door panel. Staff just chatted away to me about family, I didn't feel embarrassed." A relative told us, "Dignity is respected 100%, they are tactful and considerate of how [X] is feeling; when they change his catheter they always have him covered up and distract him with a chat and some banter if he is in that mood." Family members were allowed quiet time on their own and could sit in any of the lounges without being disturbed.

Family support was recognised by staff as vital to people's wellbeing and staff strived to meet the emotional needs of people's relatives and families. Staff were aware of the need to support families through the process of losing a loved one. One nurse told us that they knew this was important for people who were going through end of life care as it gave them comfort to know that their families were also being cared for by the hospice staff. They told us 'We know that it can lessen feelings of distress for people if they know that we are looking after their family members'. A person told us how a nurse specialist visited them after they were given a terminal diagnosis, saying, "They offered practical advice, worked closely with my doctor and straight away arranged some counselling for me. This has helped me cope."

Support was continual, beyond the provision of care for people. Where necessary, staff supported people and their relatives to regain their personal strengths, to help them cope and come to terms with illness or death. The Family support team included a manager, eight qualified counsellors volunteers, a welfare advisor, a social worker, four chaplain volunteers and additional five volunteers who helped man the 'drop in' service. Counselling and therapy was available for individuals, couples, families and children, during illness or after bereavement. People and their families were offered group hypnotherapy, and 12 one to one counselling sessions that could be extended according to individual needs. Counselling was provided with children who were aged four and above, and for children under three, the counsellors worked with parents so they could support their children. Specialised reading material was provided to offer guidance during the bereavement process.

Social work support was provided, that included psychological support, advocacy, and signposting for practical matters. The social worker worked closely with parents and local schools on how to support children. The welfare advisor helped people with their entitlements and offered advice on a range of matters such as employment, housing, pensions, utilities and legal matters. A referral had been received for a person who was facing eviction from his home. The patient had a tracheotomy (an incision in the windpipe made to relieve an obstruction to breathing) and so found access to support services challenging. The social worker had accompanied him to a meeting with the housing department and advocated for them to be provided with alternative accommodation which would be local to his support network. This accommodation was

successfully secured and the person was able to move into a brand new supported flat, close to his friends and family.

Spiritual care played a vital part in the holistic care that was offered to people and their families. The chaplain supervised a team of five bereavement volunteers and provided on-going daily support, although their post was shortly due to be taken over by chaplaincy volunteers and religious leaders in the community. There were two annual memorial remembrance services that included 'Light up a life' service where families and friends could get together and enjoy readings, carols and music; a 'Sunflower appeal' where seeds were sowed and plants grown. There was a sculpted memory tree where relatives and friends could place a copper leaf with messages for their loved ones. Families were invited six weeks after their loved one's death to attend the drop-in service and discuss the services available to see if they may wish to engage. There was a sculpture in the garden in the form of a reflection tree and this had the names of people who had been supported by the hospice in the past, etched on individual leaves attached to the tree.

Attention was paid to diversity and equality throughout the service. There were comprehensive policies in place relating to diversity and equality and dignity at work. There was also an equality and diversity lead within the service and we saw that there was a project group which was active in promoting equality and diversity within the hospice. A person held a particular religious faith and as a consequence had chosen to decline pain relief medicines. Nurses had been trained to observe their verbal and non-verbal cues and act upon them to reduce pain and distress. The registered manager told us, "During the time this person was with us we had regular multi-disciplinary discussions and reflection sessions to support the nurses and we respected his personal religious and cultural choices and beliefs."

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. This included the complaints procedures and a wide range of booklets and leaflets designed and written by the service, clear to understand and available in different formats. A new 'welcome pack' was in the process of being re-designed and feedback from a 'Hospice User Group' had been sought to that effect. People in the IPU were provided with a folder describing all services available to them. People and relatives were also signposted to other services and a wide range of leaflets was displayed in the service to that effect.

People were supported at the end of their life to have a comfortable, dignified and pain-free death and their wishes were at the centre of the service. The doctors and clinical nurses followed a process based on the 'Gold Standards Framework' for their assessments. The Gold Standards Framework is a systematic, evidence based approach, developed to improve quality of care for patients with a life-limiting illness, adopted by all organisations providing end of life care. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. Each person in the IPU had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered. Staff stayed with people when they approached the end of their life when they did not have families present. With such caring approach from staff, people could be confident that staff spent time with them when needed and had genuine concern for their wellbeing.

Is the service responsive?

Our findings

People and their relatives told us that staff responded exceptionally well to their needs. They told us that staff respected their preferred routine and decisions about any aspect of their care. A person told us, "I can do what I want and when I want to, no fixed routine as such. I didn't feel like having a bath this morning and have been told to buzz when I want to have it." A person told us they had asked staff to open the door to the garden to let the sun in, saying, "I am going ask staff to wheel me into the garden this afternoon; they're always so willing to do whatever makes me happy." Another person told us, "I told the staff I don't like people fussing over me, they respected that and let me decide what help I want and when. It's all about me and not what they want to do for me." A relative told us that their loved one was no longer able to respond. They said, "[X] have just had a lovely wash and shave this morning; they know he always liked to have a daily wash."

There was an overwhelming amount of written accounts and compliments sent to the service, expressing gratitude and detailing how staff had responded to their needs, using terms such as, "outstanding", "wonderful", exceptionally sensitive " and, "always went the extra mile in making [X] and the family so very comfortable." A relative had depicted the service as, "The Heart of Kent is truly the heart of Kent; a beautiful, caring loving heart which needs to be kept beating for others."

At our last inspection in February 2016, we had found that people were not routinely invited to take part in 'advance care plans' (ACP) and not consistently supported during the process. These plans give people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. At this inspection, we found that improvements had been implemented as a new system and processes had been embedded in practice.

Staff actively assisted people with the completion of their advance care plans. These plans included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to be their legal representative. Advance care plans meetings were held where people, their family, the medical team and the HCA who were caring for the person could discuss together how best to manage people's hopes, wishes, and preferences about their end of life care. All parties had been active participants and decisions were made taking full account people's personal wishes.

Staff took account of- and responded to- people's individual needs and requests. People's needs were assessed before support was provided to ensure their particular needs were met. They had been asked about their physical condition, medical history, their symptoms, preferred place of care, whether they had documentation about their resuscitation status, and whether they had a legal representative. A folder containing key information that had been gathered before or during people's admissions to the IPU was kept in the IPU office for all clinical staff to access. This included a new 'Hello' document that detailed what people liked and disliked in respect of their food, routine, activities, and their general preferences. When people had consented, these 'Hello' documents were displayed in their room. People and their relatives were encouraged to write any additional information onto a notice board in people's room, which also

displayed the name of the nurse allocated to the person's care for the day.

People were able to self-refer and were contacted that same day to ensure a prompt response to their needs. The response times were monitored and reported monthly at Executive Team meetings and Patient Services Committee. Once people were admitted in the IPU, doctors and nurses completed thorough assessments of their medical and nursing needs, and inputted this data in a computerised system that was shared by the clinical team. Outpatients and their carers were invited to attend an introductory day for an assessment of their needs, where they could agree on attendance and set up goals that were reviewed after six to 12 weeks. An 'outcomes measurement tool' was used at regular intervals in the IPU, the Outpatient Centre and in the community. This tool was used to influence care plans and interventions and ensure needs were effectively responded to.

Care plans were developed within 24 hours of admission and were updated continuously by staff who remained vigilant to people's changing needs. There were additional care plans that were updated hourly when people approached the end of their life, to monitor closely their comfort and respond to their changing needs. The care plans were centred on the individual, included food and drink, symptom control and psychological, social and spiritual support. Sensitive communication took place between staff and the person, and those identified as important to them. Therefore people's needs in the last hours of their life were met by well-informed staff who were knowledgeable about people's individual requirements.

Staff responded to people's individual needs in their daily practice. The hospice occupational therapist had identified a need for promoting mealtime independence for some people who lived with a neurological disease; in response the fundraising team had secured a grant to buy a specialised cutlery assessment kit. A person told us how staff helped them when they experienced difficulties, they told us, "My hand tremors mean my food is sometimes all over the place and a medicine change has helped; the nurse has shown me how to hold my fork so it is much steadier; today I asked for have my tea in a cup and saucer instead of the beaker. I have not spilled a drop." The chef was aware of the importance of providing meals for relatives as well as people who were receiving care at the hospice due to the social importance of sharing meals with family members. They told us, "People will sometimes be encouraged to eat when they are offered meals with their families because this is what they are used to at home." When a person had become anxious in the community, staff had arranged for a befriender to visit them every week, for a 'sit and a chat'. Their relative told us, "They are very good at listening, [X] enjoys having these visitors, and the anxiety is lessened." A twice weekly Lymphoedema clinic (Lymphoedema is a condition that causes swelling in the body's tissues) had been created in October 2016, to help several people who had to travel some distance away to receive that service.

Specialist dementia care was provided by the service as an innovative response to the increase of dementia in the community, led by two full time specialist dementia nurses who had received enhanced training and attended conferences on the subject. The dementia lead nurses sat on the local 'Acute Trust Dementia Strategy Group' and contributed to influence dementia end of life care in the acute NHS setting. Referrals were received for people who had been diagnosed as living with dementia in the community. In the last year, 333 people living with dementia and their carers had received support in the community. This service benefitted people and their carers. For example, one relative described their spouse's dementia as a "final blow" and how they had become "solely a carer, having been robbed of the role of a supportive wife". The carer stated being overwhelmed, emotionally and physically exhausted, without the strength to "navigate the system" and locate the relevant health care professionals. Having one point of contact at the hospice alleviated this pressure and as a result the carer was offered support and respite, a referral to a home support service, counselling and advice on coping mechanisms. The registered manager told us, "We provide availability of someone on the end of a telephone who can listen, to enable the patient to remain in

their own environment for as long as possible."

One specialist dementia nurse told us how passionate they felt towards their role. They told us, "We currently support 188 people living with dementia in the community, and 30 residential or nursing homes. We also support staff in the hospice when anyone is admitted with dementia." They ensured a rapport was established with people and their families and helped them complete documentation. This included advance care plans regarding end of life care wishes; 'This is Me' booklets that could be used a 'passport' should they need to go in hospital; and 'At risk of going missing' forms that could be handed to the Police with probable places that people may go to should they become disorientated and lost.

The specialist dementia nurses gave practical advice to nursing homes about how to manage symptoms of dementia, which benefitted people. A nursing home manager told us, "We get superb service from the hospice team, advice, information, and practical help." For example, a person was displaying behaviours that may challenge daily at 3am and the staff were unable to identify appropriate interventions to manage this effectively. The specialist dementia nurse looked at his history and understood that, as the person had been a postman all of his working life, they may need to continue having a sense of purpose. They suggested staff to give him a bag of letters to deliver each morning in the home. As a result of this intervention, the person's behaviour changed overnight. The specialist dementia nurse told us, "It is about appraising the whole person, and look beyond the dementia."

The service held a monthly 'dementia café' where anyone could drop in and meet others. When people living with dementia needed to leave their home, for example to live in a nursing home, the hospice continued to support carers through counselling and on-going attendance at the hospice dementia café where they gained support from peers and professionals. At the café and in the community, carers were supported with an on-going completion and update of a carer's questionnaire, based on the Zarit Burden interview model, where care givers are asked to indicate the extent of burden experienced while providing care to a loved one; burden being defined as the extent to which a care giver perceives emotional, physical health, social life, and financial consequences that impairs one's ability to provide care. The use of this method helped staff identify potential carer breakdown which could then be alleviated via adding interventions to relieve potential crisis. A second dementia café was due to be opened. Bedrooms in the IPU could be instantly converted to become dementia friendly environment with a kit that included signage, accessories and sensory equipment.

The service responded to the community's need for information about palliative care, aiming to take the stigma out of hospice care. Staff spoke at primary and secondary school assemblies and local community group meetings about life-limiting illness and the work of the hospice. The service had a team of 'Hospice Ambassadors' who spoke to schools, community groups and companies about hospice work and who built strong relationships with them. An active relationship with seventeen local schools was maintained through frequent visits by the community fundraising team to school assemblies. Staff had attended a local Member of Parliament's older persons information and advice fairs. The hospice clinical educator visited two local secondary schools to teach end of life care awareness at A level. During 'Dying Matters' week, activities had been run and linked between the hospice and the hospice café situated in the community, to forge an arena for discussions about death and dying. The service published patient stories and experiences, updates on 'patient care volunteers', fundraising matters and hospice plans, monthly in the local press and through social media. The CEO had visited the governors of two local prisons to discuss how the hospice could support them with developing end of life policies and they could support their residents. As a result, the hospice retail and catering service had facilitated work placements for two offenders from the local open prison.

The service ensured people in the community could access responsive advice, guidance and reassurance without delay. The hospice provided a 24/7 telephone advice line, as well as a 24/7 out of hours telephone service for doctors in acute hospitals or the out of hours GP service to gain specialist palliative care advice from a consultant if needed. The hospice worked with the South East Coast Ambulance Service (SECAMB), facilitating end of life care workshops for paramedics. The registered manager explained to us how palliative care patients in the community frequently call 999, and how the paramedics could ring the hospice 24/7, to receive support and advice about symptom control and medicines. They told us, "The relationship the hospice has with SECAMB means that patients are only taken into hospital during out of hours if it appropriate to do so." SECAMB had fed back to the hospice that this advice helped them "Immensely if called in a crisis as this service supported best outcomes for patients and carers."

The Community Outreach Team had a daily duty clinical nurse specialist who was able to respond immediately with clinical advice, seven days a week; IPU nurses took calls out of hours. Additionally, a weekly drop-in service responded to people's needs for informal support. It was well used by outpatients, their carers and families and the social worker told us that they "Usually had between 12-26 attendees". People's comments included, "The Drop-in is very useful. Nice and relaxed, staff and volunteers very friendly. Has been useful for my family, they can come and talk with others facing the same situation", "The Drop-in has given me somewhere to come to and say how I am feeling, they listen; really supportive staff. They are always prepared to listen when our family couldn't cope" and, "There is always someone here to talk to, either the social worker or one of the volunteers; I come for the support, I always leave feeling good." One outpatient who had joined the 'Patient and Carer Engagement Group' was talking to everyone individually explaining the benefits of the group and encouraging them to join. This group was taking part in a project titled "15 steps", which was a NHS initiative to gain patient and carers' experience feedback. On the day of the inspection a guitarist was entertaining the attendees.

The service offered complimentary therapies, reflexology, welfare support and signposting to other agencies. People were encouraged to stay for lunch in the café to build extra relationship and additional support. They took time to sit with people and check to see if anyone wanted some private time with them. The hospice welfare advice service had helped 64 people in 2016 to access an increase of their income; families to access grants, housing benefits, a reduction of working hours for carers, and had intervened on behalf of people in cases where benefit claims had been refused.

There was a range of activities available in the Outpatients Centre to respond to people's social needs. People undertook assessments to assess their suitability for group activities and set the goals they wished to achieve before a plan of activities was devised for them. A physiotherapist had been recruited to complement the activities team. Special events were held within the day centre and this had included chocolate making, a visit from a magician, a music band and special events to celebrate Christmas. There was a timetable in place which included therapeutic art, an exercise group, relaxation and reflection time. Staff responded to people's social and psychological needs by paying attention to their individuality, their past, and present interests. One person was given the opportunity to perform a comedy routine in the Outpatient Centre as they particularly enjoyed stand-up comedy. Another person had been enabled to create a 'gift of love' for his children and a 'bag of love' for their spouse, representing on-going love and support. Staff were providing activities for people in their rooms if they were not able or did not wish to access the Outpatients Centre. People were supported with a wide range of art and crafts, creating memory boxes and participating in reminiscence projects. People's paintings had been exhibited and the community had been invited to see the work that had been created. A viewer had commented, "It is an absolute joy to see what can be done even though folks may be suffering or recovering; it makes for happy yet provocative images."

As visitors were welcome at any time of day or night, and as they were enabled to remain overnight with their family members if they wished, social isolation was reduced. People's relatives including children and grandchildren were welcome to accompany their loved ones during activities. At the time of our visit, a 'pat the dog' service was visiting the home and there was a joyous atmosphere while people took part in activities and petted the visiting dog; the dementia café was well attended. The hospice had purchased a minibus and staff were planning to accompany people on an outing to a museum and to a local park.

New systems to gather people's feedback about every aspect of the service had been implemented. Comment boxes had been placed in the reception area, the IPU and in the Outpatient Centre. Collected comments were regularly logged, reviewed by the CEO and registered manager, and as a result an action plan was implemented. Where a contact name had been given, the person was responded to directly with an update of the action taken in response to their comment. A large comments wall was in the reception area, where people and visitors were invited to display any comments with sticky notes. These included, "What an amazing place! I was expecting to be in a sad environment but it's the total opposite" and, "The moment I walked through the door my fears just melted away; I was greeted by smiles and laughter, and surrounded by kindness." Twice-yearly satisfaction surveys had been scheduled for the IPU, the Community Outreach service, and the Outpatient Centre. The results of the last surveys that had been carried out in December 2016 had been analysed to identify any improvements and inform an action plan. A minibus transport survey had also been carried out.

Results of surveys were communicated to people and visitors. There was a 'You say, We did' display that showed how feedback had been acted on. For example, at people's suggestions, a hot trolley had been purchased for serving lunch; baby changing facilities had been fitted; the reception area had been re-decorated; new riser recliner chairs had been purchased in Magnolia Place; and an informative pictorial display showing staff uniforms and their individual role had been displayed. The Outpatient Centre survey carried out in Autumn 2016 found 75% people had access to symptom control advice when they wanted it, 100% reported dignity needs were being met, 100% said they felt listened to, and 92% enjoyed the activities laid on.

People knew about the complaint procedures which were displayed in the service. People and visitors told us they had nothing but praise for the service and did not have any concerns or complaints, but felt they would be able to approach a member of staff or unit manager if they had an issue. One person told me, "I have no complaints about any of the staff or what they do for me". A relative told us, "I get so much help here, I leave here feeling much better, no complaints." Complaints were logged appropriately, fully addressed in line with the service's policy, and analysed to see if lessons could be learned.

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people, which staff promoted throughout the service. People, their relatives, visitors and staff's feedback about the way the service was currently led was very positive. Their comments included, "Like anywhere the service has had many changes but the dedication by the staff to their patients has remained the same", "All the changes have been for the better", "It is a lovely place to work" and, "There is now proper structures in place, it runs much better." A relative told us, "They all work closely as a team of specialists. They provide a huge amount of reassurance, from everyone from the domestic upwards. I wouldn't have wanted my relative to be anywhere else."

At our last inspection in February 2016, we found that systems and processes had not been established and operating effectively to ensure the service was fully compliant with regulations. At this inspection, we found that improvements had been implemented consistently across the service.

The registered manager had achieved a considerable amount of improvements since she had been in post and had followed the action plan that had been written in response to our last inspection. They had kept the CQC regularly updated with their progress. They had put new processes in place to ensure that communication and cohesion was promoted across all departments. Documentation in regard to staff training, advance care planning, people's individual likes and dislikes, complaints logs and recruitment was appropriately completed and monitored. For example, there had been a 60% increase in people having participated in advance care planning since our last inspection; 64% increase in recorded likes, dislikes and wishes; and 77% increase in people having expressed wishes about resuscitation that were appropriately recorded.

There was a comprehensive programme of audits and of quality assurance checks that was in place, embedded in practice and effective. An audit and research group met every two months to discuss the auditing system's schedules, time table, and research opportunities. The heads of departments and the registered manager completed regular checks, audits and reviews to ensure good standards of care were upheld. For example, audits included spot checks of people's healthcare records to ensure all documentation was in place and completed; drug incidents; all aspects of medicines; infection control; Out of Hours activities; pressure ulcer audits, mobility and falls, bowel management on the IPU, staff attendance in regard to training and their supervision, and satisfaction surveys. Each audit was scheduled, allocated and their outcomes were analysed to identify any improvement. As a result of an audit on falls, mobility and safety care plans templates had been improved to include more details.

The registered manager had identified that the hospice was improving in relation to accident and incident reporting due to an emphasis on a 'learning from' culture that focused on how improvements could be made. Staff meetings' agendas included the importance for staff to be transparent and report each incident or accident so this could be appropriately investigated. This was confirmed by staff we spoke with as they told us they could report concerns and they were confident that managers would investigate appropriately. In the Summer of 2016, awards had been introduced to recognise staff and volunteers' contribution to the hospice's values, vision and strategy.

Action had been taken to drive improvement in staffing levels to ensure people were cared for by specialist staff. A palliative care consultant, two dementia specialist nurses, an occupational therapist and an A&E nurse had been recruited; the education department had been re-structured to render staff roles more effective; and a practice development nurse had joined the IPU.

People's feedback was taken into account in all departments, and was gathered on a daily basis. Positive feedback was used as a bench mark to improve the next satisfaction surveys. A 'patient and carer engagement group' had been re-named and its terms of reference improved, in order to become a more structured and meaningful experience feedback tool. The group invited visitors, staff and people to talk with their representatives to help them identify what worked well and could be improved in the IPU.

Staff forums were held quarterly at the service to ensure that staff were engaged with developments within the service and made aware of developments within the sector. These included 'Questions and answers' sessions, which were open sessions at a forum chaired by the CEO. The questions the registered manager asked to the heads of departments were based on the Health and Social Care Act requirements and formed a 'Critical Friend Inspection Project', from which learning was used by staff to ensure compliance of regulations and ensure readiness for the CQC inspection. where the registered manager provided a topic relevant to care to each head of department for them to discuss with their individual team and report their findings to the forums. A new representative group called 'The Voice' had been created to attend quarterly meetings with the CEO and head of human resources, to discuss the service, represent their views and bring new ideas and approaches to the fore. All staff had been invited to nominate their representatives. Schwartz Rounds for staff (forums where all staff come together regularly to discuss the emotional and social aspects of their work) and 'Bite size' training sessions were well attended by staff, and a complex case review was held every third week to positively challenge staff knowledge and resourcefulness.

There was a clear management structure in place. The CEO was actively involved in the service and oversaw four directors including the patient services director who was the registered manager; the medical consultant; the finance director and the income generation director. Each director oversaw between two to eight departments each, which were well organised.

All the feedback we obtained on the management team was very positive. The CEO was described as 'receptive to ideas' and several staff members commented on how 'visible' they were within the hospice. Staff and volunteers within the hospice told us that they could always approach the CEO if they had concerns or comments. One staff member told us, "It doesn't matter how busy she is, I've never felt it was an issue to approach her". Another staff member told us the CEO was 'amazing' and commented that they always took time to speak with staff and the people they supported within the hospice. A volunteer told us that the CEO "Always addresses people by their Christian name and gets to know them." They commented that 'This ethos filters down into the ethos of the place'.

The Registered Manager led an initiative where she and four colleagues submitted five abstracts to the International Palliative Care Congress (ICPC); all five were successful and four posters were presented at the ICPC in Scotland in March 2016. The poster topics were, Hospice Innovative Dementia Service, Innovation in introducing trained Patient Care Volunteers, Bite-size Learning and Education within the Hospice Environment. The fifth piece of work was a Creative Art project (collage) carried out by patients called "What makes me happy"; this piece of work went on to be a finalists in the Building Better Healthcare Awards.

Staff were positive about the support they received from the registered manager. A staff member told us that

the registered manager 'Has her finger on the pulse'. Another staff member described the manager as "One of us" and "Respectful." They said the registered manager was prepared to "'roll up her sleeves" and help when this was needed. The registered manager and the CEO both had an open door policy and they were keen for staff to share ideas. A staff member told us "They want our input; they value what we have to say". Thirty-five volunteers had been trained and wore uniforms in the IPU and the Outpatient centre, working alongside staff. One volunteer told us, "The way we work together is inspiring, we feel supported and uplifted by the whole staff team, the managers, the 'whole feel' of this place."

The manager of the IPU was described by staff as 'organised' and 'approachable'. They told us that this made their own jobs easier and they had confidence in the leadership within the hospice at all levels. A staff member commented that they had been supported in their development and expressed the view that the managers within the hospice had the expertise and experience to train more junior staff effectively. They told us, "I know that I'm being taught all I need to know. They know how to develop me in my role". Staff in the community team described their new manager as "energetic", "empathetic" and "full of ideas."

New trustees had attended an induction and this included an introduction to the work of all of the departments within the hospice. The patron for the hospice was also closely involved with the operation of the hospice and often visited. There was a regular programme of trustee visits that included a review of all aspects of the service.

Links with the community continued to be actively sought and maintained through a series of fundraising events and challenges. These included a Christmas Fayre, sponsored golfing days, marathons, fun runs, moonlight walks, countryside walks, fire walks, bike rides inland and abroad, skydiving and trekking in the Sahara desert. Such events improved people's experiences as they were actively included and connected with their local community. There were approximately 600 volunteers actively supporting the service. Fourteen shops, an established café/bistro in the hospice and a second café/bistro situated in the centre of the town provided opportunities for people to engage in social gatherings.

The premises had been undergoing a redecoration programme. An IPU 'face lift group' had been created to re-design and re-decorate nurses' office and corridors, and new furniture had been purchased. The décor and interior design created a welcoming environment. People told us, "This is a wonderful place, they made it like a home from home" and, "This place is happy, inviting, the opposite of doom and gloom."

Archived records were kept for the appropriate period of time in accordance with legal requirements and disposed of safely. All records relevant to people's care were well organised, fit for purpose and kept securely and confidentially