

Peace Hospice Care

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Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 28 April 2016 and was unannounced.

Peace Hospice is registered to provide specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver physical, emotional, spiritual and holistic care through teams of nurses, doctors, counsellors and other professionals including therapists. The service provides care for people through an 'In-Patient Unit', Day Service, 'Out-Patient Care' and 'Community Outreach Team'. The out-patient services included rehabilitation, wellbeing, bereavement and counselling support. The community outreach team consisted of a single point of referral for 'Hospice at Home' service and 'Herts Neighbours' service which reached out to people in the community and provided a range of services offered by volunteers employed by the hospice. 'Herts Neighbours' service did not include an activity regulated by the Care Quality Commission (CQC).

At the time of the inspection there were six people using the inpatient service and 60 people using hospice at home services. The day services called 'Starlight Centre' offered a range of services to people recently diagnosed with life limiting conditions, their carers and families. The service provided specialist advice, courses, complimentary therapy sessions and clinics and aimed to empower people to be in control of their condition and achieve what was important to them. The Starlight Centre also offered counselling and bereavement service through teams of volunteers and contracted accredited counsellors to people and family carers.

Peace Hospice had 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.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risks to people's well-being were assessed by staff daily and the majority had measures in place to mitigate risks and keep people safe. Hospice at home staff communicated any risks to people's health and well-being to health and social care professionals involved in people's care in the community. They followed up and reviewed risks regularly to ensure these were appropriately managed and mitigated.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. People told us they were fully involved in setting their priorities for care. Care plans in regard to all aspects of people's medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people respecting their wishes and preferences.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. Staff reported any concerns so that these could be reviewed and discussed to identify if lessons

could be learnt to reduce the likelihood of reoccurrence.

Recruitment procedures were robust and ensured that staff working at the service were qualified and skilled to meet people`s complex needs. There were sufficient numbers of staff to ensure people received support when they needed it.

The service operated a 24 hour medical and duty manager on-call system for all the services offered by the hospice to ensure people received the same support and advice during the day as during the night. People using the inpatient service had their medical needs met by a team of doctors employed by the hospice.

People who used the Starlight Centre told us that this service enabled them to meet people with similar conditions and helped them prepare for the future. People told us that staff understood their individual care needs and were compassionate and understanding. Staff told us they undertook training which enabled them to provide good quality care to people in the inpatient unit and in their own homes.

People's medicines were administered by trained and qualified staff who had their competency assessed by the practice development nurse and monitored by their manager. Any changes in people`s medication were discussed by the medical team, nurses and pharmacist to manage and support people's symptoms and pain management. Medicines were regularly reviewed and audited to ensure they met people's needs.

The registered manager and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were dedicated in their approach to supporting people to make informed decisions about their care.

People and relatives were very positive about the caring and compassionate attitude of the staff delivering the service. They told us they were completely satisfied with their care and thought highly about staff and management. Staff were very motivated and demonstrated a commitment to providing the best quality end of life care in a compassionate way. People's wishes for their final days were respected; staff went beyond their duty of care to ensure people could have their last wishes fulfilled.

The management structure was under review and the provider was making changes in lines of responsibility and authority for decision making and leadership in the operation and direction of the hospice and its services. Although this was under review staff we spoke with were clear about their responsibilities and the lines of authorities within the service. The registered manager and the provider was committed to improve and broaden the services the hospice offered.

The service actively encouraged and provided a range of opportunities for people who used the service and their relatives to provide feedback and comment upon the service in order to continue to drive improvement.

There was a comprehensive auditing programme for all the services the hospice provided carried out by the management team. Action plans were comprehensive in detailing actions taken, time frames and the responsible person for the actions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Staff had been trained to recognise and respond to any actual or potential abuse. The service had developed systems for reporting and monitoring allegations of abuse.

Potential risks to people were assessed and measures put in place to reduce risks. Accidents and incidents were analysed and learning was shared amongst staff to prevent reoccurrence.

There were sufficient numbers of staff with the appropriate skills and knowledge to meet people`s needs at all times.

People received their medicines from staff who were trained and qualified in safe administration of medicines and the use of specialist equipment to ensure people received their medicines in time and safely.

Good 

Is the service effective?

The service was effective.

People received support and care from a staff team who were trained to meet their needs. Training was well managed by a dedicated team within the service. Staff were encouraged to develop their knowledge and skills.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making decisions about all aspects of their treatment and care.

People were supported to eat and drink and maintain a balanced diet. People were able to choose from a varied menu, which included a range of specialist drinks for those with a reduced appetite.

People's health needs were carefully monitored by nursing staff and if people`s health required, appropriate referrals were made to other professionals.

Good 

Is the service caring?

The service was very caring. People's and their relative's feedback about the caring approach of the service and staff was overwhelmingly positive.

Staff showed kindness and knew how to show empathy when people faced challenging situations. People valued their relationship with the staff team who often performed beyond the scope of their duties and helped people achieve their last wishes.

The service was very flexible and responded quickly to people's changing needs or wishes. Staff communicated effectively with people and treated them with 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.

Outstanding 

Is the service responsive?

The service was responsive.

People and their families were fully involved in assessing and reviewing their needs and planning how their care should be provided, which included their wishes and priorities regarding their end of life care and preferred place of death.

The service provided person-centred care based on best practice and focussed on continuous improvement. Staff understood and anticipated people's needs which enhanced the quality of the care people received.

The service encouraged people with life limiting conditions and their family's early involvement in the hospice by organising diverse activity groups part of the Starlight service and complimentary therapies.

People's families were offered bereavement support and counselling as long as they needed it.

The provider had a positive approach to using complaints and concerns to improve the quality of the service and this was closely monitored by the management team.

Good 

Is the service well-led?

Good 

The service was well-led.

The service promoted a positive and open culture and provided a range of opportunities for people who used the service, their relatives and people from the wider community to comment and influence the quality of service provided.

The Board of Trustees, the Chief Executive and the Registered Manager were implementing a new management structure in the hospice and re-organising services to ensure they offered a long term sustainable service.

The service worked in partnership with other organisations to ensure they followed best practice and provided a high quality service.

There were robust auditing systems in place to ensure the quality of the service was constantly monitored and actions were in place to constantly drive improvement.

Peace Hospice Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 28 April 2016 and was unannounced.

The inspection was carried out by one inspector, a pharmacy inspector, a specialist advisor and an expert by experience. The specialist advisor had the experience of working as a nurse within the community and within the field of palliative care. The expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before our inspection we reviewed information that the provider had sent to us which included notifications of significant events that affect the health and safety of people who used the service.

We spoke with eight people who used the inpatient service and hospice at home service, 12 relatives, three volunteers, 10 staff and this included nurses, physiotherapist and care assistants. In addition we talked to a pharmacist, two service managers, the chief executive and the director of patient services who was also the registered manager for Peace Hospice.

We reviewed people's care plans to see how their support was planned and delivered. We looked at a selection of medication records to check medicines were managed safely. We looked at a range of policies and procedures, quality assurance and clinical audits and meeting minutes for different departments.

Is the service safe?

Our findings

People who used the inpatient unit and hospice at home service and their relatives were highly complementary about the service they received, they told us they felt safe and well looked after by staff who were knowledgeable and met their needs. One person told us, "I feel very safe. I would not know how to cope without them [staff]." Another person told us, "They [staff] are lovely. I feel reassured and safe because of them. I wish to reassure you [inspector] they [staff] look after me very well." One relative told us, "They [staff] are excellent. They couldn't have done more for my [relative]. When I got ill, I knew I want them [staff from hospice] to look after me."

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. Staff told us and we saw that they had safeguarding training and regular updates to ensure they were knowledgeable in safeguarding vulnerable people from abuse. They described how they would refer people to the appropriate organisation if they had concerns to ensure people were protected from potential abuse. We found that systems of reporting to safeguarding authorities and clinical incident reporting through the organisation's governance structure were robust and followed by staff. For example a staff member reported to their manager that they had found an unsigned gap in a person's medicine records. The manager followed this up with the staff member who was on shift and omitted to sign the records to ensure the person received their medicines. Although this was confirmed by the staff member it was also reported to the safeguarding authorities. This demonstrated that there was a strong commitment shown by staff and the management team to safeguard people from any harm or potential abuse.

People had individual risk assessments which were reviewed every time they received support from the service. We found that an initial assessment 'holistic assessment' was done for each person when they started using the service. This assessment looked at people's care needs, their wishes as well as the risks to every person's well-being. This was reviewed and developed further by nurses and other professionals depending on the needs of the person. However we found that at times there was a delay in updating records in relation to risks when people's needs changed. For example records for a person stated they were using their zimmer frame for moving around. We observed staff using the hoist to assist the person with transfers. Staff told us that the person was not strong enough to use their zimmer frame anymore. The physiotherapist has seen the person and recorded that they were too weak to use their frame, however there was no updated mobility care plan or risk assessment to detail what hoist and sling type they needed. Staff were knowledgeable and told us what equipment they had to use and we were reassured that the lack of records had no impact on the person's care.

Staff knew people well and were familiar with their needs and how to manage risks in a positive way to make it possible for people to achieve things that were important for them. For example a family carer of a person told us that their loved one wished to die at home and under no circumstances they wanted to be in hospital or any other care facility. The hospice staff made arrangements for specialist equipment including a bed and mattress to be fitted in the person's own home. As the person's health deteriorated staff increased their support not just for the person, but for their family carer as well to ensure they had time for themselves and that they could rest. They assessed the risks involved and communicated with the family carer and

person when they were still able to take decisions and respected the person's last wishes. The family carer told us, "[Person] would hate to be anywhere else but home, the staff from the hospice helps them to stay here as part of the family." They continued to say, "They [staff] help me look after [relative], without them [staff] this would not be possible." This meant that staff understood what was important for people and they offered support centred on the needs of the person and their family which enabled them to positively manage the risks involved in their decisions and helped them achieve their wishes.

Incidents and accidents were monitored by the registered manager who collated the information and this was then analysed and discussed in regular clinical governance meetings. Staff told us they were encouraged to report any incidents or near misses which occurred. These were categorised by the management team to ensure relevant actions could be taken to prevent re-occurrence. For example there were safeguarding incidents, incidents involving medicines administration, incidents regarding record keeping. Each type of incident had different actions and learning points which were shared with the relevant staff in meetings and handovers so lessons could be learned. There was an incident where a person had developed a pressure ulcer whilst using the inpatient unit at the hospice. The manager had investigated the matter and as part of the actions and learning they put together a team of nursing and care staff to analyse the evidence they gathered during the investigation and discuss what happened, what they have done well, what could improve and if the pressure ulcer could have been avoided. The team concluded that although due to the person's health the pressure ulcer was unavoidable they also identified areas they could do better. For example, full assessment to be done on the first day people started using the service, assessments to be checked and signed by nurses and any risks of developing pressure ulcers or any wounds discovered on admission to be discussed with the person or rightful representative. This meant that learning and awareness was promoted and staff at all levels were involved in improving the service delivered to people who used the service. This practice improved the quality of care people received and aimed to ensure people were comfortable and pain free.

People and their relatives for the hospice at home service told us staff were always on time and spent as much time with the person as needed. One person told us, "When they [staff] say they will be here, you can bet on it they [staff] will." One relative told us, "They never keep me waiting, they are always in time." Another relative told us, "They come and sit with my [relative] two hours a week; this gives me time to do things. The service staff gives us is marvellous. I cannot leave [relative] alone at all so it is priceless for me that I can rely on [staff] to come."

People in the inpatient unit told us their needs were met by staff at all times and staff were quick in answering if they had to press their bell for assistance. On the day of the inspection we saw staff assisting people in an unhurried way, call bells were answered promptly and staff were seen talking to people and their relatives as often or as long as there was a need for it. One person told us, "I was told by staff if I have a problem just ring the bell. They [staff] come quickly when I ring the bell." Another person said, "I feel very well looked after. They [staff] are always checking on you, including at night which is very reassuring."

The registered manager told us that they had proposed to the Board of Trustees to temporarily reduce the number of beds in the inpatient unit from 12 to eight due to staffing issues. Although they were advertising for the staff vacancies they had not found the right skills and experience they were looking for in the candidates. The registered manager told us that if the eight beds were occupied and they received a referral for the inpatient services they were assessing their rota's and if staffing levels were assessed as safe and meeting people's needs they opened an extra bed. We saw an example on the day of the inspection when there were planned admissions in the empty beds and the need for the ninth bed rose. The registered manager was assessing the staff rota's and discussing staffing with the chief executive to ensure there were sufficient staff to meet people's needs at all times.

Staff told us they had enough time to spend with people and they felt there were enough staff around to meet people's needs. They told us they valued the help of the volunteers working at the service. They appreciated that the registered manager took action and reduced the pressure on existing staff by reducing the bed capacity in the inpatient unit. They also told us that recently they had newly employed staff members joining the team. One staff member said, "We [staff] rely and appreciate the support from the volunteers." Another staff member said, "We [staff] are fine, we had new staff starting recently. There are enough staff to attend to people."

Staff rotas were planned for six weeks in advance and ensured there was a good skill mix within the teams. For example there was always a senior nurse and a manager on duty or on-call. Different levels of qualifications for nurses and experience was considered when doing the rotas. Staff leave and absence was managed and covered by regular agency staff who always worked with a permanent staff member and had a thorough induction when they started at the service. One agency staff told us, "I work with another healthcare assistant and at times a nurse. When I started they showed me where things were, like the sluice and the forms to fill in and what I'm expected to do." They continued to say, "The staff are very supportive, they do an amazing job, they are advertising for jobs, so I may apply for a permanent position." This meant that there were enough staff with the right skills and experience to deliver safe and effective care to people who used the service.

Safe recruitment processes were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the hospice until it had been established that they were suitable to work with people. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and were obtained from their most recent employer.

People and relatives told us people had their medicine when they needed it and staff were quick to respond to any need they had. One person told us, "Here everybody seems to know what's going on when medications are changed they are on top of everything."

All staff involved in medicines administration had regular training and had undergone competency checks. We saw there were regular medicines management group meetings involving doctors, nurses and the pharmacist. This group was responsible for medicine policy review and audit. Medicine incidents were being reviewed at these meetings. There was a system in place to deal with alerts and recalls of medicines. People and their relatives had weekly care review meetings where nurses and doctors discussed with them issues around medicines and they consulted people and agreed medicine management plans. In addition the pharmacist was currently developing a leaflet to supply to people when medicines were used outside their licence to allow people to make an informed choice about their treatment. (The use of medicines outside their license is widespread within pain and palliative care e.g. mixing medicines together in a syringe pump and given through the skin). This meant that people were helped to make informed decisions about their treatment and this was administered to them by trained and competent staff.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room. There was a system in place to check that all medicines were within date and suitable for use. There were medicines available for use in an emergency and these were being checked regularly.

Medicines were checked when people were admitted to the hospice by the admitting nurse and then the doctor continued the prescription if appropriate. Every week each person received a review of their medicines in a therapeutics meeting conducted by the doctor and the pharmacist employed by the hospice three days a week who regularly monitored the medicines prescribed.

Staff had access to up to date references which provided information about the safe and correct use of medicines. Prescriptions forms were used so that people using the hospice at home service could get medicines from community pharmacies. A system was in place to track and monitor these prescriptions, however the way prescriptions were tracked was not fully effective and staff at the hospice would be unaware if some prescriptions were to go missing. We discussed this with the pharmacist who took appropriate action to rectify this issue.

At the time of the inspection people using the inpatient service were not self-administering their medicines but systems were in place should people request to do so. Blue medication cards were given to people when they left the hospice which listed all their medicines and explained how to use them. If people needed help with their medicines before they were discharged sometimes medicines were put into blister packs (devices designed to help people to take their medicines). Staff ensured that people were able to administer their own medicines from these packs before they left the hospice to ensure that they could use them appropriately. This practice helped people to independently take their medicines safely as intended by the prescriber even after they left the service.

Is the service effective?

Our findings

People and relatives we spoke with said that they thought that all the staff were well trained and they delivered an excellent service. One person said, "When they [staff] are helping me there's no moment when I don't feel they [staff] are not in control." Another person said, "Staff come and visit me regularly, they [staff] are so good and I don't worry for anything because they [staff] know what they are doing." One relative told us, "I have to praise every single one of them [staff]. They are very knowledgeable. They suggested a cream for [relative] to be used and that helped a lot and improved [relative] `s skin condition."

People were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and to the specific care needs of individuals. One staff member told us, "We have a lot of training and all staff are expected to go." Staff told us they received all the training that was required to work effectively and to provide the best quality of care. One staff member told us, "We have in-house, e-learning and external training. Every week we have Teaching, Information, Curiosity Learning (TICL) every Tuesday of the week with different topics on top of the ones we need to do."

Staff had access to training essential for their role and they were supported to maintain their professional registrations. There was specific clinical practice training such as advanced pain and symptom management, syringe pump driver updates and managing heart failure. Other training provided included ABC for palliative care, holding difficult conversations and mindfulness training which were undertaken by relevant staff according to their roles and responsibilities.

There was also specialist training in areas such as advance care planning and spiritual care for all the staff employed throughout the hospice. There were regular nurse revalidation workshops for the nursing staff registered with the National Midwifery Council to ensure they kept their registration and were kept up to date with recommended care practices. One nurse told us, "We have re-validation workshops and we learn how to write reflective practice notes which is part of our appraisal as well. This helps us keep on top of the work we need to do to keep our pin."

Staff told us they had regular supervision meetings with their manager where they discussed their training needs and performance. Staff said they met their manager often, usually monthly, and felt managers listened to their views. One staff member told us, "We have regular 1-1 meetings and yearly appraisals. We are very well supported by managers who are all very approachable." Another staff member said, "We have Clinical Supervision six weekly which is led by a staff member from the Bereavement Team. These sessions are very useful, if a death has been upsetting for us." They told us that staff had access to a support system outside of the hospice where they can ring and have support sessions confidentially. This support helped to ensure the care people received was provided by staff who were emotionally supported and valued and had the opportunity to reflect on their work and practices to drive improvement.

The registered manager appointed qualified and experienced nursing staff to take on lead roles in different areas like infection control and tissue viability (Skin and wound care). The staff taking on these roles were offered more specialist training and they were able to support staff working at the hospice daily with their

expertise. One staff member told us they had an update in their lead role and they were putting together an information pack for staff to use on a daily basis for people to receive consistent care which followed best practice.

New staff completed a comprehensive induction programme which included topics related to health and safety and infection control, incident reporting and communications skills and also training on how to sensitively handle subjects surrounding death. We found that the same induction training was offered to volunteers who worked at the hospice. After the induction process all staff attended a five day palliative care competency programme, to support their knowledge and skills of working in the hospice. This practice helped to ensure that the care people received was consistent and staff were competent and skilled to meet people`s needs effectively.

People told us and we saw that they were asked for their consent to the care and the services they received from the hospice. One person told us, "They [staff] listen to me and they check if it is ok with me before they do anything." Another person said, "They [staff] explain clearly why I should think about changing something in my care, but they also ask me how I feel about it, and what I think. If I said I didn't want something then they wouldn't make me have it." One relative said, "[Relative] `s speech is not good, nobody can understand what they are saying, however staff will always talk to them and ask if it is ok what they are doing. They are very good."

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. We saw examples when people were supported and involved in decisions if they wanted to be resuscitated in case of a cardiac arrest. Do Not Attempt Cardio Respiratory Resuscitation forms had been signed by the person and only after it was explained what were the implications of having this in place. This meant that people were enabled to make informed choices and decisions regarding their life and treatment.

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 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. At the time of our inspection people using the service had capacity and did not require any DoLS. However staff understood the role of the MCA and the need to act in a person's best interests if the person they cared for had difficulty making a decision, for example about their treatment or their wishes as they approached the end of life. Staff described how medical staff assessed the person's mental capacity and they would discuss whether the service needed to make decisions in the person's best interest. Best interest decisions were taken following a process which involved a meeting with nursing staff, consultant and the person was present or their rightful representative. The registered manager submitted applications to the relevant authorities.

People and relatives we spoke with commented favourably on the choice and quality of food available and on the steps taken by staff to ensure that people had food they preferred to eat. One person told us, "The food is top notch; couldn't get any better. There are two choices on the menu and if you don't like what's on the menu, they [kitchen staff] will get you something else." One relative told us, "Staff checked out what [person] didn't like when they moved in." Another relative said, "The chef knows what [person] has been eating and comes round in the afternoon to discuss and advise on the evening meal. The food is good, well cooked and the soups are exceptional."

Staff told us that they were in the process of using a new Nutritional Care Assessment for people when they started using the service. This assessment was more detailed about people`s choices and requirements than the one staff used before. We saw a detailed research carried out by a group of staff in partnership with a dietician and the chef. They looked at meal times, menus, people`s choices and preferences and also to effectively use food supplements for people with poor appetite or low food and fluid intake. As a result of the research there were new menus introduced and the nutrition policy was under review to reflect the changes made.

Staff were not routinely weighing people on admission, unless this was a requirement as a result of a multi disciplinary meeting. One staff member told us, "We don't weigh people unless it has been requested by the GP or there is a reason such as heart failure, where we may need to monitor the weight due to fluid retention. Some people can be sensitive about this due to their illness causing weight loss." Staff told us they offered people choices if their appetite had reduced. They said they could offer people smoothies with a high calorie count or snacks if people felt they were unable to eat a full meal. They also offered a range of choices which met people's cultural traditions.

Staff liaised with the community nurses and GP surgeries regarding people`s health who used the hospice at home service. People in the inpatient unit had on-going medical support. Various complimentary therapy sessions were available at the hospice where people had on- going support from a physiotherapist, specialist nurses and other complementary and creative therapy specialists. People also had access to services provided by a social worker and spiritual care coordinator. The aim of these clinics was to provide support to people with regards to symptoms and managing their life limiting condition. It was an important aspect of supporting people to maintain their health and receive on-going support. People told us attending these clinics and the day service was an opportunity for them to meet with others who had similar symptoms and it helped them learn about their condition and how to effectively manage these.

People had medical support over weekends as well. The medical team worked closely with doctors from a similar service and they covered weekends on an alternate rota to ensure people and staff had medical advice and continuity of care was maintained out of hours as well. Staff from the hospice at home service told us their first point of call for medical advice was people`s own GP however for more specialist advice or out of hours they turned to the consultant from the partner hospice or Peace Hospice who was able to give the advice and even carry out visits to people if it was needed. This meant that people using the service had access to professional help and advice over a 24 hour period. This gave people reassurance and advice on pain and symptom management and helped people to cope with their condition. One relative told us, "I called them [staff] on Christmas Day and they came and got everything under control."

Is the service caring?

Our findings

People and relatives were overwhelmingly positive about the care provided by the hospice staff. They told us staff were approachable and showed empathy towards people. People and relatives told us staff were exceptionally friendly, kind and caring. One person told us, "They're extremely caring; nothing seems to be too much trouble." Another person said, "The care is outstanding here." One relative said "They give the complete package; they think what support the family needs as well as the person. They've been so helpful in talking to [person] who is finding all this very difficult."

People told us and we observed staff respected their privacy and dignity. We saw staff knocking on bedroom doors and closing curtains if they were caring for the person as well as closing doors. Discussions regarding people`s care and needs were held in private and in an empathic way. One person told us, "Staff and the doctors have explained things very clearly to me and they have done it very sympathetically." One staff member told us, "Against all odds we work in a very happy and peaceful place. We meet unique people and families and it is very humbling to be able to walk with people in the journey they have." This meant that people were treated as individuals and staff were knowledgeable and understood how to promote privacy and dignity for people in a very vulnerable position.

Staff developed very positive working relationships with people. We observed staff attending to and approaching people using the service. From the discussions they had with people it was obvious they were knowledgeable about their needs and how to support them. All staff we observed had a gentle and calm approach. They created a sense of peace and comfort for people. For example we overheard a staff member talking to a person down in the lift, they were reassuring the person saying, "I will meet you downstairs next week when you visit, you never have to walk in the corridors on your own." This meant that people were supported in a caring way by staff who recognised their individuality and the support staff gave to people was personalised to each individual.

People we spoke with told us that they had made decisions about their care, which included advanced decisions with regards to future treatment. People told us that each week they had a care review where the team from the hospice, doctor, nurse, social worker, the person and their family reviewed the care the person received and agreed changes if any. One person told us, "If I'm feeling down there's no hesitation in talking to me. There's always someone to talk to and that's a really big help. I have a care review weekly where we discuss everything." Another person said, "I am involved in planning what is happening and they [staff] have a meeting with everyone together. "

One person who was using the hospice at home service told us that staff from the hospice looked after their family member who died in the inpatient unit a while ago. They told us, "They couldn`t have done more for [family member], so when I got ill I knew I wanted them [staff] from the hospice to look after me." They continued, "They [staff] talked to me about my wishes and my preferred place of death. I told them [staff] I want to be in the inpatient unit at the hospice. I could not think of a better place to be looked after in my final days."

This meant that people were involved and informed about the care they received. Staff having discussions with people about the future when they started using the service enabled people to prepare and make informed decisions about what was important for them and make the most of their remaining time. We talked to the social worker employed by the hospice who told us about this distinctive skill, "We help people to feel at peace with themselves and their illness. We help them establish what is important to them and prioritise." They told us about a person who they were working with to build up a "Legacy of happy moments" to leave behind for their family to remember them after death. During the inspection we saw the social worker meeting with the family and the person to talk about the priorities and how to achieve those. They told us, "First we work closely with the medical team to build the person`s strength up. Then we will start on building the memories they want."

We talked with a group of staff working at the hospice and we asked them to tell us why they were working at the hospice and to tell us if they felt they were making a difference to people nearing the end of their life. They gave us numerous examples of compassion, when they helped people accomplish their last wishes which then gave people a sense of achievement, happiness and peace before death. For example staff talked about a person who`s last wish was to feel the sand from the beach where they grew up and have exotic cocktails whilst at a beach party. Staff decorated the person`s room, brought sand in and a water pool and made cocktails for the person to enjoy. Staff told us the person enjoyed their beach party, they were happy and laughed.

Staff told us about a wedding they organised in two days for a person who`s last wish was to marry their partner. Staff were bridesmaids and witnesses which made the person feel very happy and accomplished. Staff told us the person died very shortly after the wedding.

We heard several examples where staff took people out in a bus to a dancing competition, admitted a person in the inpatient unit with their pet as they were inseparable, they even organised a horse to visit for a person who was dying and wanted to pet a horse for the last time. One of the staff told us, "It is not about big things it's about everyday little things people care about in the end. Speaking to people as adults and not ill people makes a huge difference and people will open up and tell us their wishes. We will do everything we can to make it happen and see them die in peace." This meant that people were supported in a caring way by staff who went over and beyond their duty of care to help people achieve their last wishes before they died.

People had access to information about the services provided by Peace Hospice, which was given to them when they started using the service. The information leaflets provided covered a range of topics, which included practical support, information about advocacy services, and information of other organisations that provided support. Information booklets about specific health related conditions were used by staff in the hospice and given to people to help them understand their health needs and how to manage them. People had access to an information hub within the hospice where they had internet, computers, video and reading materials to find information about their illness and services available to them. This meant people were supported to have access to information relevant to them to help them make decisions about their care.

Is the service responsive?

Our findings

People told us the service staff delivered was very responsive to their needs. People and relatives from the inpatient unit and hospice at home service appreciated that staff involved them in regular reviews of their care. They kept all the agencies involved and up to date with regards to people's needs who used the hospice at home service. One person told us, "Staff keep me in the loop and talks to my GP if there is a need for it. This is a huge help for me." Another person said, "We are definitely fully consulted about planning care and what happens next." One relative said, "They [staff] care for you by doing it with you rather than doing it to you."

We observed medical and nursing staff in the inpatient area discussing and developing plans with the relatives of a person whose health was deteriorating. Relatives told us they appreciated the responsiveness of staff and their ability to give them clear straightforward information empathetically.

The staff from the hospice provided a range of rehabilitation, wellbeing, counselling and bereavement services through its Starlight Centre. During the day of the inspection we observed and talked to people whilst they were participating in a 'breathlessness' session for people with lung conditions and people were also observed participating in meditation and Help Overcoming Problems Effectively (HOPE) sessions.

A wide range of therapies that were additional to medical and nursing care were available to respond to people's needs in regard to relaxation and general wellbeing. Complementary therapies included aromatherapy, massage, reflexology, music therapy, yoga, occupational therapy and physiotherapy. People were able to try and choose the therapies they preferred and when they wished to have them.

People told us that they appreciated and valued the services and in particular the social interaction and support which these enabled. One person said, "It's made an awful difference to me; staff listen to me and I can get things off my chest." Another person who had breathing difficulties told us, "It helps with my breathing and you can have a chat with other people." Another person told us, "The best thing is that staff do listen to us, talk to us and encourage us."

The service employed a social worker whose role was to support people and their families with legal issues like making a will, dealing with safeguarding issues, dealing with people's and families anxieties and fears, care planning and arranging safe discharges to people's own homes or other services. They told us, "I am privileged to do a work which is rewarding and makes such a difference to people and their families." They told us they worked very closely with the spiritual leader and bereavement support staff and volunteers to ensure people and families had all the services available to meet their needs holistically. They said, "Very often people need spiritual support, as they are searching for some meaning and answer to 'why' they are going through this journey. This is not necessarily linked to their religion, however we built links with representatives of all main faiths in the community and if people need it we arrange the support for them."

The 'Quiet Room' within the hospice had resources appropriate to the spiritual needs of all main faiths and we saw this was often used by people and families in search of peace and quiet.

People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life. There was a 'memory tree' onto which relatives placed remembrance messages. They were encouraged to attend support groups and socialise in the support groups at the Starlight Centre in a comforting setting to ease their grief. A relative described the service as a "Gift from above." Therefore the service provided emotional support for families that was continual, beyond the provision of care for people.

People's care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the inpatient unit, and when people received support from the hospice at the home service, staff sat with people, enabling them to spend as much time as they needed and encouraged them to ask questions, discuss their options and reflect upon them. As people and staff worked as a team to ensure each support plan was unique and responded to specific needs, people felt valued and understood. People were encouraged and helped to complete advance care plans to record their wishes regarding how and where they wanted their end of life care to be managed.

People's wishes were at the centre of their care planning. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. People`s constantly changing needs were assessed and discussed by staff on a daily basis or more frequently in order to address them appropriately. Staff attended thorough handover meetings at the beginning of their shift. Each person was discussed in depth including care needs, changes to treatment and care plans and medication requirements. There was a two hour overlap between the morning and afternoon shifts. Staff told us this time was used for a more in-depth handover if it was required, or to attend training. This was an excellent practice, it demonstrated there was dedicated time for handover and recognition that people`s needs and condition could change quickly, as well as their care or medication needs. It also recognised that training was essential to maintain the knowledge and skills of the staff to enable them to deliver the best possible support to people.

People, relatives and staff were encouraged to comment on the way care was provided. There was a robust complaints procedure in place. Staff, people and their relatives told us they would be comfortable to complain and would do so if necessary, however they had no complaints about the hospice, only praise. One person said, "I don't have anything to complain about. I cannot praise the service high enough." Another person said, "I have no worries and no complaints. I am pleased with the staff and the care I receive."

The registered manager provided us with detailed information about one complaint that had been made by a relative recently. They thoroughly investigated the complaint and responded appropriately. There were regular surveys carried out to seek the views of people using the service. We saw that results were analysed and where people suggested areas the service could improve on these were developed in an action plan and discussed on management and Board of Trustees meetings to ensure everyone worked collaboratively to improve the service. For example one survey highlighted that people who were using the inpatient service although they had staff available at all times, they felt isolated in their bedrooms. They suggested a communal sitting area close to their rooms in case they had to return to their bedroom to give them the opportunity to socialise more. We found that this area was created by the registered manager and used by people and their families to socialise. They told us they liked being out from their room and see staff walking around and be close to their own room should they needed to rest. This demonstrated that the provider valued and listened to people`s voice and acted on their suggestion to adapt and respond to their needs.

Is the service well-led?

Our findings

People and their families were all very positive about the care provided and the management of the hospice services. One person told us, "I think it's well managed and although it's a hospice it feels a happy place." One relative told us, "The hospice is well organised; everyone knows what they're doing; it's calm and friendly; and everywhere you go you meet someone who asks if they can help you."

Every person we spoke with told us that all staff, regardless of their role were friendly, kind and supportive and gave them comfort and a `sense of calmness`. Our observations and discussions we had with staff demonstrated that across all areas within the service they were motivated and enthusiastic and committed to providing a high quality service, to people, and their families. One staff member told us, "I feel I have an important role and that I'm respected by seniors, managers and doctors." Another staff member said, "I'm doing something worthwhile, and everybody appreciates it."

Staff told us they felt well supported and are encouraged to learn and improve their skills and knowledge. They felt part of a team and valued by the senior staff, managers and doctors. The system implemented by the registered manager of having lead roles so that staff developed training skills, improved their knowledge and took ownership of areas such as tissue viability, infection control and health and safety and acted as a resource for others was an excellent method of maintaining high standards of care.

Staff talked to us with passion about the hospice and the people in their care. They told us they enjoyed their job despite the challenges and the nature of the work and they valued the support they received from their peers and senior managers. They told us they knew about changes in the management roles in the different departments in the hospice and although the change was unsettling for them they felt well supported. One staff member told us, "Managers, even the Chief Executive is very supportive. They come on the floor and talk to us. We get regular updates on where the hospice is going." Another staff member said, "I understand the need for change and that we have to be cost effective, I love this job to be able to get people into the best place, it could be the unit or at home. The change will enable us to continue to do this."

There was a management structure with senior staff allocated in lead roles; this included a registered manager for the service, clinical audit lead, head of education and a manager of each of the services offered by the hospice. The management structure for the services offered was under review. Some of the management roles were merging together and job roles for managers were changing. However throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards. This meant that the change was managed effectively and had no impact on the services people received. The Chief Executive told us, "Communication is the key. Change can be unsettling, however this is managed in the way we engage staff in the change."

The registered manager was involved in national organisations representative of hospice services and they were dedicated to constantly improve the service. They were involved in a recent study funded by the

Clinical Commissioning Group (CCG) to offer support to lonely and isolated people with a life limiting illness in the community. This was called `Herts Neighbouring Service`. The manager of this service told us, "This service proved to be a very successful one. We run it with volunteers and offer befriending support, socialising, taking people to appointments and anything else they need."

Following the study the evaluation of the service was done by a university, however the service manager conducted a survey amongst the people who used this service and presented the results to the registered manager and chief executive. Due to the positive impact this service had on people`s life this was presented to the Board of Trustees who agreed funding for the hospice to continue the service until a decision was made by the cabinet office. This meant that the management was responsive to the needs of the people in their community and services offered by the hospice were shaped to meet these needs.

The registered manager regularly evaluated the service they ensured regular surveys were sent to people their families and staff to gather feedback on their experience of the service. We saw that these were carefully analysed and actions were taken to improve the service. For example, a person`s relative mentioned in the survey that over the weekend there was no availability of a variety of meals specific to the person`s culture and religion. The registered manger had a meeting with the person and their relative and put measures and actions in place to resolve this issue. They discussed with the chef and contracted a catering service who was able to provide the type of food this person needed. This demonstrated that managers and staff were respectful of people's cultural and religious needs.

Volunteers were an important part of the service and provided support in a variety of ways. Volunteers who were trained provided support for people who used the hospice at home and to their families. Others helped with daily tasks in the day service, serving tea and coffee to people and visitors and greeting visitors at reception. One volunteer told us they valued the introduction they had when starting working at the hospice and the regular meetings to keep them up to date with general hospice issues and developments. They said, "We [volunteers] are constantly being invited to "thank you events" and other meetings."

The registered manager worked with other organisations which provided a similar service for staff to health and social care providers and professionals to promote good practice through training and learning events. This enabled the management team to continually review the quality of the service provided and drive improvement. The provider also promoted learning and development within the wider medical community; they offered placements for trainee nurses and doctors.

The registered manager implemented systems to ensure they shared information with external organisations in a timely way, accidents and incidents were reported to relevant outside agencies including the CQC. This demonstrated that the management team promoted an open and transparent culture.

The registered manager explained to us the role of The Board of Trustees, whose members had specific areas of responsibility for which they oversaw and were responsible for. The Board of Trustees had an active role in the leadership of the service and met every eight weeks, providing clear directives to enable the service to work well. Senior management at the hospice had the responsibility for running the service, under the direction of The Board of Trustees. The Chief Executive and the Director of Patient and Quality Services [registered manager] attended board meetings and gave regular updates on all aspects of the service provided. We saw comprehensive reports on different aspects of the service provision and a long term service developments programme which was discussed at these meetings. This meant there was a good, effective and transparent governance system in place which ensured that the service people received was at a high standard.

There was a comprehensive auditing programme for all the services the hospice provided. These covered health and safety, medicines, incidents and accidents, training, care records and staff competency checks. Risk assessments were reviewed daily by nurses and health care professionals involved in people`s care and were updated appropriately. Staff were aware of the risks that related to each person and measures in place to mitigate these. We found one example where records were not updated promptly to reflect a person`s changing needs. The nurse in charge took this very seriously and immediate actions were taken to amend the records and also to highlight the need of further training for newly employed nursing staff. This demonstrated a `no blame culture` amongst staff and management and mistakes and errors were used as a learning point to drive improvement across the services offered.