

St. Luke's Hospice (Harrow & Brent) Ltd

# St Luke's Hospice Kenton Grange Hospice Harrow & Brent

## 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?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

This inspection took place on the 13, 15 and 16 September 2016 and was unannounced.

St Luke's Hospice Kenton Grange Hospice Harrow & Brent is a registered charity providing specialist palliative and clinical support for people over the age of 18 years with life limiting illnesses irrespective of diagnosis. The services provided included a 12 bed in-patient unit, a day service, outpatients' service and care in people's own homes provided by community teams. The hospice also provides support for families, friends and carers of people using its services.

At the time of our inspection there were approximately 760 people using or known to the service. Two of the beds in the inpatient unit were closed to ensure people's safety whilst there were a number of nurse vacant posts. The number of inpatients varied each day of the inspection.

The service had a registered manager who was the Director of Nursing and Patient Services of the hospice. A registered manager is a person who has registered with the Care Quality Commission [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 and associated Regulations about how the service is run. The registered manager was supported in the managing and running of the services by the Chief Executive Officer (CEO), Board of Trustees, Medical Director and other management staff.

People were very positive about the care and support they received from highly motivated staff. They told us staff were very kind, listened to them and respected their wishes and preferences regarding their care and support needs. People received a service which was person centred in meeting each person's individual needs. People were supported to be fully involved and to take the lead in all decisions about the care and support they received. They told us they felt listened to and were respected by staff.

People received care and support from a multi-disciplinary team [MDT] and volunteers. The staff we spoke with from all the services were very enthusiastic about their jobs and had a good understanding of their role and responsibilities. They showed they cared very much about the people they supported and were committed to deliver a high standard of service to people. Staff treated people with sensitivity and respect and had positive and caring relationships with people using the hospice services, people's families and others important to them. People's emotional, spiritual and other individual needs were met by staff who were competent, compassionate and caring.

People received the care, treatment and emotional support they needed as staff and volunteers had the training they needed to develop their skills and provide them with the knowledge and competence to meet people's individual care needs.

The hospice was committed to promoting high quality end of life care for people by providing education and training for a wide range of health and social care professionals working in the community, hospitals

and nursing homes. People with life limiting illnesses and those at the end of their life benefitted by receiving the care and support they needed from skilled and caring staff and were more likely to avoid hospital admission.

The hospice was responsive to people's feedback and very proactive in working in partnership with an exceptional number of other professionals and organisations to develop best practice and provide people with a range of services that met their individual needs including advice and emotional support.

People received the medicines they needed on time and in a safe manner. People's pain was monitored closely and managed well.

The hospice provided a 24 hour advice line for people in Harrow that used its services, their families and friends and for health and social care professionals. This service provided a range of advice including management of pain, symptom control for people receiving end of life care or support with managing a life limiting illness in their own home, hospital or nursing home. A rapid response team provided support, care and treatment for people within 24 hours. This and the telephone advice line contributed to people being supported to remain in their preferred place and avoid hospital admission.

People told us they felt safe when receiving care and support from the hospice services. Staff knew how to report concerns internally and to outside agencies and were confident concerns would be addressed appropriately.

There were systems and processes in place to protect people from the risk of harm. Staff knew how to recognise signs of abuse and report any concerns. Risks to people's well-being were assessed by staff and measures were in place to mitigate risks and keep people safe within the hospice and in their own home. There was a system in place to record, assess and monitor accidents and incidents. Incidents were analysed to minimise avoidable risks and the risk of re-occurrence.

The provider's staff recruitment process made sure that staff and volunteers were suitable to work with people who needed care and support. The registered manager and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and supported people to make informed decisions about their care. Staff knew when a person did not have the capacity to make a decision about their care and treatment that it would need to be made in a person's best interest. Staff knew when safeguards needed to be in place to protect people who were unable to make decisions about their care.

People knew how to complain and were confident that they would be listened to and any concerns they raised would be addressed appropriately. People were asked for their feedback about the service they received and staff were committed to learning from people's experiences and making improvements to the services when this was required.

People told us they enjoyed the meals, were offered choices and had their individual food preferences catered for. The importance of good nutrition was understood by staff and promoted. Risks of malnutrition were assessed and measures to support people to have the nutrition they needed were in place and regularly reviewed.

A range of activities were available for people using the day service or inpatient unit. These included complementary therapies which people spoke very positively about.

Staff and people using the service told us that the service had an open, inclusive and positive culture. Senior

staff showed clear lines of responsibility and leadership. They with their staff teams demonstrated a strong commitment to providing people with a safe, high quality and caring service and worked hard to promote, improve, extend and develop the service to reach as many people as possible within Brent and Harrow.

Systems were in place to maintain the safety of the hospice. This included addressing maintenance issues, fire prevention and carrying out health and safety checks of equipment and the building. A high standard of cleanliness was maintained in the hospice. Systems and processes were in place to monitor standards of hygiene and control of infection and to make improvements when needed.

A range of comprehensive and effective systems were in place to monitor and improve the quality of the services provided.

## 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.

People told us they felt safe. Staff knew how to recognise and respond to abuse and understood their responsibility to keep people safe and protect them from harm.

People received the care and support they needed from sufficient numbers of skilled staff. Staffing levels and skill mix within the hospice were adjusted to make sure there were sufficient staff at all times so people received the care they required in the way they wanted.

Risks to people were identified and measures were in place to protect people from harm whilst receiving care and support within the hospice or in their own home.

Medicines were managed and administered to people safely.

Recruitment and selection arrangements made sure only suitable staff and volunteers with appropriate skills and experience were employed to provide care and support for people.

### Is the service effective?

Good 

The service was effective.

People were cared for by staff who were skilled, motivated and committed to provide people with the care and support they needed. Staff received the training and support they needed to enable them to carry out their responsibilities in providing the specialist care people required.

People were provided with a choice of meals and refreshments that met their preferences and dietary needs.

People's health needs were carefully monitored by clinical staff and referrals were made to a range of other health and social care professionals when this was required.

People's liberty was not unnecessarily restricted. Staff were

aware of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and their implications for people using the hospice services.

### **Is the service caring?**

**Good** ●

The service was caring.

People spoke very highly about the care and support they received. Staff were approachable, listened to people and consulted them about their care and support.

People's emotional, spiritual and social needs were understood and valued. Staff demonstrated compassion, empathy and understanding of people's individual needs and respected their right to privacy and communicated with people in ways they could understand.

People at the end of their lives received the care they needed in a peaceful, comfortable and respectful way by very caring staff.

The well-being of people using the services and those important to them was promoted and supported. Bereavement services were personalised to meet the needs of family members and others important to them to be more able to cope with the loss of their loved one.

### **Is the service responsive?**

**Good** ●

The service was responsive.

Staff understood people's varied and often complex needs. People received personalised care that was flexible so people's individual needs and wishes were met at all times.

A dedicated contact line run by the hospice offered people, their families, carers and health and social care professionals' in Harrow advice and support. People could also contact the hospice at any time when they needed information and guidance.

People who attended the day service or inpatient unit were supported to take part in a range of recreational activities including complimentary therapies to promote their well-being and minimise social isolation.

A system was in place for addressing complaints. The provider had a positive attitude towards complaints and saw their role in

improving the service. People were confident that any concerns and complaints would be addressed appropriately.

### **Is the service well-led?**

**Good** ●

The service was well led. People and others who had contact with the service spoke positively about the services and the way they were run.

The leadership team promoted an open and inclusive culture, which fully involved people using services, those important to them, staff and the local community.

Staff demonstrated resolve to continually develop and improve the services they provided to benefit as many people as possible within Brent and Harrow. Staff were listened to and their individual skills and experience valued.

The service worked in partnership with a range of organisations to ensure they followed and promoted best practice within the hospice services and other care services so people with life limiting conditions received high quality care and support.

There were a wide range of quality monitoring systems to monitor and review people's care and to ensure the environment was safe. Action was continuously being taken to develop and improve the quality of the service.

# St Luke's Hospice Kenton Grange Hospice Harrow & Brent

## **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 13, 15, and 16 September 2016 and was unannounced. We also spent one day making calls to people using the service, staff and others who had contact with the hospice. The inspection team consisted of a lead inspector, a pharmacist inspector, a specialist nurse advisor who had palliative care knowledge and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR had been completed comprehensively and was discussed with the registered manager during the inspection.

We also reviewed other information we held about the service which included previous inspection reports and notifications. A notification is important information events which the service is required to send us by law.

During the course of the inspection we spoke with, either in person or on the telephone, eleven people who used the service and nine relatives and visitors. We also spoke to thirty one members of staff and two volunteers. This included the chief executive, registered manager, Trustees and other managers. We also



received feedback from six external healthcare professionals and representatives of organisations who had contact with the hospice.

We spent time in the inpatient unit and the Woodgrange Centre [day service] observing care and support. We were present during a staff handover meeting and during part of a 'ward round' in the inpatient unit.

We looked at six people's care records and other records relating to the management of the hospice. These records included; five staff recruitment records, staff duty rosters, accident and incident reports, complaints, compliments, health and safety, maintenance, governance and quality monitoring records and reports.

## Is the service safe?

### Our findings

People who used the range of services told us they felt safe when receiving care and support and had no concerns about their safety. Comments from people included "Yes, I always feel safe, the staff are competent and kind" and "Regular staff visit my [relative]. [Person] knows them. They explain everything and are kind and caring."

Staff and volunteers were aware of the policies and procedures to follow if they suspected abuse or poor care. They told us they would immediately report any concerns or suspicions of abuse to the registered manager and/or other senior staff and were confident that any safeguarding concerns would be addressed appropriately by them. They knew they could report abuse to the local safeguarding team, CQC and the police. Records showed that staff had received training about safeguarding adults. The registered manager told us and records showed that some staff were due refresher safeguarding training which was in the process of being put in place. Records showed staff had recently learnt about safeguarding people during a learning group session. A system was in place to record, report, monitor and review all safeguarding issues and to ensure learning and improvements were made when required.

There were systems in place to manage and monitor the staffing of the service so people received safe care and treatment. People's care needs were assessed and their dependency needs determined the staffing levels and skill mix needed to meet their range of often complex requirements in the inpatient unit. Senior staff told us this meant that staffing was flexible and increased when people's dependency needs were high. The registered manager told us that in response to there being five nurse vacancies a decision had been made by herself and other senior staff to temporarily close two inpatient beds to make sure there was minimal risk of people receiving unsafe care and treatment. This showed that the service was responsive to changes in staffing and people's needs so people received a safe effective service.

A person using the inpatient service and their relative told us they felt there were enough staff on duty at all times. Another person's relative told us "There are enough staff, they do a good job." An inpatient informed us that staff responded quickly to their call bell. We found call bells were accessible to people and promptly answered during the inspection and pain medicine administered without delay which indicated there were sufficient staff on duty. Staff told us they felt there were enough staff on duty to meet people's needs. We found from our observation, looking at staff rotas and discussion with staff that sufficient staff were deployed in the inpatient unit and the day service to ensure people's needs were met. Requests for assistance were responded to promptly and staff provided people with the care, treatment and support they needed. People using the services told us that staff also had time to sit with them and chat with them which they enjoyed and promoted their well-being.

People were protected because risks for each person were identified and managed. People's care and treatment records showed risks were assessed and guidance was in place for staff to follow to minimise the risk of people being harmed. People's personalised risk assessments included risk of pressure ulcers, malnutrition, falls, use of bedrails and moving and handling risks. Risks had been reviewed and updated regularly by clinical staff to reflect people's current needs and to minimise any risk. For example pressure

relieving equipment had been put in place and regular repositioning carried out to minimise the risk of a person developing a pressure ulcer. People's care records showed people using the service were fully involved in their risk assessments

Accidents and incidents were reported, recorded and reviewed to minimise the risk of further similar incidents. Staff were aware of how to report incidents and accidents and had notified us as required of significant incidents including a fall which had resulted in the person being injured. Staff demonstrated they had responded to the incident appropriately, learnt from it and taken action to minimise the risk of similar incidents occurring again.

A facilities manager and maintenance team were responsible for ensuring a range of health and safety checks were carried out to make sure the premises and systems within the hospice and community services were safe so people were protected. Equipment was regularly checked and tested to make sure it was safe and met legislation requirements. Regular checks of the hot water temperature of outlets; Legionella bacteria water checks, and regular servicing of the fire safety, gas and electric systems were also carried out to keep people safe. There was a maintenance on-call system that made sure a maintenance person was available when required. The maintenance team were responsive to the individual needs of people using services. For example they made sure they promptly tested the safety of all electrical equipment such as personal music systems brought into the hospice by people using the service. This enabled people to have access to their personal electrical equipment soon after their admission which met their needs and benefitted their well-being.

We heard a member of staff contact the maintenance team about a maintenance issue. This was responded to promptly. However, there was no record available to show an audit trail of the day to day maintenance jobs that were requested by staff and when addressed. The maintenance team told us a maintenance record book would be commenced and be available to all staff. The facilities manager told us that they were currently in the process of reviewing the health and safety and maintenance systems throughout the services to make them more effective. Health and safety meetings took place regularly where health and safety issues were discussed, action taken and minutes supplied to the board of trustees for review.

We noted that two hot water taps located on washbasins in a staff bathroom facility and in the kitchen were producing hot water at a temperature that felt very hot to the touch. Records showed that although checks of hot water outlets were taken place regularly the checks had not included these two taps. The facilities manager following the inspection informed us about the action that had been taken to ensure staff and people using the service were safe. This included more frequent checking of all the hot water outlets including those in non-clinical areas, and fitting thermostatic mixer valves [TMVs] to these washbasin outlets.

The provider received alerts about patient safety in respect of medical products, equipment and medicines and circulated these to the appropriate staff to take action if needed to make sure people were safe.

A fire emergency plan including evacuation procedure was displayed. Records showed that fire alarm checks and fire drills took place regularly. Although records confirmed that staff took part in fire drills they did not show that each member of staff including night staff had participated in them regularly to ensure they remain familiar with evacuation fire safety procedures. The maintenance person who had responsibility for fire drills told us they would ensure this was addressed and put a system in place which would indicate when staff needed to take part in a fire drill. Health and safety staff and senior staff told us and records showed that an emergency plan was in the process of being developed.

The five staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure only suitable staff were employed to care for people. These included checks to find out if the prospective employee had a criminal record or had been barred from working with people who needed care and support. Nurses registration with the Nursing and Midwifery Council [NMC] was checked monthly to make sure nurses were entitled to practise in the United Kingdom.

A person using the service told us about the medicines they received and confirmed they were administered at the right time. Nurses administered medicines. We observed them administering medicines to people in a considerate and safe manner. A person's relative said "The staff explain the medication, but [person] doesn't remember. If I ask them, they will write it down [for Person]."

We heard a doctor discussing a person's medicines during a 'ward round' on the inpatient unit. The doctor explained the medicines to the person and waited for the person to consent before increasing a dose of pain relieving medicine. During observation we saw staff responded promptly to requests from people for pain relief medicines.

We saw medication was stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so fit for use. At the hospice FP10 prescriptions [prescriptions used for outpatients that can be taken to any community pharmacy to be dispensed] were used for making sure people received the medicine they needed when discharged from the hospice and when attending outpatients. These prescriptions were stored securely and a log was kept of the prescriptions issued so it was possible to identify if any blank prescriptions were lost or stolen.

We saw appropriate arrangements were in place for obtaining medicines for people. Staff were knowledgeable of these arrangements and we saw that appropriate supplies of medicines were available to enable patients to have the medicines they had been prescribed when they needed them.

We looked at the prescription and medicine administration records (MAR) for four patients. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were receiving their medicines when they needed them. No gaps on the administration records indicated people received their medicines as prescribed and any reason for not giving people their medicines was recorded. However, when medicines to be given only when they were needed [prn] were written on the medicines' administration records, the doctors who had prescribed the medicine did not always include the maximum dose that could be administered within 24 hours. This possibly could put people at some risk of being administered more of a medicine than it was safe to do so. Action was promptly taken to address this and on the second day of the inspection we checked three people's prn medicine records and found they were recorded appropriately and safely.

The hospice received pharmacy and support via a service level agreement with a local provider. A pharmacist visited six times per month to review MAR charts, complete medicines audits and take part in the hospice medicines management group which met every two months to discuss medicines management and administration carried out by the service.

The hospice did not use any patient group directions [PGD], which are directions to a nurse signed by a doctor and agreed by a pharmacist, which permits a nurse to supply and/or administer prescription only medicines [POMs] to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. No patients were self-administering medicines when we inspected.

Controlled drugs were managed appropriately and the registered manager was the accountable officer

[person responsible for the management of controlled drugs and related governance issues in the organisation]. The hospice was a member of the controlled drug local intelligence network [LIN] which share information about controlled drugs incidents and concerns and, when necessary set up an incident panel to investigate a serious concern according to their local protocols and submitted as required quarterly occurrence reports about reportable medicines concerns and trends.]

Comments from people about the cleanliness of the service included; "It's clean." "It's very clean," "It's spotless" and "If there's even a spot of soup on the bedding, they change it. The floor is always shining." A person's relative told us that when a person needed to move to another bed staff were seen to clean the beds thoroughly.

The service had infection control policies and procedures. The hospice inpatient unit and day service were clean. Soap and paper towels were available and staff had access to protective clothing including disposable gloves and aprons. Hand cleanser was accessible to staff and visitors to minimise the risk of infection. The service has a designated infection prevention link nurse who had a role in undertaking specific tasks and supporting areas of practice on infection control. Nurses and doctors were seen to wash their hands in between having contact with people using the service on the inpatient unit. Cleaning schedules of daily and weekly tasks were carried out to control infection. Records showed infection control audits had been completed and action taken to make improvements when needed.

People's care plans included guidance about the signs and symptoms of the person having an infection and detailed the actions needed to be taken in response to any infection, which included reporting to nursing and medical staff.

A recent food safety check carried out by a local authority that included assessment of kitchen safety and infection control systems had rated the service as very good.

## Is the service effective?

### Our findings

People using the hospice services consistently praised the standards of care and support they received from staff. They told us they were very happy with the care and support they received from staff, who they said were very kind to them and provided them with the advice and support they needed. Comments from people about the staff and the service included; "They [staff] are wonderful," "They are kind and involve me in my care," "The staff are good," "The staff are very good. They've been excellent. They are very caring, very attentive, very calm, every single member of staff. They're checking on [Person] all the time." A person's relative told us that staff kept them and the person using the service well informed. They commented "I am very happy."

Staff including doctors, nurses and healthcare assistants were seen to respond to people's individual needs in manner that was very sensitive and compassionate and that indicated they had a good understanding of people's varied and complex needs within the inpatient unit and day service. Staff we spoke with in the community team were also very knowledgeable of the needs of people they cared for. People using the services and those important to them told us they felt all staff were competent and had the skills they needed to provide people with the service they needed and wanted.

Staff spoke in a very positive manner about their experiences of working in the hospice and the community team and showed significant motivation and enthusiasm when speaking about their jobs. All staff and volunteers we spoke with told us they enjoyed their work and were clear about their roles and responsibilities. They showed they were very caring, empathetic and knowledgeable about the needs of people using the service. They told us about the support they provided to people and those important to them. It was clear from talking with staff and from observation that the staff had a team approach to providing people with the care services they needed and wanted. Comments from staff included; "I love my job," "I love the relationships that you build with people [using the service]," and "I feel well supported."

The education team ensured staff received the induction and training they needed to undertake their wide range of duties. Staff, volunteers and an agency nurse informed us that when they started working in the hospice services they had received an induction, which included learning about the organisation and shadowing more experienced staff. They told us the induction had helped them to know what was expected of them when carrying out their role in providing people with the care and support they needed. Staff induction included a hospice induction day when new staff met all the team. Care staff received the Care Certificate induction which is currently the benchmark set for the induction of new care workers. The registered manager told us that the hospice works jointly with a local hospital to provide care staff with the Care Certificate induction. A healthcare assistant told us about their positive experience of their hospice induction and of the process of completing the Care Certificate. They told us they thought Care Certificate was "excellent" and said they had been well supported by staff when they completed it.

A volunteer spoke about having 'shadowed' another volunteer on several occasions which had helped them get to know the service and develop their skills for the volunteer role they planned to undertake. We were told by management that a Volunteering Development manager had recently been appointed to support

the team of volunteers and the training needs of volunteers were in the process of being reviewed so volunteers received improved training and support with their development.

Most health care assistants had completed vocational qualifications in health and social care which were relevant to their roles and responsibilities. A manager told us that in recognition of some health care assistants' abilities they had been supported to develop their skills to be competent to carry out a range of tasks to meet people's particular care needs such as changing a person's colostomy bag [a colostomy is surgical procedure to divert one end of the large intestine (colon) through an opening in the person's abdominal wall]. Healthcare assistants told us they were supported to develop their skills and competencies in a pace that suited their learning needs.

Records showed and staff told us they had received relevant training and learning to carry out their responsibilities. The hospice had a staff training plan. Staff training included face to face and electronic learning. Training records showed staff had completed training in a range of areas relevant to their roles. This included mandatory training such as; moving and handling, safeguarding adults, emergency first aid, health and safety, food safety, fire safety and infection control. Some staff were trained to provide manual handling training to other staff, which meant new staff could be promptly trained in safe moving and handling techniques, so start their jobs without delay and others remained competent. Training/learning was planned and developed to meet each member of staff's individual and specific needs such as providing IT training for staff who were deficient in computer skills.

Staff had also received training in other relevant areas including; management of oxygen, safeguarding children, cardio-pulmonary resuscitation, Mental Capacity Act [MCA] and lone working. Records showed the dates when refresher training was due for each member of staff and that reminders had been sent to some staff to prompt them to complete refresher electronic learning in some subjects. The registered manager told us that some staff had completed dementia awareness sessions and the hospice was looking at introducing dementia training for staff and appointing a nurse to be the dementia lead.

Staff we spoke with told us the training they received was good and when they identified particular training they needed their manager and the education team supported them in accessing it. The chef told us they had received food and hygiene training and had recently completed training about food allergies and food intolerance. A nurse spoke positively about completing a palliative care module course and told us they "really loved it."

The education team was responsive to making sure nurses clinical skills were up to date and they were safe and competent. For example a senior member of the education team had recently carried out a teaching session for nurses and other staff make sure they were competent to support a person with complex medical needs. The education and professional development manager told us many similar teaching sessions regularly took place. They informed us they would in future make sure these learning/training sessions with details of their content were recorded to demonstrate the range of learning carried out within the service.

Management told us and records showed that until the end of 2015 Schwartz rounds were carried out by the hospice. Schwartz rounds are where all staff come together regularly to discuss the emotional and social aspects of working in healthcare. The Schwartz rounds stopped as the facilitator left the service. We were told that their resumption was being considered and other support for staff had been put in place which included Monday matters and Your Voice meetings where staff had the opportunity to raise issues about their work, participate in debriefing sessions about complex cases and receive emotional and other support by the staff team. Staff told us "I have confidence action will be taken when I raise issues," and "My manager



listens and tells us about any changes to the service. I have never worked before in such a nice team."

Records showed that nurse revalidation sessions had taken place. The registered manager told us a range of topics were discussed and reviewed to support nursing staff to remain registered with the NMC. A nurse showed us their re-validation folder which included information about their clinical practice, training and learning they had received.

The hospice recognised the importance of working with external healthcare professionals in educating them about good quality end of life care and developing their skills to deliver it. Healthcare professionals had the opportunity to spend a day [Taster Sessions] at the hospice to gain knowledge and information about the service. Twenty one people had participated in these sessions between April and December 2015. The hospice delivered end of life education to GPs and medical and nursing students who complete placements at the hospice. GPs have the opportunity to complete Principles of palliative Care courses and attend GP education evenings provided by the hospice who works in partnership with the London North West Healthcare NHS Trust to educate GPs in Harrow in issues affecting patients at the end of their life.

The hospice had also worked with the London Ambulance Service [LAS] to enable trainee paramedics to complete a placement with the hospice at home team as part of their learning and a team leader from LAS had provided some defibrillation [use of a device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest] training for hospice staff. This showed positive partnership working in developing the knowledge of staff and others in supporting and caring for people who use services.

A hospice consultant [senior doctor specialist in palliative care] set aside time during their working week to teach staff and others. The education and professional development manager told us they were building on the role they carried out providing training and learning for health and social care professionals outside of the service but their priority was making sure they continually review and meet the needs of the staff. Records showed that clinical staff had recently completed a survey about their education and learning needs to help in the development of an improved training strategy for staff, which aimed to support staff in developing their skills and with sharing their knowledge and competencies by teaching them to others.

All the staff and volunteers told us they felt well supported by senior staff and could approach their line manager at any time if they needed a one-one meeting to discuss anything or needed support with anything to do with their work. Some staff had regular 1-1 supervision other staff told us they mainly participated in group supervision meetings where practice issues and other topics to do with their work were discussed. Staff 1-1 supervision varied in method and frequency within the staff teams of the hospice services. Management staff told us that they would review staff and volunteers supervision and implement consistency of practice. Staff we spoke with after our visit to the service told us 1-1 supervision meetings had been arranged to take place in October 2016 which showed management staff had been very responsive to our feedback.

Staff also had the opportunity to access an employer assistance programme which is a confidential free telephone line that provides a range of support and advice for staff. Records showed and staff told us they received regular appraisal of their work and their personal development was supported. A healthcare assistant told us "They want you to develop." Another healthcare assistant told us "I feel very well supported. I have never worked anywhere where staff are so helpful and where things get responded to so quickly."

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and other staff we spoke with knew about the requirements of MCA and DoLS and knew a person's deprivation of liberty must be legally authorised. They told us that there were no people using the service who were subject to a DoLS authorisation at the time of our visit. Records showed a tracking system was in place to record and monitor DoLS.

Staff we spoke with knew that if people were unable to make a decision about their medical needs or other aspect of their care, health and social care professionals, staff, and family members would be involved in making a decision in the person's best interest. People's records included information about those who had a Lasting Power of Attorney, so staff knew who could legally make decisions about a person's treatment when the person did not have the capacity to do so. Staff including doctors, nurses and healthcare assistants were knowledgeable about the importance of obtaining people's consent when supporting people with their care and any treatment. People told us they were asked for their consent in a range of areas including prior to being assisted with personal care and before receiving treatment including medicines. A person using the service told us that staff always explained everything before asking for their consent. During a review of people's care during a daily 'ward round' we saw doctors discussing people's needs with them and obtaining their permission before speaking with family members.

Records were kept of discussions medical staff had with people about do not attempt resuscitation [DNAR] and showed the person's decision had been respected. A person's relative told us that staff had handled a discussion about DNAR in a sensitive manner with their loved one and had fully involved the person. An inpatient confirmed that staff had spoken with them about DNAR and that it had been managed in a professional and understanding way.

People's healthcare and personal care needs were understood and supported by staff. People had access to a range of healthcare professionals including physiotherapists who provided advice and treatment to meet people's healthcare needs and to promote their well-being. A range of complimentary therapies including aromatherapy, massage and acupuncture were also available to people using the service. A person spoke very positively of the acupuncture they had received, and said they were optimistic that it would alleviate some of the symptoms they had from their illness.

People using the inpatient service and the day service told us they enjoyed the meals provided by the service, and informed us they had a choice of meals and alternatives were always provided. Comments from people included, "I can't fault the food, it's delicious." "If [Person] doesn't like anything, they'll change it. They're flexible with drinks. Everything you ask for, it's no trouble" and "The food is very good, it's freshly brought."

We spoke with the chef who was very enthusiastic about their role and told us about the importance of ensuring people's preferences were always accommodated. They told us "I am very passionate about what I do. I care so much about people." They told us that they met each inpatient and their family [when applicable] to find out what their food preferences and needs are. They provided us with several examples of when people's particular personal food preferences had been promptly acquired often having been purchased at a specific shop. The chef told us people's preferences had been incorporated into the current menu and people's cultural and religious and other dietary needs were always met by the service. People's nutritional needs and preferences were recorded in their records. The chef told us they were kept informed

of people's specific dietary needs by nursing staff.

The chef told us they always asked for feedback about the meals and records showed that people's comments about the meals had been documented. Written feedback from people included "Brilliant service very satisfied all around, I find the food at the Woodgrange [day service] to be good quality and well prepared," "Keep doing what you are doing," I am happy, we are lucky to have such fresh excellent food with plenty of choice. No complaints at all."

All the people who had provided written feedback about the food confirmed they had been asked about the type of food and drink they preferred and about whether they had any special dietary requirements. The chef told us about the action they had taken to address some negative feedback about a meal however their response had not been documented. They told us they would in future record any action they took to address adverse feedback to demonstrate they had made the necessary improvements. A range of fresh fruit was available for people and they were offered a variety of drinks throughout the inspection. A person using the service said that they could ask for anything to eat at any time and if they didn't want what was on the menu this was accommodated. Everyone we spoke with said they were provided with a choice of food.

We saw meals were served in pleasant way and presented attractively. The chef told us she had plans to develop the format of the menu so it was available in picture format so people who could not read English or due to their specific needs were unable to read would be able to see what was on the menu and choose what to eat. People using the day service and inpatient unit chose what they wanted for lunch. A person's relative told us their family member liked eggs cooked in a particular way and this was accommodated by the service. They told us that having their food cooked in the way meant a lot to the person. Two people's relatives mentioned that they had been offered lunch at the hospice which they told us was important to them as they could eat with their family member which encouraged the person to eat.

The environment and atmosphere of the hospice and day service were welcoming, calm, warm, light and peaceful. The bedrooms in the inpatient unit were well decorated and led out onto the garden which was very attractively landscaped and accessible to wheelchair users. There were areas where people and their families could talk in private. Comments from people using the services included "The environment is very nice" and "It's very nice, it's beautiful."

The environment of the day service was less clinical as it was located in the old part of the hospice where original features remained. Funding had been raised to commence a project to develop and improve the day service environment and facilities.

We were informed that other refurbishment of several rooms in the hospice including the multi-faith room, and of a single room to make it into a dementia friendly environment was planned. The public areas were accessible for people with mobility problems or who used a wheelchair. There was a seating area in reception where people could meet and talk. A room containing a range of toys was accessible to supervised children who visited the hospice with their family. The bathrooms facilities included equipment such as bathing hoists so people with mobility needs could be supported with their personal care safely. We were informed that each bed in the inpatient unit had been replaced with an up to date specialist bed following fundraising by a group of people from the local community.

## Is the service caring?

### Our findings

People using the service and relatives of people all spoke positively about the care provided by the hospice's services. They told us they really appreciated the services offered and found the staff and volunteers to be very approachable, friendly, kind and understood their needs well. They told us; "Yesterday was a bad day, and the staff were on top form, the nurses were in and out, they were really caring and keeping an eye on [Person]," "They look after me very well here," "It's a godsend. They are lovely," "Its lovely coming here [day service]," "The staff are friendly, and have a good sense of humour , which I like," "They treat me with respect," "They always have a smile on their face. The doctors are so kind. It's the kindness that counts" and "They're excellent at communicating. They've offered me counselling."

During our visit we saw in the inpatient unit and the day service very positive engagement between staff and people using the service. Staff interacted with people in an empathetic, friendly, caring manner and respectful of each person's individual wishes and requirements. We heard staff introduce themselves to people and explain their role, which helped put people at ease. A health care assistant told us they always asked people their preferred name and never assumed it.

People's care was planned in a person centred way focused on the person's needs, views, experiences and aspirations. A person's relative told us that a person using the service was asked about what they wanted from the service, listened to and the person's preferences were accepted, recorded and accommodated. People confirmed they were listened to and told us staff explained issues to do with their care and treatment in a way that they understood. They told us they had been fully involved in all discussions medical staff had about their care and treatment and were offered choices to do with their care and their decisions had been respected by staff. People were given time to ask questions which were responded to in a respectful and helpful manner by staff. One person using the service told us their illness and prognosis had been discussed with them in a professional manner and their choice about not receiving treatment had been respected.

Staff developed good relationships with people quickly and understood people's range of often complex needs which included health, emotional, social and spiritual needs. Staff had discussions with people about their future and provided people with the support they needed to make a range of decisions, including supporting them to attain what was important to them such as sorting out welfare and practical issues at the end of their life. Staff told us "We 120% care," "I love my job," and "We provide people with the care and support they want and need." People's care plans showed their independence was supported and encouraged when they were being supported with their personal care needs. A person using the service confirmed this.

The Family Support Service Manager employed by the hospice told us that a significant role of their team was to offer emotional support to people using the hospice services and to those important to them which included offering pre and post bereavement support. Following a person's death the family support service contacts those important to the person offering bereavement support. This showed the hospice recognised the needs of people's family and friends during and following the end of the person's life. The team also

offered people support with the development of their personal advanced care plan, which could include people's choice of who they wanted to be with them when they were dying and their funeral wishes. Practical support for people was also provided such as giving information about support available with paying bills and helping people create memory boxes for those important to them.

The hospice staff and volunteers supported people to develop and maintain their relationships with family and friends. A friend of a person using the service spoke of the positive experience they had when they joined a person using the service for a special evening meal that had been arranged for people and their loved ones to enjoy. A person who had invited a friend to dinner was very positive about the experience. A volunteer told us they provided family members with support when they were anxious when visiting a family member in the inpatient unit. They told us "We make people feel comfortable and sometimes make them a cup of tea."

Staff respected people's privacy. They ensured doors were closed when having important conversations with people or when assisting them with personal care. In the inpatient unit there were signs that could be put on a person's door, which informed staff and visitors that a person using the service did not wish to be disturbed. Staff knew not to speak about people in front of others. In the inpatient unit staff handover meetings took place in the office with the door closed so confidentiality was respected. People's records were stored securely and staff we spoke with in all the services were very knowledgeable about the importance of confidentiality including not speaking about people using the service other than to staff and others involved in the person's care and treatment.

Significant information about each person's life including their current or previous job was recorded in people's care records. A nurse told us about the importance of obtaining "lots of information about each person so we know them well and can better understand their needs." They told us a person living with dementia had once worked as an engineer and the service had provided the person with equipment to trigger their memories and enable them to build something which occupied them, so minimised the risk of wandering and enhanced their well-being. The nurse told us they aimed become a dignity champion and promote dignity within the service.

We saw from people's records that people had discussed with staff their spiritual, cultural beliefs and other diversity needs and had spoken about how they wanted these to be met. Staff had a good understanding of the equality and diversity policy and its significance and importance in their work. A healthcare assistant told us they had learnt about the range of people's equality and diversity needs and respecting people's differences during the induction programme. Staff knew where to access information about a range of beliefs and cultures and told us that these were often discussed during staff handover meetings. A person's care plan included information about arrangements that had been made for their religious needs to be met. We were provided with an example of the understanding and support provided by the hospice to a person who had refugee status and was terminally ill. The hospice had communicated with a range of agencies to ensure the person had the information, support and care they needed at the end of their life.

A healthcare assistant from the community team told us about respecting people's cultural needs and wishes. They provided us with an example of when following discussion with a person staff wore overshoe covers in the person's home due to their preference that people did not wear shoes in their home. Some staff and volunteers represented a range of religious denominations and spoke a range of languages. This and the contact the hospice had with contacts and representatives of a range of religions and spiritual representatives offered comfort and support to people if this was requested by them. People who did not have any religious beliefs had these respected also.

A room was available where people could spend time with their loved one after they had died and also be fully involved in laying the person's body out in line with their cultural and religious needs if they wished. The service had a multi-faith room where people of all faith backgrounds and also those people who do not hold any religious beliefs could use this room to have quiet time on their own or with their family and friends. We saw in the reception area a display of information and pictures celebrating a religious celebration that had recently taken place.

There was literature available about the hospice for people and their families to read, which included funeral information, being a young carer and supporting children info that was available for people to access. The Family Support Services manager told us that the service was in the process of developing more leaflets providing a range of information to do with the service and other matters related to it.

People using the Hospice at Home community service told us they had been provided with information about the service and contact details of the hospice. A volunteer receptionist spoke of their role which included providing people with a range of information about the services provided by the hospice. Information about the hospice and all its services could also be found on their website.

The service produced regular newsletters about the service which included news about people fundraising, events and a range of activities people had participated in. The newsletters promoted the hospice and provided a range of other information about the service. A person's relative told us that a folder with information about the service was provided on the first day of receiving a service and said it contained "Everything you need to know, really informative." Another person's relative told us they had received "Lots of information."

## Is the service responsive?

### Our findings

People using the hospice services confirmed that staff and volunteers were responsive to their individual needs. They told us "They [staff] are very good, I'm kept informed" and "Any questions are answered. If I have concerns they are happy to answer questions, they give honest answers, and if they don't know they go and get the answer."

People were referred to the hospice services by a range of professionals, including GP's, hospitals and members of the palliative care team. The decision to admit someone or not was based on a multi-disciplinary assessment of each person's needs including their symptoms and emotional needs.

People's care records showed their needs were comprehensively assessed with their participation and when applicable their family involvement before they received care and support from any of the hospice services. The detailed assessment and multi-disciplinary discussions about people's needs and the care and support the hospice could provide them ensured that staff had all the relevant information they needed to provide people with effective and responsive care and support.

A person on the inpatient unit told us they had participated fully in the initial assessment of their needs and in later reviews of their needs. A family member of a person who received support from the Hospice at Home team [HHT] told us they and their family member had been fully involved when the person had their needs assessed by a member of the hospice staff. Initial assessment information was used to develop each person's plan of care and treatment. Details about people's transfer to another service or home were recorded in people's records and showed involvement from the person, the social worker team, hospice medical and nursing staff, GP and included details of follow up contact.

People who attended the day services had an opportunity to complete a self-assessment form about their needs and preferences which assisted staff in understanding the care and support people wanted and needed. The day services were flexible so people who stopped using the services can contact the service and return to the service whenever they wished. Comments from people included; "Coming to Woodgrange Centre each week is an oasis of calm and comfort in my life," "It gets me out of the house, everyone is so kind," "There are very nice people here, the food is good we have choice."

People's care records identified the support people needed with their care and treatment and other aspects of their lives including proposed outcomes and detailed progress reports. The care planning system was person centred with clear expected outcomes/targets or objectives that had been agreed with the people who use the inpatient service. People had an advanced care plan which documented their needs and wishes about their care and treatment during the end of life and other needs and desires they wished to be fulfilled. Staff supported people to realise their advanced care plan when this was requested.

People and their relatives told us they were fully involved in their plan of care and were supported to identify what was important to them and to achieve that. A person's relative told us they were impressed that staff spoke with their loved one in private before speaking with relatives. This showed staff recognised the person

took the lead in their care, their wishes were respected and details of the family involvement they wanted was established as soon as they commenced receiving a service from the hospice.

A person using the service told us "They are very supportive and treat me with respect, I feel fully involved in decisions. It is a very good service." "The nurses give me advice when I need it, I can talk to them about anything." A person's relative told us that when equipment was found to be needed to meet a person's care needs this was provided promptly. They told us that the hospice arranged for a specialist nurse to speak with the person about their medical condition and to assist in making sure the person received the care and treatment they needed. They told us "My [relative] is being listened to and support is being provided in the way that they want. An occupational therapist also came several times to assess [relative's] needs. It is a good service." Another person's relative told us "They [staff] seem very caring, professional and competent. They listen to us and involve us."

The Hospice at Home team worked closely with health professionals including GPs, district nurses and community teams to provide care and support available seven days a week to patients, families and carers usually during the final stages of illness. A system was in place so referrals to the community team could be fast tracked by hospitals and other community services so the service was responsive to people's needs. Nurses from the community team visited each person in their home; explained the service and carried out assessments including risk assessment of their needs and of the environment to gain knowledge of people's needs and keep them safe. The community Hospice at Home team provide a 14 day service for people following referral. Then on the 15th day the care service is continued by a domiciliary care service organised by the local authority Continuing Care Group [CCG]. This showed how the hospice was worked in partnership with others to provide a service that was responsive to people's needs.

The Hospice at Home team supported people with their personal care, prompting medicines and providing drinks and meals. Management, nurses and healthcare assistants all spoke positively about the care and support they provided people in the community. They told us about the significant support they provided to people's families and others important to them during the last weeks of people's lives. The community teams also signposted people to other support organisations which contributed to people being less likely admitted to hospital due to them being supported well at home.

The Single Point of Access [SPA] is a 24 hour telephone support contact service in the second year of a pilot commissioned by Harrow CCG for residents of Harrow who had a Harrow GP. The service provided advice and support to people in Harrow to achieve their choice of receiving advice and treatment during the end of their life at home. The service was very responsive to people's individual needs. Advice for people, their families, carers, GPs and healthcare professionals looking for information on complex palliative care and life-limiting illness was 24 hours a day via the dedicated helpline and the hospice inpatient unit. Clinical staff, including nurse specialists, staff the SPA helpline. The registered manager told us that the SPA and rapid response team has enabled Harrow residents to be discharged from hospital more quickly because the telephone help line and community services support people in receiving care in their homes by providing the advice and for care they need on their discharge.

One person's relative told us that they had phoned the hospice in the middle of the night for advice regarding the person's pain relief medicines and had received the reassurance, advice and support they had needed. They told us that staff were "always ready to listen, staff are very kind."

The community Rapid Response team provided people with the care and treatment they needed quickly such as wound care, urinary catheter care and pain management with the aim of preventing hospital admissions if this was what the person wanted. The team worked very flexibly to support people and to



ensure that they got the assistance they needed especially when they were very near the end of their life. Visits were planned in accordance with need. Residents of Brent not receiving the SPA service or the hospice at home service received care and treatment from a specialist palliative community team employed and based at St Luke's.

Staff from the community team told us that during staff handovers people's individual needs were assessed and reviewed at least daily to ensure that staff were knowledgeable about the care people required. People had an hour allotted for staff to support them with the care they required. A healthcare assistant told us that time was flexible so more time could be provided on occasions when a person or their relative needed additional support such as time to talk when they were feeling anxious or unhappy. People sometimes received a second visit at lunchtime if they needed further personal care. These examples of the care and support provided by the service showed the service was responsive to people's needs. The team worked alongside other health and social care professionals. For example, Marie Curie nurses provided night time care for some people.

People's care needs were reviewed regularly by the Multi-Disciplinary Team [MDT] consisting of a range of staff including clinical and social care staff. We observed a ward round and saw that people were fully involved in reviewing their needs. We heard two people ask questions about their care and their future care needs after possible discharge from the hospice. Staff told us and records showed people's needs were monitored on a day to day basis and during the night. The family support service team were available in the inpatient unit until late at night at times during the week to provide people with advice and support when they required it. They also attended transition meetings every morning to discuss referrals.

We observed a 'handover' take place in the inpatient unit during the inspection. Each person was discussed fully and any changes in people's needs were recorded and communicated to the staff working on the next shift. Staff including healthcare assistants recognised the importance of reporting any changes in people's needs such as an increase in pain, so nursing and medical staff could be responsive to the person's specific need and make sure people received the care and treatment they needed.

A person's relative told us staff offered a range of treatment to relieve their family member's pain. Heat pads and Transcutaneous Electrical Nerve Stimulation [TENS, a method of pain relief involving the use of a mild electrical current] were available as well as medicines. The relative of a person who had used the inpatient service told us a nurse had recognised when the person had been very anxious when complaining of pain and reassured them in a particularly sensitive and understanding way, which quickly led to the person being calmer and in less pain. People's pain was assessed on a daily basis to ensure the efficacy of the pain relief.

Care records were completed during each shift on the inpatient unit and during each visit to people's homes by the community team and included details about any changes in people's health, emotional and care needs so staff had up to date information about people's current needs. We saw in a person's care records that the person's condition had deteriorated rapidly and guidance had been updated to meet the person's change in needs during their terminal stage of life. People's relatives confirmed they were kept informed about people's care and treatment.

We saw from people's care documentation that the service was responsive to people's needs. For example a person had been admitted with a pressure ulcer, the care and treatment was recorded in the person's care plan and records showed that despite the person's general health having deteriorated the pressure ulcer had not got worse, which showed appropriate care was being provided to the person. A person's care records showed that the person's poor appetite had been identified by the service and action had been taken to support the person with their nutritional needs. However, we found that a person's assessment of



their risk of pressure ulcers indicated in the person's electronic records that their condition had deteriorated, but this was not recorded on the paper file. This could cause people to not receive the care they needed if staff referred only to the paper records. The registered manager told us paper records were kept in case there was a situation when the electronic records could not be accessed by staff and confirmed this issue would be addressed promptly. All the staff including health care assistants we spoke with that provided people with care and treatment told us they accessed the electronic care records so were always up to date with details of each person's condition.

Staff understood and were responsive to people's individual communication needs. A healthcare assistant from the community team told us about the way some people communicated their needs and wishes when due to their medical condition found it difficult to talk. They told us sometimes people used an electronic device to communicate or their family members helped the person to communicate with staff. A nurse from the inpatient unit had developed a range of picture cards to assist staff with communicating with people who due to their needs found expressing their needs and reading difficult such as people with communication needs such as those with dementia care needs. The cards included pictures that assisted people in communicating whether they were in pain and the level of pain they had.

The Woodgrange day service provided personal care and a range of specialist medical and therapeutic services. People attending the day service had access to health and social care professionals including doctors and nurses, therapies including complementary therapy and physiotherapy, and also the hospice family support team. One day of the week the service focused on providing people with the assistance they wanted with having a bath. Clinical treatment such as blood transfusions and wound care could also be provided. A person received a blood transfusion during our visit to the service. This showed the service was responsive to people's individual needs. One person told us "It is lovely that I can come here and see people and get the treatment I need."

The hospice family support services team had recently commenced a pilot project where St Luke's worked in partnership with the Citizen's Advice Bureau [CAB] in an integrated holistic approach in making sessions available to people using service so they, their relatives and others important to them could obtain advice and support on a range of issues including welfare and debt with the aim of reducing people's stress and anxiety and promote their well-being. The CAB and the hospice spoke positively about their working relationship and of the benefit the service provided to people.

A Community Support Volunteer Project that had been developed by the hospice which aimed to minimise social isolation for people in the community and to provide a service that met people's individual personal needs, for example a volunteer spent time with a person at the end of their life helping them fly model aeroplanes as it was an activity enjoyed by the person. Another volunteer helped a person deal with sorting their clothes out before they died. This showed how the hospice was responsive in meeting people's specific needs.

The Woodgrange day service and the inpatient unit offered a variety of different activities that people could access and participate in. These included group exercises, afternoon tea on the patio, acupuncture, guitar and vocals, bingo, general games, workshops of favourite sayings and quotes, cake decorating, sewing, flower arranging, and table top gardening. Services are provided on specific days of the week and include day services, clinical care and treatment such as physiotherapy, new referrals, clinical advice and treatment, complementary services.

The activities co-ordinator told us that people were asked about the activities they wanted to take part in and this was accommodated. People took part in a range of preferred activities, these included group

activities such as art and crafts and gardening, and one to one activities with staff such as playing a game of dominoes. Some people told us they preferred reading the newspaper, spending time in the garden, and talking with other people using the service, staff and volunteers and this was accommodated. A co-ordinator of a service that organised regular visits to the hospice of a volunteer and three pet dogs spoke positively of the service the positive impact the pets had on people using the service.

The day services activities helped to prevent social isolation. A person using the service said "Coming here gets me out of the house; it is good to have a change of scene and see other people." Another person told us they really looked forward to the day each week they spent at St Luke's, which they said was the highlight of their week. The manager of the day service told us that two physiotherapists provided a service that supported people with a range of needs including mobility requirements.

Complementary therapies such as massage, acupuncture and aromatherapy were offered to people. Two people spoke positively about the complimentary therapy they had received which had helped them relax. A complimentary therapist told us about their role and informed us following a referral from Brent or Harrow community services they carried out a home visit and provide complementary therapy sessions to a person in their own home. Sessions included beauty treatments, make up sessions and aromatherapy. They told us that they aimed to make each person "feel brilliant." Written feedback about the complementary therapy included; "So relaxing," and "I always look forward to it [the complementary therapy session]. "After it I felt so good."

The service had a complaints policy and procedure for responding to and managing complaints. This was displayed in the hospice. No one we spoke with had made a complaint. They informed us they found staff to be very approachable and if they had a concern or complaint would report them to nurses and or management staff. They told us "There's nothing to complain about." and "I have no complaints at all." Records showed that complaints had been addressed in line with the complaints procedure. We saw suggestion boxes that people could use for feedback about the service.

Staff knew they needed to take all complaints seriously and report them to the registered manager. Records showed there had been few complaints. These had been taken seriously, managed appropriately and lessons learnt. Complaints were monitored and reviewed at governance meetings to ensure that they had been suitably addressed and improvements to the service made if needed. There were several written compliments about the service, which included "Thank you for help and guidance from family members," "Thanks for all the help and kindness," "Thank you for caring," "Thank you for all you have done for me, I appreciate your compassion and understanding" and "Your care has been excellent."

## Is the service well-led?

### Our findings

People, external professionals, staff and volunteers we spoke with were all very positive about the services provided by the hospice and the way they were organised, managed and run. Comments from people using services and those important to them included; "I haven't got a single bad thing to say, it's perfect. It's more like home." "It's very nice, it's lovely." "It's brilliant, I can't fault it," "It's a well-run service," "I am very happy with the service, it's a very good service," "It's very nice. There's a nice atmosphere" and "They give you everything you want, food, medication, everything."

The hospice had a leadership team who promoted a culture of transparency, openness and person centred care. The registered manager ensured we were notified of any significant events that affected people and showed they had been responsive in taking appropriate action in closing two inpatient beds when nurse vacancies had increased and there had been a higher incidence of people falling.

Staff and volunteers were very motivated and spoke very positively about their individual roles including the delivery of palliative and end of life care and told us the hospice management team were very supportive. Good communication between staff within and across all the hospice services and with people using services was evident, which was important in ensuring people received the care, treatment and support they needed

During the inspection the registered manager, medical director and other management staff seen out and about in all areas of the hospice and communicated well with staff. A range of staff meetings within each hospice team provided staff with information about the service and gave staff the opportunity to discuss a range of aspects of the service with senior staff including management staff. Staff told us they felt listened to and felt comfortable raising any issues to do with the service and were confident these would be discussed and addressed within the open supportive culture of the service.

The CEO and trustees we spoke with were all clear about their roles in making sure the hospice services all function effectively by good governance from the Board. There were clear strategic plans in place for the continual development of the hospice services and business plan that covered the hospice's objectives, strategies, marketing and financial forecasts. Regular meetings of the trustees took place. These included sub group committee meetings where groups of trustees reviewed and developed strategies in a range of areas to do with the service including; clinical governance, fundraising and finance and general purposes. Trustees told us that there was a commitment to develop, improve, and be responsive and open to new ideas.

One way the trustees involved staff in the development of the strategy of the hospice was by inviting them to Board meetings where they had the opportunity to do a presentation about a particular aspect of their role. We were informed that the Family Support Service Manager had spoken about communication and a nurse facilitator presented information about their role in a care home project. This showed the CEO and trustees were involved and kept fully informed about the services provided by the hospice and monitored them closely. The CEO and Trustees told us they were a regular presence in the hospice and completed 'walk

rounds' where they met staff and gained feedback from them about the service. A Trustee regularly worked as a volunteer in the hospice and Trustees were also involved in hospice events and fundraising.

The hospice worked in partnership with a wide range of external organisations to provide people using services with the care and support they needed with managing life limiting illnesses and at the end of their life. Examples of the hospice working well in partnerships with others included their work with nursing homes in North Brent. In response to identifying that nursing homes needed support with caring for people at the end of their life, the hospice had funded a nurse facilitator to provide staff with end of life training and support in a range of areas including; advanced care planning. The nurse facilitator told us about how this project had helped nursing home staff to develop their skills and be more confident in providing people with good end of life care.

Further examples of partnership working and demonstration of a culture of openness included several other projects in which the hospice jointly worked with other organisations and those that were being considered or planned. The projects included working with Harrow CCG on the Single Point of Access pilot project and with the Citizen Advice Bureau regarding welfare issues and other support for people using its services. The hospice worked closely with two universities which trained nurses some of whom completed placements at St Luke's.

Other external organisations the hospice worked with included; domiciliary care agencies, Macmillan nurses, and the Marie Curie organisation which often provides night care for people receiving a service from the Hospice at Home community team. A senior member of staff from the London Ambulance Service [LAS] told us the LAS had a very positive relationship with the hospice working in partnership with them to ensure people received the type of service they wanted and needed such as being cared for at home or in the hospice rather than be admitted to hospital. We were provided with an example when the LAS contacted the hospice about a person who was dying and was not known to the hospice service, a nurse and a doctor visited the person and provided the care and treatment the person required which enabled them in accordance with their wishes to die with dignity at home.

Healthcare professionals and others from a range of organisations that worked with St Luke's we spoke with were very positive about the service including communication with management staff and comments included "Excellent hospice, so well run," "St Luke's staff are excellent, always wonderful," "All staff are more than competent," "They [staff] are always available for advice and to answer queries" and "They give us the information we need and it is well documented."

The hospice had strong links to the local community which supported and often initiated some the many events that raised funds for the service.

Staff knew about reporting any issues to do with the service to management. Where incidents had occurred, detailed records had been completed and retained at the service. Monthly review of incidents and accidents took place as part of the monitoring process and to look at whether there were any trends such as an increase in pressure ulcers or whether people with dementia were more frequently involved in incidents. Action was taken to address deficiencies and to make improvements to reduce the risk of further incidents. Information was supplied to the hospice board on a quarterly basis so they were kept informed about all significant issues to do with the service.

Health and safety systems and processes were in the process of being reviewed and developed to make them more efficient and effective. This showed the service was proactive in reviewing its systems and making improvements when needed. Regular health and safety committee meetings with the CEO, registered manager, facilities manager and other senior staff took place where a range of issues including

accidents and incidents, pressure ulcers, information governance, fire safety and health and safety were reviewed and action agreed to develop and improve the service.

People had the opportunity to provide feedback about their experience of the inpatient service and day services and to give their views about specific areas of the service including the food and complementary therapy sessions. Records showed the feedback about the services had been overwhelmingly positive and areas where improvement was needed had been addressed. The medical director told us that feedback from people using the services had helped them making improvements regarding better communication and working relationship with the London Ambulance Service. The CEO told us that the clinical governance committee on occasions invited a family member of a person using the service to the meetings to feedback and share their experience of a hospice service. A family member had recently spoken about the bereavement support they had received from the service.

A day services manager told us that in response to people's feedback the day service now provided an outpatient system where people could attend the service for specific appointments such as a complementary therapy session rather than have to attend the service for the whole day. These examples showed people were listened to and the service was effective and responsive to their particular needs.

Regular staff feedback surveys were also carried out. The registered manager told us that in response to a staff survey carried out in 2015 a focus group facilitator had been employed to help develop and improve areas of the service including staff communication.

Policies and procedures were up to date. Staff knew about policies and procedures related to the care of people and the running of the service and how to access them when required. The service had an up to date statement of purpose and people and their relatives had access to a service user guide that included a range of information about the service. Information booklets about all of the services provided by the hospice were also available.

St Luke's hospice also communicated frequently with other hospices to share good practice and knowledge and also is a member Hospice UK which champions & supports hospice care, so the service kept up to date with current best practice and guidance which benefitted people using its services.

The hospice audit and governance systems were effective in evaluating and improving practice and the standard of the services to ensure people's requirements were met by a service that was responsive to their wants and needs. Annual Quality Account reports and financial reports of the service are completed. These include details of strategy, quality and performance, feedback from people using services and stakeholders and a review of services.

The hospice has a comprehensive quality management system in place which includes a formal audit programme agreed by the Clinical Governance Committee of the board of Trustees. A range of audits were undertaken including medicines, infection control, accidents and incidents and health and safety. Action plans were completed which showed improvements were made when any deficiencies were found.

The Quality Improvement Group consisted of staff who worked together to identify where improvements to the service were needed. Human Resources regularly produced a report which included details about staffing numbers and skills, staff vacancies and turnover and included details of action taken to recruit more staff in response to needs identified within the services. Regular Board of Management meetings, Clinical Governance, Heads of Department meetings took place where all areas of the service, strategy and minutes from sub-committee meetings were reviewed and discussed. Records of these meetings and other meetings

including a range of smaller operational meetings such as Continuing Care and Hospice at Home, Clinical Development Group, St Luke's Hospice Progress meeting with Harrow CCG, showed the provider monitored closely the progress, quality and safety of services and took appropriate action without delay to address areas where progress was not achieved as expected and make improvements where deficiencies to the service were found.