

## North Herts Hospice Care Association

# Garden House Hospice

### 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 15 March 2016 and was unannounced.

Garden House 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 social holistic care through teams of nurses, doctors, counsellors, spiritual care team and other professionals including therapists. The service provides care for people through an 'In-Patient Unit', Day Service, 'Out-Patient Care', 'Drop-in Service', and 'Hospice at Home'. The hospice also offered a 24hour telephone advice line for people and their family carers to request help if there was a need for it.

The inpatient facility catered for up to 12 people, accommodated within a ward or individual rooms. At the time of the inspection there were six people using this service, beds being gradually reduced for refurbishment work. Approximately 10 people received support from the 'Hospice at Home'. The service provided specialist advice with regards to symptom control and worked in partnership with health and social care professionals to ensure that people received the best possible support.

The services provided included counselling and bereavement support, family support, chaplaincy, out-patient clinics, patient clinics, physiotherapy, complementary therapies and a lymphedema outpatient clinic (for people who experience swellings and inflammation usually to their limbs post cancer treatments).

Garden House 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. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm.

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. Plans in regard to all aspects of their 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.

People's physical, psychological, emotional and spiritual needs were met as the service employed sufficient staff with the appropriate skills to support those needs. People's needs were regularly reviewed and the service responded to their changing needs. Staff provided spiritual support and complementary therapies as well as caring for people's physical needs.

The service supported people within the community providing psychological and practical support. People from the community accessed the various clinics held in the day care facilities where staff could review their health. People told us that the day care facility enabled them to meet with people in similar circumstances and was a welcome part of the community support.

People told us that staff understood their individual care needs and were compassionate and understanding and that their cheerful and friendly approach created a welcoming and relaxed atmosphere. Staff told us they undertook training which enabled them to provide good quality care, which supported a holistic approach to care.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People and their relatives praised the food they received and they enjoyed their meal times. Staff communicated effectively with people, responded to their needs promptly, and treated them with genuine kindness and respect.

People's medication needs both within the hospice and the community were discussed by health professionals 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, their friends and relatives were consistently very positive about the caring and compassionate attitude of the staff working at the hospice. They told us they were completely satisfied with their care and thought highly about staff, volunteers 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 respected people's cultural and spiritual needs and people told us they received the religious and spiritual support they wanted and needed. Relatives told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member.

The management structure showed clear lines of responsibility and authority for decision making and leadership in the operation and direction of the hospice and its services. The Board of Trustees and 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. The registered manager was committed to improve and broaden the services the hospice offered. They told us, "We need to keep up with the changing needs of our community. We are adapting our services to ensure we reach out to more people in need."

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?

Good 

The service was safe.

Staff knew how to recognise and respond to any actual or potential abuse. They worked closely with health and social care professionals to protect people from harm.

Potential risks to people were assessed and measures put in place to reduce risks. Where accidents or incidents occurred these 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 was trained and qualified in safe administration of medicines and the use of specialist equipment to ensure people received their medicines in time and safely.

### Is the service effective?

Good 

The service was effective.

People received support and care from a staff team who were well trained and used their knowledge and skills to meet people`s needs effectively.

Staff felt supported in their role by managers. They were encouraged to develop their knowledge and skills, follow best practice in regular meetings, one to one supervision sessions and yearly appraisals.

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 maintain a healthy balanced diet. The menu provided was varied and offered plenty of choices to people.

People's health needs were carefully monitored by nursing staff

and the consultant in palliative care. If people's health required, appropriate referrals were made to other professionals.

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

The service was caring.

People and relatives told us that staff were 'very special', kind and empathetic and they provided excellent care and emotional support which was responsive to their needs.

Staff demonstrated compassion and understanding when caring for people. They were attentive and thorough in every aspect of their work to make people feel valued and well supported.

People's spiritual needs were recognised. The service worked closely with the spiritual care team which offered comfort to people and families.

Staff supported the emotional wellbeing of people and their relatives with end of life care being provided with sensitivity and compassion. The care people received enabled them to experience a comfortable, dignified and pain-free death.

People's right to privacy and dignity was promoted and respected in life and in death.

People were consulted about and fully involved in their care and treatment. The service was very flexible and responded quickly to people's changing needs or wishes.

**Good** ●

### **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.

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 families' early involvement in the hospice by organising diverse activity groups and complimentary therapies.

**Good** ●

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.

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

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 and type of service provided.

The Board of Trustees and management teams provided strong, effective leadership and provided a clear strategy for the long term development of the service.

The management team was pro-active in introducing new ways to meet the needs of people in the wider community and promote good practice.

The management team were pro-active in organising fundraising events to ensure they had the finances to provide the services needed by people and their families.

The registered manager worked with other healthcare professionals and other providers of similar services to share best practice and have a positive influence on the care people received.

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.

**Good** 

# Garden House Hospice

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 15 March 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 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 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 what improvements they plan to make. We also 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 six people who used the services provided by the hospice, seven relatives, three volunteers, two senior staff nurses, four care staff, a unit manager, a consultant and one receptionist.

We also spoke with the management team, the registered manager, managers with different responsibilities for areas within the service like, human resources, family support service, finance, quality management, training, kitchen and housekeeping staff.

We reviewed three 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 spent time observing staff interacting with people and their relatives.

We also looked at the recruitment files of four members of staff and two volunteers, a range of policies and procedures, maintenance records of equipment and the building, quality assurance and clinical audits and

meeting minutes for different departments.

## Is the service safe?

### Our findings

People and their relatives were happy with 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, "This service is unique and heaven for me. I feel safe and comfortable." One relative who overheard what the person told us said, "I cannot say anything else, I just want to double that. The care is amazing and we are thankful for everything."

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. They were able to give us examples where there was a risk of someone being abused and the steps they had taken to protect the person. 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 the management team and staff were committed to supporting people who were at risk of abuse or harm. The registered manager told us, "We take safeguarding very seriously, all the staff is trained and we work very closely with local safeguarding authorities to ensure we keep people safe from harm." The registered manager had appointed an adult safeguarding champion and a children safeguarding champion. The staff appointed for these positions had in-depth training provided in these areas and were able to support staff on a daily basis with their expertise. One staff member told us, "We all received safeguarding training and we have regular updates. Volunteers are trained as well."

Safeguarding was discussed in team meetings where staff were reminded to discuss and share any concerns they had and were given feedback if it was appropriate on any safeguarding issues involving people who were using the service.

One person told us they asked staff to put bedrails on their bed because they felt safer when the rails were in place. Staff involved the person and explained the risks related to the use of bedrails. Staff assessed the risks associated with this request and the bedrails were put in place which made the person feel safe and relaxed when they were in bed. This meant that risk assessments were centred on the needs of the person and their decision was respected and promoted by staff.

Risk assessments were reviewed daily by nurses and were updated appropriately. Staff were aware of the risks that related to each person and we saw evidence throughout care plans of people's involvement and preferences when measures were put in place to mitigate risks. Risks relating to people's skin condition and the risks of developing pressure ulcers was closely monitored by staff. Pressure relieving mattresses were used to lower the risk of people developing pressure ulcers.

Incidents and accidents were monitored by the registered manager and the quality manager. Staff told us they were encouraged to report any incidents or near misses which occurred. They said they completed an incident form as soon as the incident or accident happened. Each service within the hospice had personalised incident and accident forms. The quality manager used a computerised system to enable them to have a good overview on the type of accidents or incidents, date, time when it happened, immediate

actions taken by the responsible staff member, if the incident was reportable to outside agencies and if they had to follow up with more actions. They used a green, yellow, amber and red colour system to categorise these and search for trends and patterns and prevent reoccurrence. This meant that there was a continuous improvement of the services provided and people received care which was safe and protected them from the risks of harm.

We saw examples of serious medicine related incident reports which had been escalated and reported to the Local Intelligence Network (LIN), who monitors these incidents and to local authorities and agencies in the past year. In each instance there were actions implemented to address any learning identified as a result of the investigation and prevent re-occurrence. The registered manager told us and we saw that the numbers of incidents had reduced significantly due to this approach.

People and their relatives told us there were always enough staff on duty to meet their needs. One person told us, "I've never felt they are not enough staff; they always take time to discuss with me." One relative said, "We have no concerns on staffing the care is as good at night and weekends as on week days." Staff we spoke with told us they felt there were sufficient staff on duty to enable them to care for people safely and in a person centred way. The registered manager and nursing staff daily assessed staffing levels which were adjusted to ensure people's needs were met at all times. For example staff from the in-patient unit helped the hospice at home service when the inpatient unit was not fully occupied. Staff vacancies and absences were covered by bank staff employed by the service. The manager told us and staff rota's demonstrated that at all times there was a hierarchy of qualified management, nursing staff, care staff and medical advice available to ensure the care delivered was consistent and safe.

On the day of the inspection staff were observed responding promptly to call bells and regularly checking people in their rooms. One person told us, "Staff come quickly when I ring the bell." Another person said, "When you press the buzzer they [staff] come in no time."

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 was fast to respond to any need they had. One person told us, "They [staff] explain clearly the need for any change in my medication." One relative said, "They [staff] give a fast response to any indications of the need for pain relief."

We checked the medicines prescribed for the people who used the services in the hospice. We noted that there was clear recording of the prescribed medicines, which also included additional instructions for safe administration. Medicine charts had been written up with clear indications for administration of "when required" medicines. There was an effective system in place for obtaining medicines for people including those required in an emergency and these were checked regularly. Prescribing was done on dedicated treatment charts and records of administration were clearly documented and signed by the responsible staff member.

Medicines were stored securely in a locked treatment room, and only authorised staff had access to it. Daily temperature records were available which recorded the temperatures for the medicine refrigerator and the medicine room temperature. This ensured that medicines were stored within safe temperature ranges.

A pharmacist visited the hospice three times a week, monitored people's treatment, undertook medicines reconciliation (medication reconciliation is the process of verifying the most accurate list possible of all medications a patient is taking). They also participated in medicine review meetings for people. There was a system to deal with alerts and recalls of medicines and we saw evidence that these were discussed at the drug and therapeutics meetings.

There were systems in place to ensure staff followed good clinical practice. They had access to reference sources and guidance which provided up to date information about the safe and correct use of medicines. There were regular medicine and therapeutics meeting where medicine incidents were reviewed and escalated as appropriate. We saw evidence that actions were taken following incidents. For example, monitoring procedures were altered following problems with the adherence of analgesic transdermal patches, (a transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream). This proactive approach in medicine management helped to ensure people received their medicines safely from staff who had the appropriate knowledge and skill to do so. When people left the inpatient unit and moved to their own homes or other services they received a discharge letter from the consultant at the hospice which explained how to take and use their medicines safely. This information was shared with other health care professionals as appropriate. This meant that people could have their medicines safely even after they stopped using the service.

None of the people using the service at the time of our inspection were self-administering their medicines but systems were in place should people requested to do so. People were informed when medicines were used outside their licence, they were given information leaflets to be able to understand and agree to this treatment. Medicines are used outside their licence when they are used differently to how the company manufacturing the medicine intended. The use of medicines outside their license is widespread within palliative care and it is used to relive symptoms of pain and stress for people who were nearing the end of their life. This meant that people received care and treatment which helped them have a pain free death.

## Is the service effective?

### Our findings

People and their relatives told us they received excellent care from skilled staff. One person said, "Staff are amazing. The expertise and the compassion they show to us is unbelievable." One relative told us they thought staff was very knowledgeable around people's needs. They told us about their relative who developed pressure ulcers before they moved into the in-patient unit in the hospice. They said, "The bed sores have been dealt with really well; they [staff] managed the sores wonderfully."

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. 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 they had worked for the hospice for 14 years. They were supported by the registered manager to complete a Diploma in Palliative Care and they were currently working towards a personal development plan which included achieving a Master degree in Palliative Care and Bachelor in Nursing award. We saw that the same level of development opportunities were offered to staff at all levels who worked at the hospice. Care assistants for example were offered and supported to achieve nationally recognised vocational training. Staff told us that the registered manager considered any training that potentially improved the experience and benefitted people who used the service. One staff member told us, "We have time allocated for training so we don't have to do it in our time which is good."

Accident and incidents were discussed in regular meetings. Staff who was responsible to complete these forms were scheduled to have training in 'root cause analysis' to be able to investigate accidents and incidents as they happened and capture vital information. This training was aimed to support them in understanding the reasons of occurrence and implement more effective preventative measures. Incident and accident reporting was part of the induction training all staff had regardless of their position in the service.

Staff had access to training essential for their role and were supported to maintain their professional registrations. Training was delivered by a variety of methods which included e-learning, classroom based and external trainers. There was specific clinical practice training such as medication, resuscitation and pressure ulcer training for relevant clinical staff. Other training provided included post incident management, lone working, therapeutic interventions and supervision and appraisal which were undertaken by relevant staff according to their roles and responsibilities. There was also specialist training in areas such as advance care planning, spiritual care, bereavement care and pre-bereavement care which covered staff employed throughout the hospice. There was a monthly Nurse Revalidation workshop 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.

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, "The team leaders are brilliant; I get all the support I need." This support enabled the provider to be confident that the care being given, was provided by staff who were

supported and valued and had the opportunity to reflect on their work and practices to drive improvement. Every day there was time allocated for a debrief for all levels of staff in group sessions or, due to the difficult nature of the work, this was offered on a one to one basis by the family support team if staff felt they needed extra support. One staff member told us, "Nurses and family support staff is always available if we [staff] need to de-brief."

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 sensitive subjects surrounding death. We found that the same induction training was offered to volunteers who worked at the Hospice. At the end of the induction process care staff achieved the 'Care Certificate' qualification.

There was a Journal Club at the hospice which gave staff the chance to be updated on important journal articles from relevant palliative care, medical and nursing journals and earn continued professional development points for their appraisal and revalidation. Although the Journal Club was largely run by the medical team, it was open to the whole multidisciplinary hospice team. More recently the Journal Club had become part of the In-House Education programme.

This comprehensive training programme for all levels of staff working in the hospice helped to ensure people received care which was in line with best practice guidance, delivered by staff who was knowledgeable and up-to-date with any changes in end of life and palliative care practices and standards.

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 were enabled to make informed choices and decisions regarding their treatment. When one person's health deteriorated they were supported to take the decision to withdraw from radiotherapy.

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 were present or their rightful representative. The registered manager submitted applications to the relevant authorities in case a person had to be deprived of their liberty.

People and their relatives were complimentary about the food provided which was cooked daily from fresh ingredients. One person told us, "I think the food is good because of the choice, how it's cooked and because it's always hot." Another person said, "If there's any particular type of food I want they [staff] will try and get it for me." One relative told us, "There's fresh soup at lunch time and we (visiting relatives) can get drinks and snacks at any time."

Menus were distributed by staff working in the kitchen to people when they moved in the hospice. Catering staff asked people before meal times what they wanted to eat and drink. This way they interacted with people and were knowledgeable about their dietary needs, likes and dislikes.

Staff told us it was important that 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. People were able to ask for snacks at any time.

People told us and we saw they had a comprehensive nutritional assessment done when they moved to the hospice and a copy was shared with the kitchen staff. This identified people's dietary needs, if they needed assistance to eat or drink, what type of food they had to have soft, pureed or normal diet. There was also information available if the food had to be provided via a percutaneous endoscopic gastrostomy (PEG) or Radiologically Inserted Gastrostomy (RIG). These are systems by which people who are unable to take food or fluid by mouth receive supplements via a tube directly into their stomach.

People had on-going healthcare support from the consultants at the hospice. Staff liaised with the community nurses and GP surgeries for people using the Hospice at Home service. Various clinics operated daily within the hospice. People had on-going support from a team of physiotherapists which could be accessed as in or out patients, a visiting lymphedema specialist nurse, a team who specialised in lung and breathing and other complementary therapy specialists. The aim of these clinics was to provide support to people with regards to symptom and pain management and was an important aspect of supporting people to maintain their health and receive on-going support.

People told us attending these clinics 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.

The medical team at the hospice consisted of two consultants, a full time Medical Director and a part time consultant with special responsibility for the community, a part time Associate Specialist and a part time Medical Officer. In addition the hospice offered a full time training placement for a Specialty Training Registrar in Palliative Medicine and two training placements for GPs trainees, each for two sessions per week.

Three GP`s worked at the hospice as bank doctors and a volunteer doctor who was a Consultant in Public Health worked as a member of the medical staff for one day per week. The medical team provided support for staff and covered: admission and medical management of people on the in-patient unit, medical reviews of people attending the day hospice when clinically indicated. They also undertook medical domiciliary visits at the request of the Community Palliative Care team or local GPs to provide specialist palliative care advice for people unable to come to the hospice. The GP`s working at the hospice reached out to other services in the community. The hospice medical team offered specialist palliative care and medical advice to GP`s, nurses and other community healthcare professionals as and when it was necessary.

The medical team also worked out of hours and were available to review or admit people at the hospice and gave telephone advice to people who used the hospice at home service and the community teams. This meant that people in the inpatient unit and those using the hospice at home 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.

## Is the service caring?

### Our findings

People and relatives were very positive about the care provided by the hospice and spoke of the friendliness, approachability and empathy of staff. One person said, "Staff seem to want to be here; you can ask them anything and they will try and get you anything you need." People and their relatives all answered 'yes' when we asked if they were treated with compassion and kindness. They told us how the staff listened and talked to them to ensure their preferences and views were considered when planning their care and treatment. People's comments included, "I cannot believe sometimes how good they [staff] are." "The most caring and wonderful environment, I am so lucky to be here." One person nearing the end of their life told us, "The nurses are friendly and professional. Together with the doctor they had taken me 10 steps forward; obviously I'm dying, but whatever time I've got left they made me feel better."

One relative told us that their relative's care had been "superb; we can't fault it" and also that staff "look after us [family] as well as [person]." They told us their questions had always been answered by staff and that doctors gave clear explanations both to them and their relative. They appreciated that nurses gave them straightforward answers which they needed. They said that if they wanted "time out" staff came and sat by their relative's bed side to give them a break.

People using the service had access to services which provided support and counselling with regards to their emotional, spiritual and religious needs, which included bereavement support before, during and after death. One relative commented, "It was a blessing when the hospice chaplain visited." Family support services offered counselling and bereavement service and they remained in contact with relatives following a person's death as long as people felt it was necessary for them. One person told us, "The Family support team visit daily to talk; they are wonderful people."

People we spoke with told us that they had made decisions about their care, which included advanced decisions with regards to future treatment. We found several examples of how people's wishes were respected and staff had gone the extra mile to ensure they fulfilled people's last wishes. For example, one person wished to see their pet. This was arranged and they were visited by their dog whilst in the hospice. Staff from the hospice facilitated and assisted to organise a person's wedding. The person wished to marry their long term partner before they died and with the help of the hospice team they were able to do this.

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity, faith and sexual orientation. For example a person who used the hospice service had a long term depression and were very low in mood. After they attended the clinics in the hospice and built a trusting relationship with staff they were able to open up and talk about personal issues regarding their sexuality which they felt they had to hide. Hospice staff arranged help from specialist health care professionals and worked with the person to restore their confidence. We were not able to talk to the person; however the manager told us that as a result of the support they received from the hospice the person's physical and psychological pain and depression significantly improved. They were able to express themselves freely and they became more confident and eventually they were able to make the transition and live their life as they always wanted.

People and relatives told us they were delighted with the Hospice at home service. One person told us they felt they were in an integrated system of care and support and how important it was for them to have day and night telephone access to advice and support. The person told us, "They [staff] have given emotional support for me and my [family member]. It's such a difference to be able to pick up the phone at two in the morning and ask people for help and get it." They continued to say, "Everything is very clearly explained to you." Another relative told us, "They [staff] are wonderful people; they can't do enough for you."

All aspects of people's treatment were reviewed daily by clinical staff and a care plan put into place that supported the person to promote a comfortable and dignified death. There was evidence of preparing for end of life care and regular discussion with people about their wishes and choices and changing needs. There were regular MDT meetings (multi-disciplinary team meetings) where staff discussed each person's care in detail and if the person was currently at their preferred place and, if not, what the service would do to help people to achieve their preferences. Information was shared with people or their rightful representative to ensure the care and treatment received was in line with their choice and preference.

People had access to information about the services provided by Garden House Hospice, which were readily available throughout the service. The information leaflets provided covered a range of topics, which included practical support with finances, along with 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 as part of their consultation with health care professionals to help them understand their health needs and how to manage them.

Visitors were encouraged to visit without restriction if people were happy to receive visitors. Family members who wanted to spend more time with their dying relative were accommodated in the hospice. Staff at reception was polite and ensured that people were happy to be visited, before the visitors were taken through to the ward or room.

Staff developed very positive working relationships with people. They were knowledgeable about people and were able to clearly describe how to support people with their varying needs. All staff we observed knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. People were assisted with their personal care needs in a way that respected their dignity. These included closing doors and asking people about their personal needs discreetly. People told us their privacy and dignity was promoted by staff who "always knock before entering." Visitors and family members' privacy was respected and promoted by staff. The 'Quiet Room' within the hospice was furnished with resources appropriate to the needs of all main faiths. Relatives referred to this room as the "lovely Quiet Room" and during the visit the room was observed being used by nursing staff and bereaved relatives. We observed a staff member who stayed with and supported a bereaved relative for up to one hour to ensure they were prepared to view the deceased body of their loved one.

We saw that staff were kind and courteous and showed respect to people and family members. There was a warm, friendly atmosphere. The hospice was very busy on the day of the inspection visit; several people were requiring a high level of care. However all staff appeared calm and patient.

## Is the service responsive?

### Our findings

Staff from the hospice delivered a range of services to help people live with changes that had been brought about by their illness from the point of a life limiting diagnosis. The registered manager told us, "We aim to increase confidence, self-esteem and quality of life to empower them [people] to feel in control and live life to its greatest potential."

People, following the initial referral to the hospice, had an assessment carried out by one of the team members to discuss priorities, matters which were important to them and any goals they had, as well as any concerns people had. This gave people an opportunity to develop a plan of action collaboratively with the staff team.

The specialist hospice team provided individual medical, emotional, spiritual, psychosocial and family support as well as complementary therapies, physiotherapy, and invaluable peer support to people. To meet the unique needs of people there were a range of flexible courses which ran for an hour, two hours or half a day. These included: exercise sessions, 'Coping Well', Tai Chi, relaxation, and drop in coffee groups. Information about these services were given to people when they were referred to the hospice and shared in the community in fundraising events. People told us this was a good opportunity for them to socialise with other people with similar conditions.

During the inspection visit a "Breathlessness Exercise" group session was being run by a physiotherapist who was assisted by volunteers with participants being encouraged to agree exercise plans. People who participated said that the sessions were very helpful. One person said, "It is good to be able to talk with someone in the same boat as yourself." A relative told us they were given a hand massage by a therapist which they found very relaxing.

The admission procedure to the inpatient unit ensured that people agreed to an action plan in relation to their symptoms, emotional and spiritual support, pain relief and specialist care. Initial assessments had been undertaken to identify people's support needs and care plans had been developed outlining how these needs were to be met. There was a strong emphasis for people to receive person-centred care and support and this had a positive effect on people. For example a person who was nearing the end of their life was concerned about their relative whose first language was not English. The relative was not able to fully understand the changes and deterioration their family member was experiencing. The person had asked staff to arrange an interpreter for their relative`s next visit to support staff in explaining what the person was going through. The hospice staff was arranging this.

Staff were able to demonstrate their understanding of how to give people personalised care. People had detailed individualised care plans which described their needs, personal circumstances, preferences and choices. The care given to people followed the care described in their care plan. However staff took time and talked to people and quickly found out and responded to people`s changing needs and preferences. One person told us, "They [staff] listen to me, if I don't want something they respect this. They do everything as I want them to."

People`s constantly changing needs were assessed 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. Recent and past information was shared with care staff on return from holidays or their days off in handovers and MDT meetings. Time was given to allow for staff to discuss sad events which had occurred whilst they had been off duty.

People's care plans included strategies with regard to their pain and symptom management which were updated on a continual basis. The updates included changes in people's health and how to respond when people experienced changes in their symptoms or pain levels. Discussions with people about their wishes and their consent about any changes in their treatment were recorded. This meant that when people's pain increased they could be confident that responsive action of their choice was taken by staff.

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 can't think of anything negative; I have absolutely no concerns."

The registered manager provided us with detailed information about two complaints that had been made by relatives during 2015. They had been thoroughly and appropriately investigated and dealt with. There was clear indication that where appropriate lessons were learned and actions were taken to ensure improvements had been implemented. The service received numerous compliments and cards with very positive feedback and these were displayed on the notice board in the communal areas. There was a clear audit process to ensure that the registered manager undertook a comprehensive review of the complaints and compliments recording systems.

## 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, "This place is amazing from the top [management] to the care staff they are kind and caring and they know what we need." They told us that all staff, regardless of their role were friendly, kind and supportive and gave a sense of calmness to the service. Our observations demonstrated that staff across all areas within the service were motivated and enthusiastic and committed to providing a high quality service to people and their families.

Staff talked to us with passion about the hospice and the people in their care. They told us they enjoyed their jobs despite the challenges and the nature of the work and they valued the support they received from their peers and senior managers. One staff member told us, "I just love my job. I love caring for people and here I am supported by the manager to give my best." Another staff member said, "We have a supportive team and an effective Senior Manager. The manager made a big difference since they started working here." There were regular meetings for staff at all levels where they discussed all aspects of the services provided.

Staff received yearly counselling vouchers which could be redeemed anonymously and this service was confidential. Nursing staff working in the hospice attended annual 'Away Days' and this was provided to ensure they had the opportunity to talk about their feelings and relax.

There was a clear management structure with senior staff allocated in lead roles, this included a registered manager for the service, quality and compliance manager, finance manager, fundraising manager and a manager of each of the services offered by the hospice. 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.

The registered manager was in position since June 2015 and they were dedicated to constantly improve the service. We saw evidence of the positive impact the registered manager had on the service. They had implemented robust communication systems between services and ensured that best practice was shared between these as well as lessons were learned if it was needed to ensure constant improvement. For example there were regular clinical and senior service management meetings where the managers of all the services offered by the hospice discussed improvement plans, events and shared ideas on how the services were run.

The registered manager evaluated the service when they started at the hospice against the methodology used by the Care Quality Commission. They measured if the service was safe, effective, caring, responsive, and well-led and implemented an action plan to improve on each area. They regularly reviewed their action plan and we were able to identify the significant improvement they achieved in the past months since they were managing the service. For example they identified that medicine management systems were not robust and they implemented new ways to audit and monitor medicine management practices. They re-

trained staff to follow current best practice guidelines and as a result medicine related incidents had reduced. They improved staff training in areas like safeguarding and MCA and DoLS and we found that staff was very knowledgeable in all these areas. One staff member told us, "This is a good environment to work in and I am happy that there are going to be further improvements. I am looking forward to the improvements in the environment and processes."

The management team led by the Chief Executive Officer and Director of Patient Services (registered manager) were reviewing their policies and processes and had plans to move to a fully computerised care planning system later in the year. At the time of our inspection there was a combination of paper notes and a computerised system. All staff we spoke with were able to locate information in a timely manner and showed good knowledge of the needs of the people in their care. The systems used were easy to understand, we were able to navigate our way around the systems after a short while of being there. This showed that the management and staff team were working safely and effectively in this transition period and their systems were likely to improve further following the planned changes. All the staff were very positive about the planned changes for the hospice. They felt the computerised system will be quicker and more accurate in recording information about people.

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 inpatient service, like arranging and distributing flowers around the hospice, serving tea and coffee to people and visitors and greeting visitors at reception. Volunteers were also used to support fundraising events to raise funds to sustain the services provided by the hospice and for the hospice to be able to support more people in need.

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 told us, "We actively seek to promote a positive culture that is open and inclusive to people who use the service and their relatives, the staff who work at the service and the wider community."

The service provided a 24 hour advice telephone line, which was accessible to everyone, including health care professionals. In addition the registered manager had developed links with 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 doctors and nurses. The registered manager had plans to extend the service to host an outreach chemo-therapy clinic. The registered manager told us, "We are prepared to open our doors to the community, we don't want to work alone, we need to work in partnership with other organisations, acute and community service Specialist Palliative Care Nurses, social and health care professionals to meet the needs of the people in our community."

The finance and fundraising department led by the Chief Executive Officer was committed to providing and sharing information about the services offered by the hospice and were using a variety of ways to reach as many as people as possible. Information was provided in magazines, via their website; through social media and advertisements within the local press about fund raising events and open days. There were fundraising events planned throughout the year and these included walking the 12 London bridges - `Bridges of London`, a Thanks Giving, `Open garden` event at the hospice, `Starlight walk` and many more.

Members of the Clinical Service Team from the hospice held talks at local GP practices to raise awareness of

the services provided, visited local schools and built relationships with other organisations whose focus was on providing care to people in care homes. They were developing a Trust fund bid to be able to extend the Hospice at Home service over a 24 hour period to be able to offer respite service to people in their own homes whilst their family carer was away. Their aim was to raise awareness in the community of the services provided by the hospice and ensure people were referred to the hospice in early days of their life limiting illnesses for care and support.

The service provided opportunities for families and staff to shape the service. Regular surveys were carried out which asked feedback about the service provided. We found that the surveys gave overwhelmingly positive feedback to the service. We noted that the comments people and relatives gave about the service used words like, 'incredible', 'excellent', 'deeply appreciated' and 'greatest admiration'. The registered manager purchased two computer tablets for staff to use and gather 'live' feedback from people throughout their stay at the hospice. Using the computer tablet helped to ensure more people's views were gathered at the time when they used the service and any issues arising could be solved in a timely way to make people's experience of the hospice service a pleasant one.

The Chief Executive Officer from Garden House Hospice chaired the Bedfordshire and Hertfordshire Specialist Palliative Care Group which engaged all specialist palliative care providers across this area and shared good practice and innovative ways to engage with the community and other development ideas. 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 leadership at the hospice had the responsibility for running the service, under the direction of The Board of Trustees. The Chief Executive, Director of Patient Services [registered manager] and the Medical Director 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, nutrition and hydration and staff competency checks. The result of the audits influenced and developed the service. For example following an audit in staff competencies a need for the roles of 'Champions' was identified in areas like safeguarding, infection control and MCA and DoLS. The staff members identified to take up these roles were trained and offered on-going support to staff working in the hospice, constantly improving staff knowledge and this benefited people using the service. The results and outcomes of the audits conducted were visibly displayed on notice boards around the hospice to promote an open and transparent culture and give information to people and visitors.