

## Farleigh Hospice

# Farleigh Hospice

### Inspection report

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### Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Outstanding ☆

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

Farleigh Hospice is registered to provide care and treatment to adults and older people who have a life-limiting illness or condition. The hospice's website states, "Farleigh Hospice exists to meet the needs of local people affected by life limiting illnesses and to support those who have been bereaved."

The hospice is a registered charity and offers a wide range of services, tailored to meet each individual's medical, emotional, psychosocial and spiritual needs. Services are delivered in the way that meets the needs of each person and their family and in the place that suits the person and their family best. This can be in the person's own home, in the day care centre at the hospice or in the hospice's in-patient facility. The majority of the hospice's services are delivered to people in their own homes.

We visited the hospice site at Broomfield on 6 and 14 December 2016. On the first day there were five people staying at the hospice. We met the people who were staying at the hospice and their relatives as well as people who received care in their own homes and who were attending the day care centre. On 10 January 2017 we spoke on the telephone with a number of bereaved relatives who also used services provided by the hospice, such as the bereavement service. We also spoke on the telephone with relatives of people who were using the community or hospice at home services.

Farleigh Hospice was purpose-built about 15 years ago, very close to the Broomfield Hospital site. The hospice has an exceptional range of facilities and includes an in-patient ward, facilities for people's relatives, a restaurant, day centre, shop and reception area. The sanctuary is a multi-faith, quiet space which is open for everyone to use if they wish to. The Lantern Suite consists of a number of rooms where services such as out-patient clinics, counselling, bereavement services, hairdressing, art therapy and a range of other complementary therapies are provided.

Farleigh Hospice had a registered manager in post. 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 2008 and associated Regulations about how the service is run. The registered manager had been in post for a number of years.

People and their relatives were effusive in their praise of the staff and the services provided by the hospice. Staff were exceptionally caring, kind, compassionate and respectful of people's privacy and dignity. The hospice fulfilled its values in a culture which kept the person at the very centre of their care and treatment. Everything was based on the needs, wishes and preferences of the individual and how those needs, wishes and preferences could be recognised, supported and met. The hospice strived to give each person the highest quality of care during their life and the best, most comfortable death possible.

Staff supported relatives of the person before, during and after death for as long as, and in whatever way, the relatives needed. The bereavement service offered support to any adults who needed it and who lived in

Mid Essex. The YoYo project supported bereaved children across mid-Essex. The services were offered at the hospice, at the child's home or at their school, which meant the services were accessible to all children. The staff ran workshops for school staff to help them know how to support a bereaved child.

There were enough staff deployed to care for and support people in the way they preferred. Pre-employment checks had been carried out for new staff and volunteers to make sure they were suitable to work/volunteer at the hospice. Staff received a wide range of training relevant to their role, which made sure they had the skills and knowledge to care for and support people who were affected by life-limiting illness. Staff were very well supported by their managers and each other.

All staff had been trained in how to protect people from abuse and harm. They knew how to recognise and report any signs of abuse. Assessments of any potential risks were carried out and recognised people's changing needs. Measures to reduce risk were put in place as needed. Some aspects of medication management were not always carried out in the safest possible way.

People were at the heart of the service and were fully involved in the planning and review of their care and treatment. Care plans were personalised and based entirely on the individual's holistic needs, wishes and preferences. Services provided were responsive to people's needs and included a range of activities, therapies, events and complementary therapies. Meals were of high quality and met people's dietary and nutritional needs. The hospice worked with a range of external professionals to ensure that people's health and well-being were maintained for as long as possible.

The CQC monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People were always asked for their consent to any care and treatment they were provided with. If a person lacked the mental capacity to make certain decisions, the staff were clear about their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

The service was managed very effectively and was constantly striving for excellence and to be outstanding. People, their relatives, the staff and other healthcare professionals were encouraged to give their views about the hospice and put forward their ideas for improvements. The provider's complaints procedure was well advertised and any complaints were responded to and addressed. An effective system was in place to monitor and audit the quality of the service being provided. There was a homely, friendly and open culture in the hospice, which put the individual first.

The hospice staff worked in partnership with a wide range of other services and healthcare professionals, who praised the service that was provided to people and their relatives.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Medicines were not always handled in a way that ensured people received their medicines safely.

There was a sufficient number of staff to ensure that people received the care and treatment they needed in a timely manner. Staff and volunteers were recruited in a way that ensured they were suitable to work at this service.

Staff had been trained to recognise and report any incidents of harm and abuse. Potential risks to people were assessed and actions put in place to minimise the risks.

**Requires Improvement** 

### Is the service effective?

The service was effective.

Staff received a wide range of training appropriate for their role and were encouraged to develop their knowledge and skills. Staff were well supported by their managers and by each other.

Staff understood their responsibilities in relation to people's capacity to make decisions about their care and treatment. This meant that the rights of people who lacked capacity to make certain decisions were protected.

People were supported to eat and drink well and their nutritional needs and preferences were met. People's healthcare needs were met by a range of healthcare professionals.

**Good** 

### Is the service caring?

The service was very caring.

People and their relatives were supported by exceptionally kind, caring and compassionate staff in a way that respected their privacy and dignity.

Staff showed they cared very much about the people they were supporting and about their families. Staff frequently went

**Outstanding** 

beyond the scope of their duties to make sure people's last wishes were fulfilled.

The spiritual and religious needs of people and their families were well supported. Advocacy services were advertised for people who required the support of an independent person.

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

**Good** ●

The service was responsive.

People and their relatives were fully involved in planning and reviewing the care, treatment and support they needed and preferred. This included their end of life care and preferred place of death.

The service responded appropriately to people's changing needs and offered a range of activities, therapies and organised events.

The bereavement service and YoYo project for children ensured that people's relatives were offered support and counselling services for as long as they needed them.

The hospice had a positive approach to using complaints and concerns to improve the quality of the service.

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

**Good** ●

The service was well-led.

The service was inclusive and empowering of people and their relatives and was managed well.

People, their relatives and staff were given a range of opportunities to put forward their views about the service. These views were listened to and acted on to improve the services provided.

The management were visible and approachable and supported everyone using the service and the staff. Quality checks and audits were carried out to make sure the service continued to improve.

# Farleigh Hospice

## Detailed findings

### Background to this inspection

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

The first inspection visit to the hospice on 6 December 2016 was unannounced and was carried out by an inspection team that consisted of one inspector, a pharmacist inspector, a specialist professional advisor (SPA) and an expert by experience (ExE). The SPA was a qualified nurse with experience of providing end of life services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second visit to the hospice was carried out on 14 December 2016 by one inspector. On 10 January 2017 we spoke over the telephone with relatives of people who were using, or had used, the services provided by the hospice.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about. The information also included the Provider Information Return (PIR) that the provider completed in July 2016. This 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.

During our visits to Farleigh Hospice we observed how staff interacted with the people who were using the service. We spoke with 12 people who were using the in-patient service or the day service, seven relatives and four volunteers. We also spoke with a number of staff: seven health care assistants; four registered nurses; one development nurse; two administration staff; the Quality Improvement Lead; the Bereavement Service Lead; a representative from human resources; a chef; and the registered manager. Following our visits we spoke with a further five people who had used the services provided by the hospice, including the bereavement service and the Yo Yo project (a bereavement service for children). Four of these people had also had relatives who had used the in-patient or community/hospice at home services. Two healthcare professionals wrote to us to tell us their views about the service.

We looked at care records relating to four people as well as some other records relating to the management of the hospice. These included the Quality Account, two staff personnel records, complaints and compliments and some of the quality assurance audits that had been carried out.

# Is the service safe?

## Our findings

People in the in-patient unit told us they were happy with the way their medicines were handled. One person said, "They've sorted out my drugs. They explain clearly what's happening and why a new drug is being introduced."

There was an effective system for obtaining medicines from a community pharmacy. Prescribing was done on dedicated treatment charts and records of administration were clearly documented on the charts including drugs administered through syringe pumps (medicines that are mixed together in a syringe and given through the skin). Medicines that were required on an individual basis were supplied on FP10 prescriptions. These prescriptions were safely stored and could only be accessed by authorised staff. However, we found the processes in place to track these prescriptions would not be able to identify if any prescriptions went missing.

We examined four treatment charts. It was clear from records the actual time that people had received their medicines and people who received medicines through syringe pumps were being monitored appropriately. The medicines that were prescribed on an 'as required' basis included instructions for how frequently these drugs could be administered and the maximum doses allowed. All people were receiving their medicines as prescribed.

Medicines were stored safely and securely within a secure medicines room with electronic access only for authorised staff. There was a system in place to check that prescribed medicines were within date and suitable for use. However, we found that two of the medicines that were available for use in an emergency were out of date. There was no procedure in place to check these emergency medicines regularly.

We recommend that practices are reviewed to ensure medicines that may be required in an emergency are regularly checked to ensure they are suitable for use.

Medicines requiring cold storage were kept within a refrigerator in the treatment room and the temperature of the refrigerator was monitored. However, the refrigerator's maximum temperature had been recorded as exceeding the recommended range for over a month without any action being taken. At our second visit, the registered manager explained that the thermometer had not been reset to zero when the fridge had been repaired. They assured us that the actual temperature of the fridge had been within the correct limits. Nevertheless, this error should have been recognised and addressed sooner.

Medicines that require additional controls because of their potential for abuse (controlled drugs) should be stored securely in a controlled drug (CD) cupboard and monitored appropriately by the use of a controlled drug register. We found a quantity of a Schedule 2 controlled drug not stored in the CD cupboard and not recorded in the CD register. We were also told the procedures for disposal of controlled drugs were being followed apart from for residual amounts in discontinued syringe pumps. These schedule 2 controlled drugs were not being denatured (rendered irretrievable) before being placed in the appropriate waste container. This was not covered in the hospice's controlled drugs policy and meant that the provider was not fully

compliant with the Misuse of Drugs Regulations 2001.

Medicines were checked when people were admitted to the hospice by the admitting nurse and the doctor then reviewed and prescribed the medicines as appropriate. When people left the hospice they were given information which listed all their medicines and explained how to use them safely.

A pharmacist attended the multidisciplinary team meeting once a week and reviewed people's medicines charts. Medicine incidents were reported and reviewed at a clinical incidents meeting. A doctor told us about procedures that had changed following incidents, for example, following a medication error when a person moved to the hospice, medicines were now reviewed by doctors on admission. This meant there was a process to learn from events, to introduce measures to reduce the likelihood of a similar event occurring and to keep people safe. There was a system in place to deal with alerts and recalls of medicines.

Arrangements were in place to enable people to self-administer their own medicines if they wished to do so. No one was self-administering their medicines at the time of our inspection visits.

When medicines were used outside their licence, this was discussed with people and written information was provided in the patient guide to allow people to make an informed choice about their treatment. The use of medicines outside their license is widespread within palliative care and it is when a medicine is being used differently to how the company manufacturing the medicine intended.

There were current medicine policies in place and we were told about medicine audits that were being done by the hospice staff with regards to controlled drugs and prescribing. All staff involved in medicines administration had undergone competency checks when they joined the service. They had their competence re-assessed at regular intervals to ensure they continued to give medicines safely.

People who used the in-patient service told us they felt safe in the care of the staff. One person said, "I feel wonderfully safe in here." People gave us various different reasons to explain why they felt safe. These included that staff were always available when needed, that they were given clear explanations about care plans and medicines and that they had confidence in the competence of all the staff. People's comments included, "I know what's happening. I'm kept well-informed and I trust the doctors; they're as straight as a die" and, "When you press the buzzer they come instantly." A member of staff told us, "I [would never worry] about members of my family being here; I know they [would be] safe."

Staff demonstrated they were competent to recognise when people were at risk of avoidable harm or abuse. Staff told us they had undertaken training in safeguarding adults. Staff who worked with children and young people had also undertaken training in child protection. Staff said they would report any concerns to a senior member of staff, to the manager or to the social worker employed by the hospice. One member of staff said, "People talk to us. I would pass it on [to a nurse]." Most staff also knew how to report concerns to an external body responsible for safeguarding, such as the police or the local authority. For example, a person who was living with dementia and being cared for by their relative had told staff they were always hungry. Staff had reported this to the local authority's safeguarding team. There were posters in the hospice, which gave telephone numbers of who to contact if anyone suspected someone was at risk of avoidable harm.

Assessments of any potential risks to people were carried out and guidelines for staff were in place to minimise the identified risks to people. These recognised people's changing needs and the assessments were regularly updated. People and/or their relatives were always involved in any discussions about risks and decisions were made based on what the person wanted. Any guidelines made sure that the person's

rights to take risks were protected. Risks included each person's risk of having a fall and the risk of the person developing pressure ulcers. We saw that any falls were recorded, analysed and action taken, if possible, to prevent recurrence. We also saw that for one person who had developed a pressure ulcer, a full investigation (root cause analysis) had taken place. 'Lessons learnt' and 'actions taken' were recorded, but in this case it had been found that on root cause factors, the pressure ulcer had been unavoidable.

We checked whether there were enough staff to meet people's needs and keep people safe. People told us there were always enough staff. One person said, "They're always on hand when you press the bell." Another person told us, "There's always someone there to explain things when you need them." During our inspection visits there was a sufficient number of staff on the in-patient unit and in the day care centre to keep people safe and fully meet their needs. Staff told us that sometimes there were not enough permanent staff, but that any gaps in staffing were covered by bank staff and agency staff. A senior member of staff told us that staff were "great for doing extra shifts." They also said that only one agency was used, which tried to always send staff who had worked at Farleigh Hospice on previous occasions. This ensured people were supported by agency staff who understood the provider's policies, procedures and ways of working. In addition, the work done by the volunteers was invaluable in supporting the staff team.

The provider had a recruitment procedure in place to ensure that thorough checks were carried out before new staff started working at the hospice. These checks included references from previous employers, a criminal record check and checks on any gaps in employment history. New staff had to make a declaration of good health and provide proofs of identity. Staff signed a contract to show they were aware of their duty to provide the hospice with details of any changes to their criminal record. Staff working in the Yoyo (children's) team underwent a criminal record check every three years. Staff also underwent additional checks depending on their role. For example, anyone employed as a driver was assessed (by the occupational health team at Brookfield Hospital) for their fitness to drive. There was also a procedure in place, although rarely used, to support the management team to ensure that staff who were not suitable to work at the hospice did not continue in their employment.

Volunteers were used extensively by the hospice to support the staff. Farleigh Hospice had around 850 volunteers who had all been through the volunteer recruitment, induction and training programme, including attending a welcome event. One volunteer told us they "had waited two months while the checks were done." The volunteers we met told us how much they enjoyed working at the hospice and that they felt valued as part of the team.

## Is the service effective?

### Our findings

On the first day of our inspection visit to Farleigh Hospice, a 'Welcome Event' was being held. These events were held regularly throughout the year for new volunteers and new staff of all grades, including doctors. At the event, experienced staff gave presentations about various aspects of the history and work of the hospice service. Volunteers in particular told us they had found the event very informative and that it supported them to carry out their role effectively.

The provider had procedures in place which helped to ensure that staff and volunteers were trained and supported to effectively meet people's needs. Following their recruitment, all new staff and volunteers completed an induction programme, based on the role they were employed for. They were given an induction booklet, which they worked through with their line manager, mentor and other staff. One member of staff told us how they supported new members of the team through their first few days. They showed them how to carry out practical tasks and made sure they had emotional support. They said, "I tell them [new members of the team] to let me know if things are too much."

The registered manager told us, and staff confirmed, that staff were offered a wide range of training relevant to their role. Training was available in many forms, including external and internal courses, distance learning and electronic learning. The registered manager said that all the nurses were supported to undertake a degree in palliative care. Some of the hospice staff, such as doctors and specialist nurses, shared their learning and skills in training sessions for other staff in areas such as motor neurone disease or an aspect of dementia. One member of staff, who had been employed in care before starting work at the hospice, told us, "What a change [from my previous employment]. There's lots of training, statutory and mandatory and additional hourly sessions given by doctors and nurses." Another member of staff told us that following a session by the speech and language therapists, they now felt confident to do the right thing if someone was choking. We saw a board in the staff room that had been filled with information about dementia. Staff told us the board was changed to a different topic each month, so their knowledge in different areas was constantly updated.

Staff were appropriately supported in their work. Staff said that when they first started working at Farleigh Hospice, they had clinical supervision until they were deemed competent in that specific area of care. Staff also underwent regular checks on their competence in areas of care such as administering medicines. Staff told us their training needs were identified at their annual appraisal and actions put in place. They said they were encouraged to develop and that training was made available. They were able to apply for funding for training courses and were given time to attend training. All staff had their own training matrix, which detailed the training they were required to do. The matrix had to be 'signed off' as completed and was reviewed after six months. One member of staff told us they had completed a diploma since working at Farleigh Hospice. Another told us they were developing their skills and learning how to assess a person's psychological needs.

Several staff had taken on a role as 'champion' in an area of the service that interested them. For example, there was a tissue viability champion and a dementia champion. These members of staff made sure they

were up to date with current good practice and current thinking in their particular area. They then cascaded information to their colleagues. This ensured people received care based on up to date practices and knowledge. One member of staff told us they were a dementia champion. They said, "I get the training I need to support my role." The registered manager told us that several staff had attended training to become a 'Care Maker' (an NHS initiative to select staff who demonstrated a commitment to spreading the word about Compassion in Practice). A 'nurse development' role had been introduced to the hospice and staff in the community team told us this had been "hugely successful".

Staff felt very well supported by the management and by each other. One member of staff told us, "It's a great place to work and it moves with the times... We all get on well together and are happy to discuss any issues. [Staff] stay for years which is a reflection of the ... support within the unit." A member of staff from another team said, "[It's] a great area to work. I feel well supported by the clinical lead and the doctors. Staff stay, which is a reflection on ... team support." A third member of staff stated, "We have a fantastic team, great support, best job ever."

The hospice staff were highly regarded by their community nursing colleagues and other healthcare professionals they worked with. One healthcare professional wrote, "The Clinical Nurse Specialists...have a high level of knowledge and skills in the field of palliative and end of life care."

Volunteers were provided with ongoing support for their roles within the hospice. The head of the adult bereavement service told us about the six-day training course they ran for volunteers who were joining the team as support workers. They said, "I want them to be constantly learning." Monthly group supervisions were held for the bereavement team and each quarter a training day was arranged in a range of topics.

We saw and people told us that staff always asked people for their consent to any care or service they received. A healthcare professional said they were confident this always happened as it was clearly evidenced in each person's records. Care records showed that people had been fully involved and had consented to the care and treatment that was planned for them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether staff understood and were acting within the principles of the MCA. The registered manager told us that staff received training relating to the MCA and DoLS every year. At the time of our inspection visits, people using the service had mental capacity to make their own decisions. However, staff demonstrated they knew their responsibility to ensure decisions made on behalf of people who lacked capacity were made in the person's best interests. Best interest decisions were always made by a multi-disciplinary team and involved the person's relatives. Staff also understood their responsibility to ensure that any conditions on authorisations to deprive a person of their liberty were met. The registered manager told us that although applications for DoLS authorisations had been made to the relevant authority, the applications had been withdrawn before each person died. This was because the person's liberty became restricted by their illness and not by any actions taken by the staff. Withdrawal of the application meant that the additional procedures related to DoLS following death were not necessary, which was less stressful for their family.

People and their relatives were very satisfied with the quality and choice of food available. One person told us, "The food is delicious and always wholesome." Another person said, "The food is very good; it's stuff I can eat." Staff were fully aware of each person's nutritional needs and their preferences, including whether they needed a modified diet, such as low sugar or pureed food. The chef told us that people completed a 'choice sheet', which included a tick-box for whether the person needed a modified diet, the size of the portion they wanted and whether they had any allergies. One person told us, "I wasn't eating when I came in. I got back to eating through smelling the roast pork." A relative explained how much they appreciated that staff had continued to offer their family member food, even though they didn't want to eat.

People's day to day health needs were met by the multi-disciplinary team of hospice staff, supported by NHS specialists such as consultants, GPs and community nurses. There was consultant cover 24 hours a day, every day, to support the hospice's nursing team. A relative told us how hard the team had worked to manage their family member's pain when they were an in-patient. They had been very impressed, and very grateful, that because their family member's condition was very rare, three leading consultant oncologists had met at the hospice, during the weekend, to work out the best treatment for the person.

Various therapy sessions, including complementary therapies, were available at the hospice for people who wanted them. These sessions were an important aspect of supporting people to maintain their health and were also available to people's relatives. On the day of the inspection there were reflexology sessions for those who had booked them. The hospice had set up a small gym for people to use. The registered manager told us how proud people were of their achievements in the gym because many of them had thought they would not be able to use the equipment. One person said, "I never thought I'd be able to do something like this." A relative told us that the physiotherapist and occupational therapist had been very helpful in showing their family member what they could achieve in the gym, which had been beneficial for their wellbeing.

## Is the service caring?

### Our findings

People and their relatives were effusive in their praise of all the staff, whichever team the staff worked in. They consistently spoke of kind, caring and compassionate staff. Their comments included: "The amount of care and compassion I've been shown here is amazing"; "Everyone is really kind. I give them five out of five"; "The staff are fabulous and caring"; "They had some cracking staff"; and "We only have the highest praise for the staff. [They've been] very helpful and very friendly." A healthcare professional wrote, "The hospice staff put the patient at the centre of care and I have only witnessed kind and compassionate interactions."

One relative described their family member's last few days, which were spent in the hospice. They told us, "The level of effort that they put in [to meet person's care and treatment needs] was exceptional." They praised the whole staff team, including the consultants who had been involved in their family member's care. They also said, "The nursing staff were great. [Name of staff member] was fabulous...[they] spoke to him so beautifully and so calmly. Told him not to be afraid. Spoke to him in such a way it calmed him down. Spoke to him in such a respectful way." Staff spoke with us about their work with compassion and empathy for everyone involved. One member of staff explained that staff had "a heightened sense of caring", which also resulted in them being very sensitive to their colleagues' needs and in caring for each other.

A healthcare professional wrote, "Patients are treated with kindness, compassion and respect. Staff involve patients in decision making...they always go that extra mile."

We were told how the care people received and the way they were treated was completely person-centred. One relative said, "The team that came to see [family member] were fantastic. It was really, really personal, asking what we wanted and how they could meet [person's] needs." This relative told us that the staff had made it clear they wanted to get to know their family member as well as they possibly could. The relative reported that by the time the person arrived at the hospice all the staff knew who they were and knew about them. Staff greeted them by their preferred name, which the person "really appreciated." Staff had taken on board details about the person's life, such as the job they did, which gave staff an insight into the type of person they were and how they would want to be treated. The relative said, "They made a lot of effort about knowing who he was as a person: it was done in such a lovely way." A person who used the day services, speaking of their experience in the hospice, said, "They've got to know the real me." A member of staff told us that most of the staff "have an overwhelming desire to look after and help people." However, staff recognised that this was too much for some people, so "everyone gets the same level of care and compassion, based on what they want."

People and their relatives told us they were fully involved in all the decisions about their care, including care at the end of their life. People were supported to make their own decisions, including advance decisions not to have treatment. One relative explained how grateful they were that their family member was listened to and their wishes respected about the way they wanted their life to end. Another relative was very pleased that staff listened to them and their family member. Staff took time to explain everything to people and their relatives and relatives told us how much they appreciated the effort staff had made in this area. They said there was also very helpful written information available, which staff had made sure they received:

"They gave us a booklet that gave us all the information we needed, quite detailed, including what to expect after the death." They also said that the terminology used by all staff "really helped." For example, staff "explained he was going to lie in the patients' lie-in area (not the cold room)."

There were no restrictions on visiting and relatives spoke of being welcomed by staff who were observant of their needs. One relative told us how the whole family had been able to stay at the hospice continuously for several days. Visitors were always made to feel that they were a very important part of the team caring for their family member. One relative told us, "The treatment of [name] was exemplary. What I hadn't expected was the way we as a family were looked after: it was faultless. The staff just seemed to know what [families] going through such a horrendous time needed." Another relative told us how relieved they were that all the staff listened to the family, acknowledging that family members were the ones who knew the person best. A third relative said, "[Staff] have been really kind and caring; they've answered my questions clearly and involved me in my [family member's] care." A health care professional wrote, "Patients are listened to and they are actively involved in the decisions regarding their care."

Staff were diligent about respecting people's privacy and dignity at all times. One relative said, "They showed a real level of respect." We saw that staff always knocked on doors and waited for an answer before entering the room. Notices on the bedroom doors indicated when care was being given, staff used privacy screens and curtains when providing personal care in bedrooms and staff did not talk about people in front of anyone else. Staff told us, as an example of helping to maintain people's dignity, that they used "lots of bubbles" in the bath. People and their relatives confirmed that privacy and dignity was respected by staff. One person said, "Everyone is polite and respectful. Even the cleaners ask me if it's okay for them to come in and clean." A relative told us, "They [staff] were fantastic. They screened calls and visitors for us – we gave them a list and no-one else was allowed." In the PIR the registered manager wrote, "There are appointed Dignity Champions who ensure dignity and respect are at the heart of all the hospice does."

Several people, relatives and staff gave us examples of where they felt that staff had 'gone the extra mile'. One person said, "You don't get the feeling you're being a nuisance to them at three in the morning." One relative said that their family member had been in such pain that they had not wanted personal care such as being shaved, even though they had always been very particular about how they looked. Staff had asked the relatives for a photograph of the person and once the pain was under control they "made such an effort." Staff washed and shaved the person, trimmed the person's moustache and generally made them clean and fresh. It helped the family hugely that their last memories were of someone who once again looked like the person they had known. We were told that when one person died, the registered manager, one of the nurses and the doctor had all come in on their day off to see the person and the family. A member of staff told us about a time when they had had to go and meet a person who was about to be admitted to the in-patient unit, in reception. They spent a lot of time with the person because "they couldn't get any further." Another member of staff recalled when a staff member's friend had brought a classic car to the hospice because a person had talked about their passion for classic cars. Staff had helped the person sit in the car and the friend had kept their promise to the person to take the car to their funeral. A relative who did not live in Mid Essex told us that the bereavement service had found a counselling service for them in the area in which they lived.

The hospice ensured that people and their families had support available to meet their emotional, spiritual and religious needs. Staff were trained to be aware of the cultural needs of people and their families and to ensure that when a person died those needs were met in a sensitive and culturally appropriate way. People commended the hospice's spiritual care services. One person said, "[Name], the chaplain is an inspiration."

Relatives who had used the bereavement service were overwhelmingly pleased with the service they had

received. One relative, speaking about the counselling service, told us, "[It was] absolutely brilliant. There was no time limit, it helped me enormously and I could keep going until I was ready [to stop]." Another relative told us they had received counselling following the death of their family member. They said, "Farleigh have done their level best to hold my hand and guide me through the process [of grieving]." They added that just as they felt they had got through it, another close family member died. Farleigh Hospice staff "let me decide to continue with the service." A third relative said, "They're the experts, they're brilliant. I'm really happy with the service and I'd recommend it to anyone." A health care professional wrote that relatives they knew had been "pleased with the service they have received and have felt supported."

Relatives also told us about other areas of support that they were able to access for as long as they wanted following their family member's death. These included "a wall of remembrance – you can go anytime and write a message"; and "a book you can write in – people continue the story, sometimes for years, telling the person about the year they've had." One relative told us that the bereavement service had arranged a young widows' group and they had met someone in a similar position who had become a very good friend.

Staff told us about the Yo-Yo project for children who were bereaved. This project, partly funded by Children in Need, supported children aged four to 18 years who were struggling with bereavement. A relative said that this project "really helped" their child. The child was very angry and the counsellor had helped the child understand what they were going through. As well as individual counselling and groups for children to meet other bereaved children, the service arranged events such as a magic show and setting up a gallery of pictures of the person each child had lost. The relative said, "[My child] thoroughly enjoyed it... including meeting other children who'd lost someone." The relative added, "I can't praise them [staff in the bereavement service] enough. They've really helped us deal with our grief."

The registered manager spoke with us about advocacy services that were available if anyone needed the support of an independent person. The registered manager understood the role of the independent mental capacity advocate (IMCA) if a person did not have mental capacity and needed an independent person to act on their behalf. However, IMCAs were rarely requested. The hospice had links with a number of other organisations, such as the Macmillan welfare team, Age UK and the local authority who would all support a person if they needed an advocate.

## Is the service responsive?

### Our findings

The hospice operated an open referral system for all of the services they provided. This meant that people could refer themselves, or be referred by other healthcare professionals, friends and relatives. A 'rag' system was used to triage all referrals to ensure the referral met the hospice's criteria and to prioritise them. All referrals were presented at a weekly meeting of the multi-disciplinary team so that decisions could be made about the services people might require. A healthcare professional told us, "The referrals to Farleigh are triaged and dealt with in a timely manner."

Assessments of people's needs were undertaken by relevant staff. These assessments were holistic and very detailed. One relative told us that a member of the hospice team (who became their keyworker) worked with a social worker from the local authority to find out about their family member's needs. They spent two hours discussing what the person wanted with them and their relatives. This relative told us, "It's [the hospice is] working so well with local services. That's very important because the hospice on its own has limited resources. So it's good they work so closely with others such as the social services, the equipment suppliers and the carers [domiciliary care staff]."

Each person's care records, including their care plan, were held on an electronic system so that, with the person's consent, their records could be shared with other healthcare professionals. This improved communication and sharing of information between services. Healthcare professionals told us that the weekly multi-disciplinary team meetings demonstrated that people were involved in decisions about their care and treatment. A healthcare professional told us, "Communication is generally good and the patient is usually at the centre of care and decision making."

People and their relatives told us that the hospice provided services that were fully responsive to their needs. They were involved in any decisions about their care and treatment and in any changes. They felt in control of their care and that staff understood them. The registered manager explained that for at least half of the people using the hospice's services, their home was their preferred place of care (PPC) and the hospice was their preferred place of death (PPD). This meant that a lot of people had chosen to spend just a few days at the hospice at the very end of their lives. There was a 24 hour on-call system so that people who needed it could have support at any time.

Farleigh Hospice provided a bereavement service for adults and children across mid-Essex. A wide range of services could be arranged, based on what each person wanted and based on the understanding that people's needs changed frequently when the person they had been caring for died. The range of services included one-to-one face-to-face or telephone support; group sessions; sessions at home or at the hospice; cookery and art courses; drop-in sessions and bi-monthly memorial services. There was a children's room at the hospice where children could have therapy and counselling sessions. However, staff told us that most of the sessions were offered to children at their school. This meant that the service was accessible to every child as parents did not have to worry about transporting their child to the hospice and the child was in a familiar environment. A family meal was held once a year to show people they could still have fun as a family.

The registered manager and staff told us about the hospice's plans to respond to the needs of younger people who stayed at the hospice. Plans had been drawn up and approved to turn a three-bed ward in the in-patient unit into a bed-sitting room. A visitors' room, with its own shower room, television, refrigerator and telephone, was available for people's families to use when they needed to.

The registered manager explained that there had recently been some changes in the staffing structure on the in-patient unit. The skill-mix had been altered so that there was increased seniority in the team. They said this meant that people's needs were better met. For this same reason, changes were taking place in the day services that were being provided. The registered manager explained that they were moving towards a rehabilitation model of care and moving away from people's understanding that this service was only about clinical/medical need. The hospice was responding to need and wanted people to understand that they could do more, even though they were ill.

As well as the services provided at the hospice and in people's homes, the hospice staff and volunteers provided services to respond to the needs of the wider community. For example, the bereavement team had held workshops to share strategies with school staff in how they could support children who were bereaved. Over 200 school staff had been to the workshops. The team was also working with a provider of services to people with a learning disability, to enhance the skills of their support workers in supporting people with a learning disability who were bereaved.

Hospice staff worked hard to provide meaningful activity for those people who wanted to participate. People and their relatives were offered complementary therapy sessions such as reflexology and counselling sessions were arranged for those who needed them. A hairdresser visited the hospice and there was an art room in the Lantern suite where regular art therapy sessions were arranged. People told us how much they enjoyed the art sessions. One person said, "I really enjoyed this morning, it's been really helpful to me." On the first day we visited, one of several Christmas parties being held in the day services centre was underway. A carol service was held in the Sanctuary followed by an informal discussion led by a volunteer.

There was a well-stocked shop in the reception area. A volunteer who had worked at the hospice for many years told us how the shop fulfilled a service for people. They described the shop as "a facility for patients... It gives people the chance to buy gifts without their relatives".

The hospice had a well-advertised complaints procedure, which impressed on everyone that the hospice management welcomed comments and complaints. People and relatives we spoke with told us they had no concerns about the care service provided by the hospice and they had never had to make a complaint. The registered manager showed us that when concerns had been raised, they had been addressed. A healthcare professional confirmed that the hospice team used people's experiences, concerns and complaints (anonymised) as learning tools for all staff and other professionals involved in providing care and treatment at the hospice.

In the PIR the registered manager outlined themes from complaints received during the previous 12 months and gave examples of what had been done to address the issues. For example, staff attitude and communication had been a theme. The registered manager wrote, "Staff sometimes get it wrong." They had deduced that there was a need for constant learning and refining of communication skills, which they said they had addressed with a combination of shadowing more experienced staff; supervision and reflection; and training. This demonstrated that the hospice used comments made about the service provided to drive improvements.

## Is the service well-led?

### Our findings

People and their relatives were consistent and fulsome in the praise they gave to all aspects of the service provided by Farleigh Hospice. One relative, whose family member had been an in-patient for several days, told us they had written to the Chief Executive to tell them that "the whole process has been exemplary." Another relative told us, "We consider ourselves very lucky that Farleigh Hospice has taken us under their wing." A third relative said, "I've been singing their praises to various people...it's a brilliant institution." Another relative, who was also a healthcare professional, admitted that they were "overly critical and seldom impressed". However, their experience of Farleigh Hospice had been "a real eye-opener...excellent from the very beginning." A number of relatives explained that they made donations and raised funds for the hospice because they were so grateful for the quality of care they and their family members had received.

A healthcare professional, who also described themselves as a service user as the hospice had looked after their relative, wrote, "I will never forget the wonderful care and support we received as a family." They continued, "Strong leadership...ensures not only that Farleigh is an effective, caring and highly respected organisation in Mid Essex, but that the patients who are under their care receive excellent, caring, high quality, safe and compassionate care."

Our discussions with everyone involved with the hospice confirmed that the service had an inclusive and empowering culture. It focussed firmly on responding to the needs and goals of each family and each individual family member. Staff and management went out of their way to ensure that everyone was fully involved in the service provided to them and to ensure that the service was of the highest possible quality. The registered manager showed us a document entitled "Farleigh Hospice Culture". They told us this was sent to all prospective staff with the job description and described "how we do things round here and the behaviour we expect." One member of staff said, "[As a team] we are passionate about what we do and we all have the same ethos and values. Patient choice, respect and dignity at end of life are paramount in our approach. We know we do it by the thanks we get from families."

Families told us their views were always sought, and acted on whenever possible. A healthcare professional told us, "Farleigh understand their business and work with us and other organisations to deliver a seamless service for patients who are on their journey. Collaboration is encouraged from within Farleigh and this is evident in the way we work together." The majority of staff we spoke with told us that they had opportunities to put their views forward and their ideas were acted on. For example, the registered manager said they had listened to the staff and re-designed the intranet. We saw team meeting minutes, which recorded the actions that had been taken since the previous meeting. Staff told us they completed a written survey annually. One team of staff, who were being affected by some of the changes in service delivery that were taking place, were not quite so happy as the others. They felt they had not really been listened to.

Volunteers said they enjoyed working at the hospice, felt valued and part of the team. Comments from volunteers included, "The people here are so friendly"; "I certainly feel valued"; and "I'm kept informed and am absolutely made to feel part of the team." Staff also told us how much they enjoyed working at the hospice. One member of staff said, "I feel very privileged to work here." Another stated, "I like the job that I

do...the future looks good. I always feel valued here." A member of the administration team said, "I love my role and I like the people who work here." A nurse told us, "I love working here, everyone is very supportive, I can approach anyone and I know they will listen."

People, relatives and staff praised the management of the hospice. They told us that the hospice was well managed and that management and staff were accessible and approachable. Everyone knew who the managers were and felt comfortable about talking to them. Our discussions and evidence we found during the inspection showed us that the service was managed well. The manager was very visible and everyone we spoke with knew members of the management team. One member of staff said, "The management within the unit is really good. We have two managers who support us fully." In the PIR the registered manager wrote, "There is a clear management and governance structure which facilitates a culture of consultative and open leadership."

Each year the Quality and Improvement Lead produced a Quality Account. This member of the management team told us that as soon as the Quality Account was produced, work started towards the next year's Quality Account. They told us, "We're very keen to get people's feedback about our service." The Quality Account for the period April 2015 to March 2016 was entitled 'Living our values'. The Quality Account set out what had already been achieved and how the hospice planned to meet its objectives during the coming year. In the introduction to this 44-page document, the CEO wrote, "The aim of this report is to give clear information about the quality of our services so that patients feel safe and well cared for, and their carers and families are supported and reassured that all of our services are of a very high standard and well governed at all levels throughout the organisation." The registered manager said that they had "talked to everyone" when they developed the four-year Strategic Plan and Operational Plan, to make sure that everyone's views were considered.

The hospice had a clear vision, mission and set of core values, which were displayed in numerous places around the hospice and in many of the information documents available to people. The hospice's vision "is of a community in which anyone affected by life-limiting illness or bereavement has access to skilled, compassionate care and support at the right time for them and in a place of their choice." Part of their mission statement states "By giving people choice and involvement in the care they receive we strive to make a real difference when and where it matters most." From their comments, people, their relatives, staff and other stakeholders showed that they felt the hospice was achieving its vision, was fulfilling its mission and that staff demonstrated the hospice's values.

The registered manager was keen to develop and improve the service provided. They stated, "Farleigh has always been looking to do things differently, not just change for change sake." For example, there was a project taking place entitled LEAN. The objective of this project was to streamline and improve every aspect of the services offered by the hospice and the way the services were delivered. For example, 'go lean, go green' involved everyone thinking about, and being more pro-active about recycling. The project had been presented at the national hospice conference.

The registered manager had completed a CQC Provider Information Return (PIR) in July 2016 in which they described various aspects of the service. In the PIR the registered manager also gave us information about what the service hoped to achieve 'in the following 12 months'. We discussed this on the day of the inspection and some of the planned improvements had already been achieved. Our records showed that during the 12 months before the inspection, CQC had received notifications from the service, as required by the regulations.

The hospice had a wide range of ways in which they checked that the quality of the service was as high as

possible. In the Quality Account, the CEO said, "We undertake satisfaction surveys, policy reviews and have a comprehensive audit programme to ensure high quality care." People, relatives and staff told us they were given opportunities to comment on the quality of the service, including via written questionnaires, meetings, emails and informal chats. Open meetings with the Chief Executive Officer (CEO) were arranged and the registered manager encouraged everyone to talk to her about any aspect of the service. An independent facilitator had been engaged to interview people and their relatives about the quality of the service they received. Everyone involved with the hospice had opportunities to have their say about the way the hospice developed. The registered manager told us, "Surveys back up whether we've got it right or not." The registered manager said that 'outcome measures' looked at "whether we've made a difference to people's lives." An action plan, developed from everyone's views and feedback including complaints was produced, checked monthly and signed off when each action had been completed. For example, people had mentioned the noise from the call bells in the in-patient unit. A pager system had been introduced so that people were not disturbed.

The registered manager said that a cleaning audit carried out by an external assessor had been "really interesting" as it had "thrown up different things." The latest cleaning audit of the in-patient unit had come out at 100%. The tool that Farleigh Hospice used for auditing had been shared with and adopted by other hospices.

A number of staff had volunteered to become a 'CQC champion'. Amongst the ways in which they ensured the hospice was ready for a CQC inspection, these members of staff carried out observational visits to all areas of the service and talked to people using the services about their experiences. The trustees carried out provider visits to check the quality of the service. All staff were given a booklet entitled 'Let's aim to be outstanding', which gave them the opportunity to check their knowledge and practice against the regulations and fundamental standards.