

Pilgrims Hospices in East Kent

Pilgrims Hospice Canterbury

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 

Overall summary

The inspection was unannounced. At the previous inspection in December 2013, we found that there were no breaches of legal requirements.

Pilgrims Hospice Canterbury is one of three hospice locations for the provider, Pilgrims Hospices in East Kent. It provides specialist end of life care and care to people with life limiting illnesses, their carers and families. Pilgrims Hospice Canterbury has a 16 bed in-patient unit and provides day therapy and bereavement counselling. The service also provides services for people in the community including hospice services for people at home, outreach clinics in Faversham, Whitstable and

Dover, support groups and 24 hour advice. Services are provided by a multidisciplinary team of health and social care professionals and volunteers. The service was providing services to 393 people in the community and in the hospice at the time of the inspection.

The hospice is run by a registered manager, who was present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People said that they felt safe receiving care from the hospice. Staff had been trained in safeguarding adults and received regular refresher courses. Staff gave clear explanations of the different types of abuse to be aware of and demonstrated that they knew the action to take in the event of any suspicion of abuse.

Risks to people's safety were assessed and managed appropriately. Assessments identified people's specific needs, and showed how risks could be minimised. Environmental and health and safety checks were carried out to ensure that the environment was safe and that equipment was in good working order. There were systems in place to review accidents and incidents and make any relevant improvements.

Checks were carried out on all staff at the service, to ensure that they were fit and suitable for their role. This included interviewing applicants and undertaking criminal record/barring checks and character references.

People said that there were enough staff available to promptly attend to their needs. Staff did not rush people and had time to give people and their family member's individual time and support. Staffing levels were flexible and based on people's individual needs.

Safe systems were in place for the ordering, storage, administration, recording and disposal of medicines.

The hospice provided a relaxed, comfortable, clean and attractive environment. This included facilities for families to relax in during the day and to stay overnight. There was a quiet reflective area in the chapel and well maintained gardens for people to spend time in.

People said that staff had the skills and knowledge to support them. They said that staff always explained what they were going to do, and sought their consent, before supporting them with their care needs. New staff received a comprehensive induction, which included training in areas necessary to their roles and also completed a wide variety of additional specialist training to make sure that they had the right knowledge and skills to meet people's needs effectively.

People said that the quality of the food provided was "excellent". They were offered a variety of choices, which took into consideration people's dietary, health and individual needs and preferences. The chef and catering staff provided specific items requested by people, and in preparing and presenting food in an attractive way.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The service had not needed to make an application under DoLS to ensure that people were not deprived of their liberty unnecessarily.

Everyone commented on the kind, compassionate and caring manner of the staff team. People said that they were always treated with dignity and respect, and were encouraged to continue to do tasks that they were able to do and be involved in making day to day decisions.

The hospice had a holistic approach to caring for people at the end stages of life, and for providing expert care and advice to people needing symptom management, or other support with life limiting illnesses. They supported the person to continue relationships with their family, to support their spiritual needs, achieve end of life wishes and offered complementary therapies. People's families were supported by the caring nature of the staff team, and in addition by support groups and bereavement counselling if they wished.

People's needs were thoroughly assessed before they were offered services at the hospice and once a referral had been made. The staff team ensured that care and support was offered in a timely way, and services were offered flexibly depending on people's needs. People's care plans were personalised and contained detailed information about their preferences and advanced decisions in relation to end of life care.

People said that they were involved in planning their care and treatment and were confident that staff explained everything to them clearly. Care plans were stored electronically and were reviewed and updated on a daily basis.

Summary of findings

The service viewed complaints as a way to learn and to improve the service. People knew how to make a complaint and the service was effective in responding to any complaint or concern that was raised.

The registered manager and senior staff were available and provided reliable and helpful support for people, relatives and staff. Staff understood the ethos and values of the service and how to put these into practice. Staff were motivated and said that there was good team working and communication, which enabled them to give good care to people who used the service.

There were systems in place to review all aspects of the service and assess if the hospice provided quality care for the people who used it. The service was proactive in education, research and local community projects to improve end of life care and care for people with life limiting illnesses and their families. Feedback from people who used the service was sought and acted upon.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Staffing numbers were assessed on a regular basis and were adjusted to ensure there were always sufficient numbers of trained and experienced staff to meet people's needs. Checks were carried out on all staff who were employed by the service.

Staff were trained in safeguarding adults and knew the action to take if they were concerned that abuse might be taking place. There were effective systems in place to manage general risks in the service and risks for individual people.

Staff managed people's medicines safely and effectively.

The premises and equipment were maintained to a high standard and were kept clean to promote good infection control

Good



Is the service effective?

The service was effective.

Staff were trained to ensure that they had the skills and additional specialist knowledge to care and support people at the end of their lives, and to provide on-going care and support to their families. Staff also had the knowledge and skills to care for people needing management of symptoms and for people with life limiting illnesses. Staff were encouraged to take further training courses to develop their skills and competencies. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and how to act in people's best interests.

People's dietary needs and preferences were taken into account and people were encouraged to eat as little or as much of anything they wanted. Meal times were important social events, which could be shared with other people, staff and/or family members. Meals were tasty, appetising and nutritious.

The hospice used a multi-disciplinary approach to meet people's health needs. This included providing people and their families with information, practical assistance and 24 hour telephone support, so that they were able to seek advice at any time.

Good



Is the service caring?

The service was caring.

Staff were friendly, caring and welcoming and carried out their duties in a calm and gentle manner. They knew people well and ensured that their individual wishes were taken into account.

People said that they were always treated with dignity and respect when staff talked with them and offered support. The hospice provided facilities to enable relatives to stay with in-patients for as long as they wished, including overnight rooms.

Support was available to people which met their spiritual needs and improved their wellbeing, such as complementary therapies and access to religious leaders and groups. A range of support was also available to people's families including counselling and bereavement services and support groups.

Good



Summary of findings

Is the service responsive?

The service was responsive.

People's were involved in planning and assessing their needs. Staff were knowledgeable about people's support needs and preferences so that care given was personalised.

Staff at the hospice liaised with other health and social care professionals in order to provide people with the care they needed and to respond to people's changing needs.

People knew how to make a complaint and information about how to make a complaint was clearly displayed at the hospice. Community staff provided people with information about making complaints about the service. Complaint information was in a suitable format and staff knew how to respond to any concerns that were raised.

Good



Is the service well-led?

The hospice was proactive in continually striving to improve and took part in education and research projects with other organisations to achieve this.

The service had been through a period of significant change. Staff understood the vision and values of the service and how to put these into practice.

There were systems in place to monitor the quality of the service. The service undertook training and research in order to identify and share best practice in supporting people with life limiting illnesses.

Good



Pilgrims Hospice Canterbury

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 checked 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 21 January 2015 and was unannounced. The inspection team consisted of two inspectors, a pharmacist, a specialist nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). 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. The provider returned a PIR within the set time scale. We also obtained feedback from questionnaires sent to people who use services, relatives and friends, community professionals, and care, nursing and medical staff.

We spoke to nine people receiving day or in-patient care, five relatives/visitors, and 15 staff. Including nursing staff, care staff, the pharmacist, a community nurse, chef, and office based staff responsible for human resources and quality assurance. We also spoke to a visiting minister. The registered manager was present on the day and supported us with the inspection.

We observed staff helping people with food and drink at lunchtime, assisting people with their needs and talking with people during the day. We saw the in-patient ward, patient lounge, chapel, and gym and day services. We also looked at three people's care plans and spoke to staff about their care needs. This was to track how their care was planned and delivered.

During the inspection we viewed a number of records including three staff recruitment records; the staff training programme; medicine records; medicines, safeguarding, complaints and infection control policies and procedures; environment and health and safety records; risk assessments and audits; user group and health and safety minutes; menus, compliments and complaints logs and quality assurance questionnaires.

Is the service safe?

Our findings

People said that they felt very safe living at Pilgrims Hospice Canterbury. Comments included, “It is very safe. My husband is happy to know that he can leave me”; “I feel safe on the ward”; and “I feel safe because there is a button, which, if I pressed, would send a lot of staff hurrying to me”.

People said that they had the freedom to go where they preferred and that there were enough staff available for them to do this. One person told us, “We have quality nurses and volunteers and sometimes there are more staff than patients!” Another person told us, “There are plenty of staff. You get help straight away”. People told us that they received their medicines at the times that they were prescribed by their doctor to be administered. Comments included, “When I call for pain relief, staff come very quickly”; “I get my medication when I expect it and if in pain they give me tablets”; and, “There is a medication regime to help with my improvement”. Staff had received training and regular updates in how to safeguard people. They spoke confidently about what they would do if they received an allegation of abuse. Staff had access to the policy and procedures in relation to safeguarding. These contained definitions of different types of abuse, staff’s accountability, and a flow chart on how to report abuse and to whom. Staff knew who to report any concerns to, and that if their concerns were not listened to that they could contact the local authority safeguarding team. Staff had the contact numbers of other agencies so that they could report any concerns without delay. Staff understood the service’s whistle blowing policy and were confident about the circumstances when they might “blow the whistle”. This is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

As part of the recruitment of new staff, they completed an application form, including a history of their previous employment. Applicants were then shortlisted and asked to attend an interview at which they were asked a number of standard questions to ensure that each applicant was treated fairly. A record was kept of the interview, which showed that staff were asked questions about their role and experience. The service’s recruitment policy was under review at the time of our visit. We were sent an updated

copy of the policy after our visit which stated that in exceptional circumstances and dependent on the nature of the post, staff may start work without any references, if the staff member was closely supervised.

We looked at the staff records of the last three people who had been employed at the service which was two staff who worked directly with people, and one office based member of staff. For staff who worked directly with people, checks had been made with the vetting and barring service. This helps employers make safer recruitment decisions and prevent unsuitable people from working with people who use care services. For one member of staff, two references had been received and for the other staff member one reference had been received from their last employer. No references had been received for the office based member of staff. There was a system in place to re-contact referees to ensure that references were received.

The service used a large number of volunteers to carry out different aspects of work such as reception duties, gardening, working in the shop and fund-raising. The recruitment of volunteers was undertaken separately and included a comprehensive interview processes and criminal record/barring and vetting checks.

We saw that people’s needs were attended to promptly. Staff working on the ward, in the day hospice and in the community told us that there were enough staff to enable them to carry out their roles fully. Staff said that the ratio of staff to patients enabled them to go the “extra mile” for people using the service and also support their relatives and friends.

Staffing levels on the ward were flexible and adjusted in accordance with the staff skill mix, the number of in-patients and the complexity of people’s needs. There were two full time nursing sisters who took responsibility for the day to day running of the ward. They were supported by registered nurses and health care assistants, to provide the care people on the ward needed. The day hospice was run by staff and volunteers, and community services were provided by experienced trained staff. There were many volunteers who supported the staff on the ward and in the day hospice as well as working in the reception. Some volunteers also provided specialist services in the hospice and in the community, such as hair dressing and hand massage. In addition the service employed a team of health and social care professionals including social

Is the service safe?

workers, bereavement counsellors, occupational therapists and physiotherapists. These professionals supported people and their families using the hospice and also people who lived in the community.

The hospice had good support from the pharmacist who also worked at the local hospital. The information technology system to support safe management of medicines was robust. This included an alert if medication on admission was not checked by a health care professional. This ensured that people received their medicines as intended by their doctor.

The pharmacist held drop-in information sessions for carers and relatives so that they could ask questions about the medicines prescribed and have a better understanding of these medicines.

Community staff, who supported people in their own homes, told us that on occasions they found it difficult to access injectable medicine for pain relief quickly, when people were at the end of their life. Meetings were held by a working group, consisting of members from stakeholder organisations, to look at providing a 'just in case' box of injectable medicines required in end of life care. Once established this would benefit positively the people who required these medicines.

The service had a good reporting culture for reporting medicine errors and incidents including near misses. These were investigated and learning was disseminated to all qualified staff through internal communications. Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CD) and have stricter controls by the law. Prescribing and handling of controlled drugs (CD's) by the hospice was managed according to the law.

Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as the risk of falls, moving and handling and pressure care. These assessments were kept under regular review and included clear guidance for staff about any action they needed to take to make sure people were protected from harm. The Canterbury Hospice was working with colleagues in the Margate and Ashford Hospices, on how to improve the care of people's skin, which started to fail at the end of people's lives, resulting in pressure ulcers.

Regular environmental and health and safety checks were carried out to ensure that the environment was safe and

that equipment was fit for use. There were checks to ensure that equipment was in good working order such as hoists, the nurse call system, gas and electrical services, fire equipment and the shaft lift. The service had started a register which included all medical equipment, such as syringe drivers (used to give a person a continuous dosage of pain relieving medicines) and defibrillators (used to start a person's heart after a heart attack), as an additional check to ensure that equipment was fit for purpose. Environmental risk assessments were also in place to minimise the risks of people living and working at the hospice from hazards such as slips, trips and falls, storing portable oxygen safety, use of chemicals and electrical equipment and the disposal of waste materials. There were also assessments of risks for outreach locations. Risk assessments identified any actions needed, and highlighted the action that needed to be taken to minimise the risk that were presented. All accidents and incidents were recorded and investigated. These were fed into local reports and discussed at the group health and safety committee.

The hospice had business continuity and seasonal pressure plan for emergency situations such as bad weather, increased infections and high levels of staff annual leave. This policy had been tested the previous week, through the use of a relevant scenario and it was planned to be tested every six months. This involved the staff nurse on duty being phoned and asked what immediate action they would take to safeguard patients and staff. This was to ensure that staff knew what action to take in any emergency.

The premises were clean and in good order, and the bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices. There were clearly labelled clinical waste bins, liquid soap, disposable hand towels and foot operated rubbish bins in the relevant areas. There was hand gel at various points in the building for people to use to help protect vulnerable patients from infection. A lead nurse for infection control had recently been appointed to work across the three hospices in addition to a link nurse at the Canterbury Hospice. This was to ensure best practice guidance was being followed consistently across the organisation. A comprehensive infection control policy was in place and this included schedules for cleaning. These had been agreed with the housekeeping staff so they understood what was expected of them. The schedules were

Is the service safe?

sufficiently detailed to include frequency of cleaning and cleaning products to be used. Housekeeping staff then

signed check lists to indicate that cleaning had been carried out to the agreed standard. Infection control audits were regularly carried out to ensure all areas of the hospice were sufficiently clean and to reduce the risk of infection.

Is the service effective?

Our findings

Feedback from people who received a questionnaire from us was that they received effective care. People responded that staff had the skills and knowledge to give them the care, treatment and support that they needed; and supported them to manage their symptoms as well as they could. During our visit, people also commented on the skills of the staff team. “Staff always talk to me about what they are going to do. When they do something for me, they always ask first”. People said they had access to health care professionals and they could see the doctor when they needed. Comments included, “The doctors are on call here and you can see them at any time; “I get physiotherapy and breathing management classes”; and “The gym is very beneficial, you know it if you miss it. Using it brings on a very positive feeling”.

New staff received a comprehensive staff induction programme. This included a corporate induction which gave an overview of the Pilgrims Hospices and training in subjects essential to their role. New staff then worked alongside other staff until they had been assessed as being able to work on their own. Each staff member had a review meeting at the end of their probationary period to discuss their progress. Staff told us that their induction prepared them for their role.

The staff training records showed that there was an on-going programme of development to make sure that all staff were kept up to date with required training subjects. These included health and safety, fire awareness, moving and handling, emergency first aid, infection control and safeguarding adults. Staff received training relevant to their role and a range of additional training was considered on an individual basis. All staff had received palliative care training and all medical and nursing staff had training in pain management and end of life care. In addition six staff had completed training in Advance Care Planning and more nursing staff had been booked on this course. Most staff had undertaken a course in bereavement. Staff training was managed from a central training team based at the hospice. The training included online computer courses and face to face training. Staff training records were held in a computer system that showed when training had taken place and when it was due to be refreshed. Staff said

they had excellent access to training and were sent reminders when they were due to undertake an update. Volunteers received induction and training in accordance with their duties.

Staff told us that they received excellent support from their colleagues and line manager. Support was achieved through regular individual supervision sessions and an annual appraisal. Staff said that feedback about their performance was given regularly and in a helpful constructive way. These meetings provided staff with opportunities to reflect on their practice and to discuss the management of patient care.

Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this. Staff had a sound knowledge of their roles and responsibilities in relation to this legislation. Staff were motivated about ensuring that people’s individual decisions were listened to and were followed. We observed staff asking patients permission before giving any care. If there was any doubt that people were unable to make complex decisions, staff were aware of the correct procedures to follow in arranging for them and their next of kin or representative to meet with relevant staff and social workers to make a decision on their behalf and in their best interests. Staff were aware that there were times when people may be temporarily unable to make a complex decision, such as after receiving pain relief. Staff were therefore careful to discuss issues with patients at times when they could fully enter into discussions, as far as possible. The registered manager had not found it necessary to make any DoLS applications.

People’s care records contained a do not attempt resuscitation (DNAR) form. These people had been assessed as having the capacity to make this decision for themselves. The doctor had discussed this decision with the person and their relatives, so that everyone was aware of the person’s wishes.

Health care for patients was provided by a multi-disciplinary team made up of consultants, doctors, advanced nurse practitioners and specialist palliative nurses, health care assistants, occupational therapists and

Is the service effective?

physiotherapists. Each patient had a named nurse so that people were provided with continuity of care. Patient records showed in detail how patients were supported with their medical and health care. Staff worked to accepted good practice protocols in relation to caring for people with specialist healthcare needs, such as people with Percutaneous Endoscopic Gastrostomy (PEG) tubes and feeding regimes, pain management, and caring for people with chest drains. Assessments were made of people's risk of falls, of developing pressure sores and risk of malnutrition. These assessments of risk were regularly reviewed due to changes in people's conditions. Action had been taken to minimise these risks such as additional charts in place to monitor when people had been supported to change position to prevent pressure area damage, and fluid charts to encourage people to drink adequate liquids. One person had had two falls. Their risk assessment had been updated and they had been provided with a pressure mat, so that staff were aware when they were up and about and could support them with their mobility.

The hospice had an on-site gym to promote people's health so that they could remain mobile and active. The gym was staffed by two physiotherapists. Each person had an individual programme. People moved between the eight activity stations and their activity time was controlled and their achievements were recorded, so that they could monitor their progress.

The staff had a handover for in-patients at each shift change. These meetings were used to plan care and to pass on medical and health information within the staff team. Each patient was discussed in detail including information about their family, primary diagnoses, medical issues and other important health care needs.

The hospice delivered information and health programmes to people in the hospice, in their own homes, care homes and at outreach clinics. This included sessions on healthy living, how to manage breathlessness, how to relax and support and advice on how to live with a life limiting illness. A range of information leaflets were also available to people and their families or carers such as "facing loss", "living with a serious illness" and "syringe drivers".

As well as supporting people who were day or in-patients, the hospice also served people in the community. The hospice managed a team of community nurses whose role

was to visit people in the community who had palliative care needs. Pilgrims Hospices East Kent ran a 24 hour, seven days per week telephone service where patients in the community could phone at any time for support or advice. There was a duty nurse each day who discussed patients' or relatives' concerns. This could include help with personal care or medical treatment, help with obtaining specific equipment, help from social workers with family or home situations, advice from nurses or doctors or arrangements for an emergency admission if this was deemed the best course of action. A rapid response team called 'hospice at home' could be mobilised within four hours to support people in achieving their preferred place of death in their home. Staff from the hospice at home team stayed with the person to give them personal care or company at night, so that they were reassured they were provided with care and support when they most needed it.

Everyone said they thought the food was good, they got a choice and their individual needs were taken into account. Comments included, "I need gluten free food and the chef does special dishes for me"; "The food is very good and you get a choice. If you are not keen on the menu, they will do something different." and, "The quality of the food is excellent with plenty of choice. They are always topping up my water and offering tea to visitors". Staff encouraged people to eat as little or as much of anything that they felt like, during the day.

The hospice had a kitchen on-site which provided nutritional and freshly cooked meals to people. The chef and his team had received training in how to produce food for people who may have difficulty chewing or swallowing. The chef said that menus were based on the availability of seasonal food. Menus provided people with a range of meal options to accommodate light meals and people's health and/or cultural needs. The chef and the team regularly talked to people to make sure that their requests were met. We joined some people for lunch. There were three main course choices and three different deserts available. The food was hot, well presented and looked, smelt and tasted appetising. In addition, there were alternative meals available if people requested them. Drinks were available with lunch and at other times during the day. Everyone told us that they had enjoyed their meal. The chef told us that kitchen staff were especially chosen for their love of making meals and the love of serving patients.

Is the service caring?

Our findings

Everyone told us that the staff were kind and caring and provided high quality care. One person told us, “The care couldn’t be better, staff are so kind. I can’t fault the care given here. It’s like being at home”. Another person told us, “There is plenty of staff interaction”. People said they were treated with dignity and respect, their independence was encouraged and that visitors were always made welcome and could visit at any time. Comments included, “They do give me privacy when giving me personal care and if I need a chat about personal things, we can go to a private room”; “They always draw the curtains when attending to me”. People and their relatives told us that they felt they were involved by staff as much as they could be in planning their or their relative’s care.

Staff were provided with regular training and information on how to communicate with people in a way that was appropriate and that people could understand. This was centred around treating people as individuals and planning their care and treatment around the individual. Staff used these skills in practice to deliver care was delivered in a compassionate and sensitive manner. Staff treated people with kindness and there was a lot of one to one interaction between staff and people. For example, staff observed a person struggling to undertake a task by themselves. The staff member asked them if they would like some help, or if they could manage by themselves. The person responded that they could do with some help and afterwards said that they felt much better.

People were able to make choices and decisions about all aspects of their lives including, choosing to take part in activities, what they ate and when to get up and go to sleep. Relatives were actively involved in care and decision making when appropriate.

Staff were aware of the content of people’s care plans and knew about people’s preferences about their daily routines, likes and dislikes. Care plans were stored electronically and were password protected to maintain confidentiality. Care plans were promptly completed in discussion with people and reviewed every day to make sure that they were up to date with people’s changing needs.

People had a privacy curtain around their bed and these were used to give people privacy when being assisted with

personal care. Staff used signage on doors to indicate when rooms were in use, such as for private meetings, counselling and therapies, so that people were not disturbed.

The ethos of the hospice was to provide psychosocial, spiritual and therapeutic care for people and their families. Psychosocial support is where a person is helped to be an active survivor, rather than a passive victim. This was achieved with the support of paid staff, links with other organisations and a large number of volunteers. As well as caring for people who used the hospice services, the service ensured that people’s families were central to people’s well-being. Feedback from relatives who received a questionnaire from us was that they were well supported by hospice staff. Relatives were welcomed at the hospice and could spend as much time with their loved ones as they wanted. This included provision to enable relatives to stay overnight if they wished. Carer support groups were available for relatives and carers to share their experiences with other people and professionals. When relatives returned to the hospice following a person’s death, staff took that opportunity to ask them if they were happy with the care their loved one had received. The hospice offered individual and group bereavement counselling to adults and children who had been affected by the loss of a loved one.

Spiritual support was available to people, and the spiritual coordinator had lead responsibility for this role. A minister was present on the day of the visit and said they were a regular visitor to the hospice. Staff told us that weddings and religious ceremonies of all faiths had been arranged previously at people’s request.

The staff worked with other health and social care professionals and volunteer groups to enable people to carry out their specific wishes, especially where people had expressed things that they wished to do before the end of their lives. On the day of our visit one person was baptised at the hospice chapel. People who were important to them had been invited to join in the celebration and a special cake had been made to mark the event.

People’s care plans contained detailed information about their care wishes, including their preferred place of care, preferred place of death and preferences regarding decision making and information giving. Staff demonstrated that they were clear about any

Is the service caring?

arrangements and decisions people had made before and after death that must be observed. We observed that staff handled the removal from the ward of a person who had died, in a sensitive and compassionate manner.

The hospice had its own mortuary so that the service could provide care for families through the whole process. People found it comforting to know that they could continue to spend time on the premises with their loved one after they

had died as they were familiar with the hospice environment. One person's family had requested that the hospice keep their loved one on the hospice premises until their funeral, which was arranged a few weeks after the person's death. This was because the family felt that as the hospice staff had provided excellent end of life care that they would continue to do so after the person's death.

Is the service responsive?

Our findings

People said that the care that they were given was ‘patient focussed’ and that they were aware of the content of their plan of care. One person told us that, “All my needs are met”, and another person said, “I get the care I am expecting”. People said that activities were available which they could join in if they wished. One person told us, “In the day hospice we do have some activities if you want to join in, but they don’t force us to do anything”. Everyone said that they would complain or comment on anything that they were not happy about, but that they had not had to. Comments included, “I’m sure they would sort out a problem, if there is one. They are always very eager to please; “I’ve never complained, but would go to the head of the unit if I had to”; and “My transition from hospital to here was managed by the Hospice in a way that gave me absolutely no concerns”.

People were referred to the in-patient service by their doctor or hospital. The hospice consultant worked with the palliative care team at the local acute hospital, to assess patients and make decisions with the specialist nurses to facilitate an admission to the hospice, if appropriate. Hospice staff had access to relevant patient data at the hospital through a secure system. The hospice protocol was to respond quickly to people’s needs and to admit people to the hospice on the same day as their referral whenever possible.

People were asked about their needs and preferences by the nursing staff. People’s choices and wishes were recorded in their plans of care to guide other staff about how to care for them according to their individual needs. , Nursing staff shared people’s information with other relevant people at the hospice. For example information about people’s diets and preferences was shared with the chef and kitchen staff. Information about other aspects of care were shared with the appropriate members of the multi-disciplinary team. The staff discussed people’s preferences and lifestyles with them from the beginning, so that community staff or hospice staff could get to know how people liked things to be done, and how the staff could most effectively support them through such difficult times. Staff talked knowledgeably about people’s care and how to provide support for their physical, mental, emotional and spiritual needs in a way that considered their likes and dislikes. The ethos of the hospice centred on

ensuring that each person was seen and treated as an individual. A thorough assessment was carried out at the commencement of a person’s referral to the hospice. The assessments took into account people’s personal needs, such as helping them with personal care, mobility, nutrition, wound care and medicines; social needs, including taking part in activities, hobbies and going out into the gardens; and care of their family members.

The hospice maintained an electronic ‘Share my Care’ register, which provided an overview of patient’s preferences and decisions. The register included details such as if the person was aware of their diagnosis, if they lived on their own, their preferred place of death and if they had made a decision about ‘Do not attempt Resuscitation’ (DNAR). This allowed the hospice to share people’s advanced care wishes with other healthcare professionals and ensure that services effectively worked together for the benefit of people who used a range of services.

Staff responded to people’s changing needs by completing a symptoms and concerns checklist. This was to establish a base line for people’s health and wellbeing and to monitor if it changed over time. This included how the person experienced pain, mood and breathlessness. Staff also responded to people’s needs on a daily basis. For example, one person’s care plan stated that they used a frame and wheelchair, and both items of equipment were seen in use at their bedside. For people who required wound dressings, records showed that these were changed at the appropriate times and people confirmed this.

Staff received a comprehensive handover about people’s care and were allocated to provide care to certain individuals. Efforts were made to maintain continuity of care by allocating the same staff to individuals on each shift. Staff were aware of people’s preferences through the information given at handover and from reading people’s care plans. Staff said there was sufficient time for them to read and understand people’s care plans, and this was seen as a very important part of their day. Continuity of care was also provided in the community with one or two staff providing care and advice to individuals.

Staff were knowledgeable about the complaints procedure and knew what they should do if a complaint was made to them. There was written information in the entrance area for people to refer to should they wish to make a complaint. The complaints leaflet was called, “Making a complaint – helping us to improve”. Staff said that they

Is the service responsive?

viewed complaints as a way to improve and senior staff said they tried not to view complaints negatively, but as a way to improve the service they offered. The complaints leaflet gave clear guidance for people about how to make a complaint. It stated that they could make a complaint in person, writing or by e-mail and set out their expectations in how long they would receive a response and what to do if their complaint was not dealt with to their satisfaction.

Complaints were logged centrally and were followed up to check for any trends. All complaints were taken seriously including those made by people or their relatives and by

staff who worked at the service. Appropriate action was taken to respond to each complaint, such as meeting with the complainant, or responding by letter. The registered manager promoted an honest assessment of how well actions were being taken or not in response to people's comments and there was a strong emphasis throughout the staff team on continual improvement. Senior staff were trained in resolving conflict and complaints management and all staff and volunteers were given guidelines on how to respond to any concerns or complaints and how to pass them on to the relevant head of department.

Is the service well-led?

Our findings

People were very complimentary about the management of the service. They said that the registered manager was available and the staff team worked well together. Comments included, “This hospice is managed extremely well considering the little funding they get. I have seen the manager: She is lovely”; “The staff all pull together”; and, “Staff are well managed”. People said that their views were sought about how the service could improve. One person told us that they had received a questionnaire to feedback on the changes that had taken place at the service. Other people told us that they were confident that the service would act on any improvement or suggestions that were made. “I’m so impressed with the range of services and truly feel I couldn’t have managed without them”.

The service had received a number of compliments from relatives about the high quality of care that people had received whilst at the hospice. These included, “Without exception you have all added quality to his life and you have extended to his family the same loving care”; The love and care that you showed him made his final days such a comfort. He praised you all every day. He especially liked having his lovely bath”; and, “For the fantastic care and dignified ending, for sympathy and laughs and more tea than I think I can ever drink again. Thank you for the real nursing and kindness rather than the ‘machine driven’ nursing”.

The hospice had a comment box, where people could voice their views about the service. More formal ways of gaining peoples’ views were also in place. User group meetings had been re-established as a way to talk about how to maintain and improve services. At the last meeting in October 2014 people had talked about the day services timetable and how to make people aware of hospice events and services. Everyone at the meeting agreed the hospice played an important role in helping to maintain the quality of life of people who used it and their carers. The hospice was also undertaking a “patient feedback pilot”. This was a questionnaire undertaken with people on their arrival at the hospice and asked people about their care in relation to their confidence in the nursing team, if they felt involved in decisions about their care and treatment, whether their food preferences had been discussed with the catering staff and to rate their overall experience.

Staff were clear about the aims, visions and values of the service and told us that people were at the heart of everything they did. Staff had been involved in drawing up and reviewing documents in relation to these values. The values and target behaviours of the service included integrity, developing excellence, friendliness, taking ownership and developing other people for success. These values underpinned staff recruitment, staff appraisal and the standards for which the service aims.

The leadership of the hospice was visible at all levels. Feedback from community professionals was that the interim chief executive was visible and communicated well. Also, that the governance manager was active in promoting across agency communication in order to benefit patient care. The registered manager and senior nurse led by example and were approachable. Staff said that management were supportive and gave them constructive feedback. They felt that their immediate line managers worked with them in an open way which encouraged them to voice their opinions. Staff described excellent support from their line managers when dealing with stressful situations. They said that team meetings were held regularly to give staff opportunities to discuss concerns and as a learning opportunity.

The service had been through a period of reorganisation and restructure which had not yet been completed. A number of staff and volunteers were engaged in the ‘Future Hospice Programme’, which was set up to help shape the future plans of the hospice. However, a minority of staff felt that they had not been informed of all the proposed changes that were taking place. In response to the changes and due to staff feedback, the management team had set up quarterly staff communication and consultation group meetings. At these events, representatives from staff and the executive team met to exchange views. Staff were also encouraged to take part in an annual ‘Help the Hospices’ staff survey for the company, which fed into action plans to bring about changes in the service. as a result of their input. The service provided staff ‘ideas’ boxes, as a way of enabling staff to raise any ideas that were important to them; and these could be completed anonymously if they wished.

The service had a structured approach to monitoring the quality of its service delivery. There was a six month audit plan which included medicines and controlled drugs, safeguarding, infection control and complaints. This

Is the service well-led?

showed that there were processes for an on-going assessment and improvement of the hospice at all times. The service also took part in Help the Hospices benchmark study in 2013, on patient falls, pressure care and medicines management, which rated their performance against other hospices nationally. This provided them with an on-going challenge to be the best in relation to other services and an action plan was developed as a result to improve people's experience whilst at the hospice.

The service was proactive in providing education and undertaking research to identify and share best practice. The hospice had its own training department and research team, which linked with the University of Kent and University of Greenwich. The hospice had taken part in a pain study and was currently taking part in a hydration study led by the University of Surrey. The hospice had many links with the local community and had run a forgotten mourners project with twelve schools represented to

support bereaved children in school. They were also working with external partners on a volunteer befriending service so that community patients could access help with day to day chores.

The hospice had developed a tool to assess the quality of the service in relation to the areas of safe, effective, caring, responsive and well-led. However, it had not been effective in identifying the shortfalls in the staff recruitment process. The service was linked to other organisations which assisted the management in monitoring different aspects of the hospice. These organisations included 'The Gold Standards Framework for Palliative Care'; 'Social Care Institute of Excellence'; and 'Skills for Health delivery of "Six Steps for Success" to care homes, via the National End of Life Care Programme,' This enabled the hospice to keep up with best practice and be informed about different models and ideas for improvements.