Harlington Hospice Association Limited

Harlington Hospice

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16, 17 and 29 November 2016. The inspection was unannounced on the first day and we informed the provider we were returning for the second and third days.

Harlington Hospice Association Limited is a registered charity which provides a range of specialist community services for people aged 18 and above with life limiting illnesses and end of life care needs. These services include personal care and nursing care for people living in their own homes, counselling and emotional support, and a Lymphoedema therapy service at the provider's premises. (Lymphoedema is a chronic condition that causes swelling in the body due to an accumulation of lymph fluid in body tissues). The service is located at a welcoming and comfortable premises, which contains a range of facilities including a purpose built day centre and bespoke treatment rooms. There is also a large and tranquil rear garden that overlooks pleasant fields. The provider does not have any inpatient services and offers three different types of care packages to support people in their own homes. Twelve people were receiving nursing or personal care at home on the first and second days of the inspection; however, due to the distinctive nature of the home care schemes there were six people using the service on our final visit. Sixty-six people were using the Lymphoedema therapy service.

The 'Homesafe Night Service' provides a maximum of three nights' of night sitting to support people to safely settle back at home following discharge from hospital. This service is delivered by either a registered nurse or a health care assistant, in accordance with a person's needs. The provider also offers this service on request from the local rapid response or integrated care team in order to prevent hospital admissions. The 'Harlington Care' service provides short-term care packages of four visits a day for up to 10 days, in order to facilitate discharge from hospital and fill the gap between the discharge date and a sustainable care package arranged by social services being operational. This service is mainly delivered by health care assistants. The 'Palliative Care at Home Service' is provided for people with an anticipated prognosis of six months or less. This service can offer up to four visits a day to provide personal care and social support. Visits are predominantly provided by health care assistants but sometimes a registered nurse can be supplied if people's needs determine the necessity for nursing care. A night sitting service can be included if required, which can be delivered by a health care assistant or registered nurse in accordance with people's assessed needs. The registered nurses are able to offer symptom management and the management of syringe drivers. (These are portable pumps used to provide a continuous dose of medicine through a syringe).

The service had a registered manager in post, who held the Clinical Lead position within the organisation and is a registered general nurse. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. During the inspection the registered manager informed us that she was due to resign as registered manager and take on another position within the organisation.

People told us they felt safe using hospice services although some practices were not consistently safe. Staff knew how to protect people from the risk of abuse as they understood the provider's safeguarding policy and had received suitable training. However, we noted that there had been an incident that potentially placed a person at risk that was not reported to the local safeguarding team. People and relatives understood how to make a complaint and the records for complaints investigations showed that the provider appropriately responded to complaints, which included monitoring staff performance and disciplinary action where required.

Comments from people and relatives showed they were happy with the reliability of staff and they felt staff were properly trained and supported to carry out their roles. Although the provider was able to demonstrate that staff were safely recruited on the final day of the inspection, we found the filing system for staff personnel records was disorganised and essential information to verify the rigorousness of recruitment practices was not available when we first checked how staff recruitment was conducted. Records showed that staff attended a range of relevant training; however, there were no formal systems in place to demonstrate that staff received regular one to one supervision, and annual appraisals of their performance and learning and development needs.

Staff had received medicines training; however the provider had not obtained written evidence for all nursing staff to show they had completed syringe driver training and an annual assessment of their competency to manage syringe drivers.

People using the home care services were protected as risks were identified and managed. However risk assessments written by district nurses were not consistently read by the provider to ensure their staff understood these risks and the required actions to take to mitigate the risks. The provider had not developed risk assessments where necessary for people who used the day centre services at the hospice.

People's human and legal rights were understood and respected by staff, who were familiar with their responsibilities in regards to the Mental Capacity Act (MCA) 2005. The provider had developed positive relationships with local health and social services and supported people where necessary to meet their health care and nutritional needs. People were consulted by staff as part of the care planning for the Palliative Care at Home Service, the care and support plans for people using the Homesafe Night Service and Harlington Care were developed by the district nursing service.

The provider had systems in place to regularly seek people's feedback about the quality of the service, which had been very positive. The registered manager supported staff in the community and carried out risk assessments for the Palliative Care at Home Service, and accompanied staff to visit people if there were complex issues to discuss. However, we found there were noticeable environmental issues at the premises and a lack of monitoring of care practices that needed to be addressed in order to promote people's safety and wellbeing. The provider had already created innovative projects to support local people and was engaged in strategic planning with other voluntary sector organisations in order to broaden its scope of services.

We have found two breaches of Regulations in relation to the provider not supporting staff with formal and regular one to one supervision and an annual appraisal, and the provider not demonstrating robust systems to assess and monitor the quality of the service delivered to people.

You can see what actions we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service is not always safe.

People were protected by staff who were trained to identify and report signs of abuse, although one potential safeguarding concern was not escalated to the local safeguarding team.

Risk assessments were in place for the three at home care services, however the provider did not have a system to routinely check that staff had the skills to comply with risk management guidelines produced by another organisation.

People and relatives told us staff had sufficient time to safely provide their care.

Systems were in place to support people with their medicines, however accurate information was not available to show nursing staff were competent to manage syringe drivers safely.

Is the service effective?

Requires Improvement

The service is not always effective.

People and relatives thought staff had appropriate skills and knowledge for their roles.

Staff were supported to access a range of training opportunities, however their learning and development was not supported through regular supervision and appraisal.

Staff demonstrated an understanding of their responsibilities in regards to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported with eating and drinking in accordance with their assessed needs and wishes.

Is the service caring?

Good

The service is caring.

People told us staff were kind, caring and compassionate.

Relatives felt supported by the nursing and care staff that looked after their family members.

People's cultural and spiritual needs, and any preferences for same gender care, were identified and respected.

Counselling was offered to people and their relatives, and bereavement support was tailored to meet the needs of children and families, and adults.

Is the service responsive?

Good

The service is responsive.

People (and relatives) needs and wishes were taken into account to plan and deliver care and support.

The provider had developed home care schemes that offered flexible care packages that could be promptly arranged to enable people to return home.

Services were in place to respond to the needs of the local community, including people living with dementia and their carers.

People knew how to complain and complaints were properly investigated.

Is the service well-led?

Requires Improvement

The service is not always well-led.

The management of the service did not always demonstrate that appropriate monitoring took place of care practices and the environment.

The absence of formal systems to support staff and appraise their performance did not demonstrate a high quality of leadership.

People and local health and social care professionals reported positive comments about the quality of the service.

Staff stated they felt supported and liked the open culture of the provider.

Harlington Hospice

Detailed findings

Background to this inspection

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

This inspection was conducted on 16, 17 and 29 November 2016 and was unannounced on the first day. We informed the provider that we intended to return on the subsequent two days. The inspection team comprised two adult social care inspectors, a specialist professional advisor with a background in palliative care nursing and an expert by experience, who has personal experience of using or caring for someone who uses this type of care service.

We looked at information we held about the service in order to help us to plan the inspection, which included the previous inspection report and statutory notifications. These are notifications of significant incidents which the provider is required by law to report to us. We contacted Healthwatch Hillingdon and obtained information they held about the provider. (Healthwatch Hillingdon is an independent consumer champion that gathers and represents the views of the public in regards to health and social care).

On the second day of the inspection spoke with eight people using the day centre service. This included one person who received personal care at home from the provider and gave us with their comments about the quality of their service. Otherwise we did not speak directly with people using the personal care and nursing care services in their own homes, due to their complex needs at the end stages of their lives. Instead we spoke by telephone with the relatives of six people who were either currently being provided with a service or had recently used the service.

During the inspection we spoke with one staff nurse and two health care assistants, a team leader for the home care service who delivered some personal care as part of their role, a volunteer, a care coordinator, the registered manager, the therapy lead for complementary therapies, the chief officer, the founder of the hospice, a lymphoedema therapist, a psychotherapist and the quality lead. We looked at a variety of documents which included six care and support plans, five recruitment folders, staff records for training and development, and a selection of policies and procedures. We also checked a range of records relating to the

management of the service. Following this inspection we contacted health and social care professionals with knowledge and experience of the service and received four comments. These professionals included representatives from social services, the local clinical commissioning group and the NHS.

Requires Improvement

Is the service safe?

Our findings

One person using the service told us, "The girls (staff) that come to my home are very good, I feel safe with them." Comments from relatives included, "[My family member] had such trust in [staff member] and built up a wonderful rapport. He/she could talk openly with [staff member] about their fears during the night and got so much reassurance" and "I would not have any other service for [my family member]. This is the best service we have ever had and [my family] member is very safe with [staff members]. A third relative stated, "It's amazing, I have no complaints and the staff are honest people."

We spoke with two staff members about their responsibilities in relation to safeguarding people. They were familiar with the provider's adult safeguarding policy and procedures, knew about the different types of abuse and described the actions they would take if they suspected that a person was being abused. Records showed that staff had received safeguarding training and we noted that the provider's whistleblowing policy advised employees how to report any concerns, including guidance about how to seek independent advice and how to contact relevant external organisations. (Whistleblowing is the term used when a worker passes on information concerning wrongdoings in their work place or within an NHS or social care setting). Staff were given written guidance about the provider's expected standards for conduct, which informed staff how to maintain professional boundaries to protect people and ensure they acted with integrity. We noted that the provider had developed a children's safeguarding policy, which reflected national guidance. This policy was in place as the provider offered counselling services at the premises for children aged four to 17 years old.

The registered manager was the safeguarding lead for the service and the staff we spoke with were aware of this. Although the registered manager presented her knowledge to us about how to report any safeguarding concerns to the local safeguarding team and of the legal requirement to notify the Care Quality Commission (CQC), we found evidence of a potential safeguarding concern in 2016 which was not reported to the local safeguarding team for their consideration or discussed with the local authority. CQC was not informed at the time. The incident was investigated by the provider and resulted in supervision and disciplinary action for the employee involved.

There were processes in place to support people to be as safe as possible in their own homes. The registered manager informed us that NHS district nursing teams carried out individual risk assessments for the End of Life Night Service. The risk assessments for the Homesafe Night Service and Harlington Care were carried out by the Hospital Discharge Team, which comprised allied health care professionals, registered nurses and social workers. These risk assessments identified and addressed risks including those associated with skin integrity, moving and handling, falls, behavioural needs, seizure management, indwelling catheters and choking. The care plans were also produced by district nurses. Care staff confirmed that they read and followed these risk assessments. However, we found there was no evidence to demonstrate a clear system for the provider to review the risk assessments written by the district nurses in order to ascertain that their staff had the necessary skills to safely provide the care and support.

We noted that the provider's own assessments for the Palliative Care at Home Service incorporated any

known information from the district nursing service and other health care professionals about actual and potential risks, and the required measures to mitigate these risks. The team leader informed us that they were responsible for carrying out risk assessments prior to the commencement of Palliative Care at Home packages, which we saw in people's care and support plans. This included environmental risk assessments to check that people and staff were not at risk from factors within the household, such as loose mats and rugs.

Staff told us they knew how to respond to unforeseen emergencies in order to promote people's safety and welfare. For example, health care assistants understood when to contact their line manager if people were experiencing increased levels of pain and appeared to need assessment by their GP or district nurse. We found staff were provided with training that promoted their competence and confidence to safely respond to specific care and support needs that might otherwise escalate into complex and urgent difficulties for people. For example, care staff had been booked into training about how to carry out bladder washouts, which was being delivered by a local NHS specialist nurse.

Relatives told us that staff had sufficient time to spend with people and they did not feel that staff worked in a pressurised and rushed manner. One relative said, "The care was faultless although sometimes we could see that staff were working hard. But they went above and beyond the call of their duty." Through our discussions with the registered manager and the comments we received from local health and social care professionals, we noted that the provider had sufficient staff to deliver a flexible and responsive approach to meet people's needs. The registered manager informed us that registered nurses with current palliative care experience at NHS services and local hospices with inpatient facilities were recruited as bank staff, and some health care assistants were contracted employees. This enabled the provider to operate in an adaptable manner to ensure that people's changing needs were met by appropriately qualified staff. The care coordinator showed us how they carried out the planning for people referred by district nurses. The care coordinator told us they clarified whether people needed nursing or personal care and checked which staff were available. They also checked whether there were specific needs and preferences to meet, for example if a person wished to be allocated a staff member of the same gender and/or a staff member that spoke their first language. The care coordinator demonstrated how this information was recorded on a computer system known as 'CharityLog' and confirmed on the daily visits' schedule.

We detected missing information in the files for one staff member and one volunteer when we checked on the robustness of recruitment practices on the first day of the inspection. The registered manager was informed about these discrepancies and we received assurances that the two individuals would not be offered work or volunteering opportunities until this matter was satisfactorily resolved. The requested documents were produced on the third day of the inspection and appeared to have originally been misfiled. The registered manager acknowledged that improvements were needed with the administration and auditing of the recruitment folders so that essential records to demonstrate safe recruitment were consistently accessible. The provider was aware of the need to ensure that any gaps in employment had been explored and we were shown evidence to demonstrate that Disclosure and Barring Service (DBS) checks had been completed before prospective employees were allowed to start employment at the service. (The Disclosure and Barring Service provides criminal record checks and barring function to help employers make safer recruitment decisions). Other checks were noted to be in place, for example proof of identity, proof of eligibility to work in the UK, evidence of current registration with the Nursing and Midwifery Council for registered nurses, health questionnaires and a minimum of two references.

People's medicines were prescribed by medical and external health care staff involved in their care. Records showed that nurses and health care assistants received medicines training by the provider. However, the management of medicines policy stated that the competency of health care assistants should be checked

annually but no evidence of this was found. The provider's medicines policy stated that if people required prompting or support with their prescribed medicines, blister packs needed to be requested through the community pharmacist. (A blister pack is a medicine administration compliance pack with designated sealed compartments and is dispensed by a pharmacist). A formal list of each person's medicines compiled by a medical or health care professional needed to be sent by email to the Harlington Hospice so that the registered manager or another employee with suitable training could transcribe onto the medicine administration record (MAR) charts. The registered manager informed us that this initial arrangement was compulsory for people who were referred through the Homesafe Night Service and Harlington Care, some of whom progressed onto using the Palliative Care at Home Service. The team leader informed us health care assistants prompted people with their medicines. The registered manager stated that people could be assigned a registered nurse if they had specific medicine needs that were not within the remit of health care assistants and some people's more complex medicine needs were met by the district nursing service. The care and support plans we looked at during the inspection showed that people were able to independently manage to take their medicines or were supported by relatives. We were not in a position to look at how staff completed MAR charts and whether the charts were audited by the provider, as these documents were kept by the district nursing service in accordance with the agreed protocols.

The provider was not able to evidence how they assessed the competency of registered nurses to manage people's syringe drivers at home. The registered manager told us that registered nurses had received core syringe driver training, and annual refresher training and competency assessments in their permanent positions at other establishments; however, this was not consistently demonstrated when we looked at staff training records. Minutes for a staff meeting showed that health care assistants had been given basic information about how syringe drivers operated so that they could monitor that the syringe driver was functioning, and also recognise problems that required the intervention of an appropriately qualified professional. The registered manager informed us on the final day of the inspection that she had contacted the permanent employers for the provider's registered nursing bank and verified their syringe driver training and competency assessment was up to date, and had requested written confirmation.

Systems were in place to protect people from the risk of acquiring health care associated infections. There was a comprehensively written policy and practice guidance to inform staff about their responsibilities in relation to infection prevention and control, which had been reviewed within the past 12 months. Records showed that staff had received online training and a separate session about safe handwashing techniques. Staff told us they were equipped with personal protective equipment including disposables gloves, aprons and shoe protectors. There was also written guidance about the management of soiled laundry at people's homes and how to ensure that food and beverages were hygienically prepared.

Requires Improvement

Is the service effective?

Our findings

We received positive remarks from people and relatives about whether staff had the knowledge and skills to competently meet the care and support needs for people with life threatening and life limiting illnesses. One relative told us, "I would give staff 10 out of 10 for the care they gave [my family member], both the clinical and the practical care, staff made a massive difference" and another relative said, "The care could not be better, they give person centred care." One relative described how the staff met their family member's needs, "I am happy with how they care for him/her, absolutely so."

Records showed that staff were provided with induction training and other relevant training. The provider had introduced the Care Certificate and three health care assistants were undertaking this course at the time of the inspection. (The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care service).

We noted that staff had attended mandatory training which included moving and handling, safeguarding adults, supporting people with medicines, pressure ulcer prevention and basic life support. The provider's training matrix clearly identified if staff had overdue training and the registered manager told us staff were not offered work if they did not complete the expected training within specified timescales. In addition to the mandatory training, staff had attended training to meet the specific needs of people who used the service, for example how to meet the needs of people living with dementia. Informal training was provided at the bi-monthly staff meetings, for example staff had asked for an opportunity to meet with a funeral director so that they could respond in a more informed manner to questions that people and/or relatives might ask. This was facilitated by the provider earlier this year. The provider had established links with the education centre at another hospice in the borough and staff were supported to attend a rolling programme of training there, which had included death, dying and bereavement, managing breathlessness, advanced care planning, and an introduction to palliative care and end of life.

A health care assistant who worked for one of the care at home projects and also worked at the hospice's day centre told us they were offered sufficient training and felt encouraged by the registered manager to pursue training opportunities. A registered nurse told us they predominantly attended training provided by their main employer, which was another local registered service. The staff nurse expressed they felt well supported by the management and was encouraged to do training and improve their practice, "I look forward to going to work, I feel the support I am given is good." However, we found that the provider had not implemented a formal system to provide staff with regular one to one supervision, which meant that staff did not have scheduled private meetings with their line manager to highlight any issues of concern related to their work and discuss their learning and development. The team leader told us they had not had a one to one supervision but attended monthly group meetings with the registered manager and felt able to informally seek guidance and support when required. We noted that one staff member had received two documented telephone supervision sessions following distressing situations. The registered manager acknowledged that formal one to one supervision was not taking place on a regular basis and confirmed that the provider had not commenced appraisals for registered nurses and health care assistants employed in the home care schemes.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 and applications must be made to the Court of Protection. Discussions with the registered manager indicated that due to the unique nature of the service, best interest decisions were usually made as necessary by statutory agencies that were the principal organisation involved in people's care and support. The registered manager told us that external local healthcare professionals spoke with people about the importance of making advanced care plans when well enough to do so, in order to ensure that people's wishes were known and understood if they reached a stage of no longer being able to express them. Staff demonstrated their understanding of the principles of MCA and the actions they would take if they had any apprehensions about a person's ability to make their own decisions. One staff member told us they had attended MCA training and stated, "If I had concerns around capacity I would speak with [registered manager] or [therapy lead] so action could be taken."

People and relatives told us they felt that staff fully consulted with people and asked them how they wished to receive their care and support. One relative told us, "They (health care assistants) provided care that worked to [my family member's] personality. They met his/her final wishes." At the day centre service we observed that staff consistently checked with people about their preferences for food and drinks as a free three course lunch was provided, and whether they wished to participate in the organised leisure sessions or spend time chatting with each other and the volunteers. We noted in people's records they had signed a consent form in relation to sharing information and a consent form in regards to photography. However, we did not find initial or ongoing consent to care and treatment forms in the care and support plans we looked at.

We did not speak with people, or relatives speaking on their behalf, that required staff support with eating and drinking. Relatives told us they currently or formerly provided their family member with any help needed to meet nutritional and hydration needs. One relative commented how the health care assistants would recognise when they felt distressed and would offer to make a cup of tea for their family member and the rest of the household, which they found comforting. A member of the home care staff team told us they supported people at mealtimes by microwaving ready meals, in line with people's agreed care and support plan. They demonstrated an awareness of finding out about people's dietary needs and ensuring these needs were appropriately met.

The provider worked closely with local health and social care bodies, for example district nurses and the integrated care team. One relative told us their family member had received "a seamless service with Harlington Hospice at the centre" and a quality monitoring survey completed by another relative praised the provider for its liaison with their family member's GP. We received very positive information from local health care professionals about the quality of the service and how the provider worked in partnership with their teams and organisations. Comments included, "Harlington Hospice colleagues, both clinical and managerial, have been highly professional in joint initiatives, specifying and initiating new services", "Working in partnership with the night sitting service, staff keep in contact and report any concerns" and "The manager is accessible and flexible, attends provider's meetings and contribute positive ideas." The provider was described as being able to support people with complex needs and "service delivery has been

very good." The provider's business plan showed that they were in the process of developing services with other voluntary sector organisations in the area in order to provide more creative and bespoke services to support people and their relatives.

The registered manager told us that registered nurses and health care assistants always checked if people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms and looked at whether the documentation was correctly completed. The registered manager stated that the registered nurses and health care assistants were accustomed to making these checks as part of their main employment at other services and would notify her if they had any concerns, so that appropriate action could be taken. Where people did not receive a care package that involved nursing care from the provider, the checking of DNACPR was the responsibility of the registered manager in order to ensure that health care assistants were following clear and robustly recorded instructions. We did not see any system in place to evidence the provider undertook these checks.

We recommend the provider implement a system to record that checks are carried out to ensure DNACPR documents are appropriately written to safely inform staff of their responsibilities.

Good

Is the service caring?

Our findings

We received entirely complimentary comments from people and relatives about the compassion and kindness they received from staff. Relatives said, "I am so glad we had access to Harlington Hospice night sitting service. [My family member] was in hospital and wanted to come home. This hospice made it possible and I can't speak highly enough of the care [my family member] was given" and [My family member] is very, very happy with the care he/she gets. Staff are really caring and kind, they do it all through their good hearts." Another relative said, "They are kind, caring and compassionate, yes they are all these things" and a fourth relative commented, "They gave [my family member] dignity, we just can't repay the staff. They were so kind, like an extended family." A person at the day centre service told us they currently did not need a care package but wished to use the provider at the point in the future when they were assessed to need home care support. The person said they enjoyed the caring atmosphere at the day centre and liked the respectful attitudes of two health care assistants that did shifts at the day centre service and the home care schemes.

Other views about the caring approach of the staff had been recorded by people and relatives in quality monitoring surveys sent to them by the provider. Comments included, "Fantastic support, your team was so pleasant, efficient, respectful and professional. The night nurse service was invaluable towards the end as was the advice on benefits", "Staff were fantastic, brilliant communication, we could not have coped without them" and "They (staff) are the best."

Relatives described how staff supported their family members to receive care and support that ensured their dignity and privacy. For example, relatives spoke about how staff were particularly sensitive to the difficulties their family members experienced due to sensory impairments. One relative told us their family member had hearing and sight loss and referred to staff as being "brilliant" in how they communicated with the person. Another relative told us that their family member had lost their sight due to their life limiting condition and was referred to the night sitting service for the final weeks of their life. The relative expressed they had initially been concerned about how their family member would develop a positive relationship with the staff member as visual communication was not possible, and had been very impressed by the employee's skilled interactions. Relatives confirmed that staff made sure that people received their personal care in a private room of their choice and were appropriately covered with towels and dressing gowns before and after a bath or shower. Staff spoke about the people they supported in a compassionate way. A team leader for the home care schemes told us they placed an emphasis on, "getting on with people, respecting them and having a friendly vibe."

Relatives told us their family members did not have any specific cultural needs. Two people who used the day centre service told us that staff respected their spiritual beliefs and they were pleased that staff had taken the time to talk with them about their religious observances. One person said, "I am Hindu which they respect" and another person said, "I tell them about being Hindu which they like listening to." The team leader told us how they would support staff to understand about people's cultural needs and provide appropriate care. A male health care assistant told us they were aware that the care coordinator always checked in advance with female service users if they were happy to receive a night sitting service from him.

The provider demonstrated an individual and holistic approach to offering people a caring service. In some circumstances, people had opportunities to become acquainted with the hospice and its staff team before they used the home care services. The registered manager told us the hospice endeavoured to become a vital and welcoming local resource for the wider community. For example, the hospice dining area offered a neighbourhood café service once a week on a day that people did not come in for services and treatments. This enabled the provider to raise funds but also introduced local people without prior knowledge of hospices to the concept of hospice care. Some people living in the borough with life limiting illnesses were referred to the hospice by external health care practitioners for complementary therapies, which included reiki, massage and reflexology. These therapies were used to support people to manage symptoms such as pain, anxiety, insomnia and breathlessness through offering relaxation and a general sense of wellbeing.

Relatives could access bereavement services at the hospice and were invited to do so. One relative told us about their experience of attending counselling for as long as they needed it and said, "I had a brilliant counsellor. I think I went about 20 times and just cried for the first few sessions." The relative explained that the hospice and its staff were now part of their family's life, "They keep in contact and they haven't forgotten us. We are asked to events and go to the Light Up A Life remembrance ceremony." Counselling was also offered to people with a life limiting illness, and their relatives. One person at the day centre service told us they had benefitted from this counselling service. There was additionally a bereavement and loss counselling service for children and young people aged between four and 17 years old living in the south part of the borough. Counsellors supported children and young people who had experienced bereavement or had someone close to them with a palliative illness and offered individual counselling, therapeutic group work and short-term family work. We were shown the dedicated room used for these sessions, which was decorated in an appealing style for children and young people and had equipment to help express grief and loss through creative mediums such as storytelling, sand play, music and movement.

People were provided with a range of written information about local advocacy organisations and about the services offered by the provider, which could be made available in community languages and accessible formats, such as large print. We were informed by the registered manager that the bereavement service could also signpost relatives to other services, for example relatives were advised about how to apply for a social services assessment if they were experiencing difficulties relating to their own health and social care needs.

On the first day of the inspection we were introduced to a group of local people who met regularly at the hospice to help plan fundraising events. People told us they had joined this group as a means of giving back to the service in gratitude for the good care and support given to their family members and friends and in order to derive ongoing mutual support from people who had experienced the loss of a loved one. We did not speak individually with people at this group about the quality of the service their family member or friend received as people acknowledged that their experiences were not recent, but noted that the provider promoted a sense of community spirit and the value of caring for one's peers through their support of this group.

Good

Is the service responsive?

Our findings

People and relatives told us the service was responsive to their needs and wishes. One relative told us, "[My family member] really took to [registered nurse]. He/she asked them questions about what would happen in their final days, he/she was young and wanted to understand. [Registered nurse] gave very good care and was with us when [my family member] died." Another relative said, "I have no complaints about how they care for [my family member]. The care is fantastic and we tell our doctor and anyone who asks that this is a great service. The staff are reliable, they never let us down." We looked at comments people and relatives had written in the provider's quality monitoring surveys about how the provider had responded to their needs, "[My family member] and I have complete confidence in the level of care being provided by your organisation" and "You got the care absolutely right, well done." People we met at the day centre service and the relatives we contacted afterwards told us that staying at home for as long as possible in the comfort of one's own surroundings was important and they believed the provider was committed to enabling them to meet their aspirations.

Health and social care professionals, and Healthwatch Hillingdon, told us they had received positive feedback from people who used the service and their relatives. One health and social care professional told us people were reluctant to move to another provider after they had received a short-term care package from Harlington Hospice as they were pleased with how their needs had been met. Another health care professional told us that the Rapid Response Service had supported people to stay out of hospital and remain in their own homes.

The registered manager informed us that the provider was able to flexibly respond to people's care and support needs at short notice, which was demonstrated when we looked at the schedule planning carried out by the care coordinator. We were informed about a person who was due for hospital discharge but the identified discharge date was subsequently postponed. The provider had set up a care package for the original date and through close liaison with the hospital discharge team was able to provide the same care package for the new discharge date. The cut off referral time for setting up a same day care package was two o'clock in the afternoon. People could be discharged from hospital at weekends and receive a care package as long as the referral was sent to the provider during a weekday.

The hospital based Discharge Team carried out and developed individual care plans for people who used the Homesafe Night Service and Harlington Care. The registered manager told us this system worked well, which was confirmed by external health and social care professionals. The provider carried out their own assessments and care planning for the Palliative Care at Home Service. A team leader told us they met people, and their representatives where applicable, prior to the commencement of a care package. This meeting sometimes took place at the hospice if people used the day centre service or another service offered at the premises, but was usually held in people's own homes. The team leader explained that the care and support plan was developed through speaking with people about their needs and wishes, and through using information from referrals and assessments by external health and social care professionals to enable a more in-depth understanding of people's needs. The care and support plans we looked at provided appropriate information to support staff to meet people's needs. We noted that the registered

manager carried out visits to people at home and conducted risk assessments if required for people who used the Palliative Care at Home Service. She was aware of people's needs and staff told us they felt supported when they sought advice about how to respond to deterioration in people's health.

We found the provider had developed services to respond to local people's needs and wishes, and the needs and wishes of their relatives. The provider had established a group for people living with dementia and their main carers, who might be a partner, relative or close friend. The group consisted of 10 to 12 pairs of participants who met weekly for eight weeks, with approximately four groups taking place each year. People living with dementia were provided with care and activities in the day centre for two to three hours while their carers attended a course titled 'Caring with Confidence'. This course included input from a counsellor. People and their carer were invited to stay for lunch after the session in order to offer a relaxing and social element to the group. The registered manager informed us that where possible people living with dementia were supported to continue to attend the Monday morning day centre session to provide their carer with respite. This service showed the provider had implemented an innovative approach to support people with a life limiting illness, and also support their relatives and friends. We saw comments written by carers, which stated "Your care has changed my life", "There are no words to say this hospice is the best" and "Facilities so good, needs extending so more people can appreciate how good it is."

At the time of the inspection approximately 66 people attended the lymphoedema service, although we were informed that the provider was expanding the service in response to new commissioning arrangements. The lymphoedema service was run by qualified specialist therapists and its aim was to support, treat and help manage lymphoedema. People were able to refer themselves to exercise classes specifically designed to aid lymphoedema but needed to be referred by a medical or health care professional for other available treatments. We read comments people had recorded in the provider's quality monitoring surveys about their experience of using the lymphoedema service which included, "The lymphoedema team provided an excellent service in both treatment and ongoing care…treated as an individual, not just a number", "Excellent, but it took a long time from the referral to first appointment due to the volume of patients needing the service" and "excellent centre, couldn't ask for more."

People and relatives told us they had no complaints about the quality of the service and had never had cause to make a complaint. Relatives said they would complain to the registered manager and had confidence in her ability to conduct a transparent and thorough investigation. We noted that people and their supporters were given straightforward information about how to make a complaint when they commenced using one or more of the services at the hospice. We looked at how the provider had investigated complaints received since the previous inspection visit and noted that the registered manager offered meetings with people and/or their relatives in order to listen to their concerns and at a later stage to discuss the complaints investigation, if they wished to. One complaint was in regards to the conduct of staff and included allegations that two staff had made inappropriate and coarse remarks to a person who used the service. This person chose to transfer to another provider soon after making the complaint. We discussed this complaint with the registered manager and found that a careful investigation had taken place, which found that one staff member required guidance and training about how to consistently maintain a satisfactory standard of professional conduct. The registered manager had spoken with the staff member involved about how certain types of remarks to people were not acceptable even if there was no intention to cause offence, and had monitored their performance following the complaint.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they felt the provider offered a valuable local service to support people to remain at home. Relatives told us they would not hesitate to recommend the service to others. The provider's own surveys demonstrated that people thought they benefitted from the home care services and described themselves as being "very pleased with your service" , "happy" and "somewhat satisfied." Comments from external health and social care professionals showed they found the service was "well managed" and the management team were helpful, cooperative and made a positive contribution to the planning of specialist community services in the borough. Staff told us they enjoyed working for the provider and described the management team as being "wonderful" and "open and encouraging."

During the inspection we made some observations which showed the need for more rigorous monitoring of practices at the hospice. For example, during our tour of the premises we found five medicated dressings were out of date. Two other dressing packs had been opened from sterile packaging and returned to the storage area. We noted that the registered nurse at the day centre service undertook dressings when necessary, hence this finding could have potentially placed people at risk. The registered manager was informed on the first day of the inspection and we discovered that all of the dressing packs had been checked on the second day. We discussed this incident with the registered manager and other senior staff on the third day of the inspection and were informed that the dressings had been donated to the hospice and placed in storage by volunteers, who were not aware that the provider would not ordinarily use donated dressing packs. We were advised by the provider that the registered nurse routinely checked the expiry date of dressing packs before carrying out a dressing and would use dressing packs individually prescribed for people.

We also detected a dusty oxygen portable cylinder with a used oxygen mask and connected tubing. Staff did not know where it came from and thought it could have been brought to the premises by a relative so that the hospice could arrange its disposal. The clinical room was not locked when we were shown it. The premises did not have any people in at the time and we were assured the door was usually kept locked. The acupuncture needles and aromatherapy oils were stored in this room but not locked in a cupboard, which meant there could have been unauthorised access to needles and oils.

We spoke with the registered manager about how the provider assessed people's needs to ensure their safety at the day centre was promoted. We were shown a day care assessment document that noted if the assessor thought there might be any risks such as falling or moving and handling, however there was no formal recognised tool in use that would objectively identify the level of risk. Consequently there were no care and support plans to detail how the provider proposed to mitigate any risks, taking into account people's independence and quality of life. There were no risk assessments for choking although people who used the day centre services had deteriorating health care conditions. The registered manager acknowledged the need to develop their documentation for attendants at the day centre services to ensure an appropriate exploration of risk factors was considered.

These findings demonstrated that the provider did not have robust systems in place to identify and

appropriately address issues that impacted on the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager had worked at the service prior to registering with the Care Quality Commission (CQC) in May 2016. We were informed on the final day of this inspection of their plan to submit their resignation from this role and this application has now been formally received by CQC. Our findings during the inspection demonstrated that the provider had delayed in establishing specific tools for improving the quality of the service, for example the lack of formal systems to monitor, support and develop staff through regular formal supervision and annual appraisals. During the inspection we spoke with the chief officer who discussed the provider's strategic plan for future development with us. The plan demonstrated the provider's objectives to develop the service and work in closer partnership with other local voluntary sector organisations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider must ensure that effective systems are in place to assess, monitor and improve the quality of the service. Regulation 17(1)(2)(a)

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use the service were not protected from the risks associated with staff not receiving appropriate supervision and appraisal to enable them to carry out their duties. Regulation 18(2)(a)