Pilgrims Hospices in East Kent

Pilgrims Hospice Ashford

Inspection report

Hythe Road
Willesborough
Ashford
Kent
TN24 0NE
Tel: Tel: 01233 504100
Website: www.pilgrimshospice.org

Date of inspection visit: 13/08/2014
Date of publication: 27/01/2015

Ratings

Overall rating for this service	Outstanding ☆
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

Overall summary

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, and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Pilgrims Hospice Ashford is one of three hospices provided by the Company, Pilgrims Hospices in East Kent. It provides specialist palliative care, advice and clinical support for people with life limiting illness, their carers and families. The hospice has a 16 bed in-patient unit and a day therapy hospice with various clinics and drop-in centres. There is a bereavement counselling service. Services are provided by health professionals and volunteers. The service was providing services to 336 people in the community and in the hospice at the time of the inspection.

Summary of findings

The hospice provides a very relaxed, comfortable, clean and attractive environment. This includes facilities for families to relax in during the day and to stay overnight. There are quiet reflective areas including a chapel; and beautifully maintained gardens for people to spend time in – either helping with the gardening, or wandering quietly in the memorial gardens or wildlife area. People said it was very important to them that they were able to receive care and support in such a peaceful environment.

The hospice is run by a registered manager, who was present on the day of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

People said that they felt safe receiving care in the hospice. Many commented that they felt safe for the first time "in a long time", because they "knew that their care and treatment was being managed effectively." One person said "It only took me ten minutes to realise I was going to be safe and comfortable here."

All of the staff had been trained in safeguarding vulnerable adults, and received regular refresher courses. Staff gave us clear explanations of the different types of abuse to be aware of; and explained that they knew the action to take in the event of any suspicion of abuse.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The manager told us that they had not found it necessary to apply for a Deprivation of Liberty Safeguard for anyone to date. Where people were unable to make complex decisions for themselves the service had considered the person's capacity under the Mental Capacity Act 2005, and had taken appropriate action to arrange meetings to make a decision within their best interests, if this was applicable.

The hospice had a wide range of risk assessments in place for the environment, and for each individual person who received care. Some people had restricted mobility and we saw that individual risk assessments had been implemented and were in use for different pieces of equipment. General risk assessments were evident for each room or area in the hospice, the gardens, maintenance activities and company vehicles.

Without exception, everyone spoke very highly of the staff, and patient surveys reflected this too. People's comments included phrases such as "The service has been outstanding"; "The consultation was conducted in an excellent manner"; and "The doctors and staff could not have been more helpful and understanding."

We saw that staff had a kind and gentle manner with people. They spent time listening to people, did not rush them, and did all they could to meet people's individual wishes and requests. The staff had suitable training and experience to meet people's assessed needs; and always encouraged people to make their own choices and promoted their independence. We found that it was a hallmark of the service that ran through every aspect of the hospice, that people were treated as individuals, and were provided with the support they needed to enable them to meet their 'wish' lists. A visiting health professional told us, "The care here is second to none. The staff really care about people and look after them extremely well."

Staff files showed there were safe recruitment practices, which included Disclosure and Barring checks. These were included for volunteers who came into contact with patients.

We inspected medicines management and found that there were clear procedures in place to provide safe storage and administration of medicines.

People said that the food provided was "excellent", and we saw that this included variety, suitable nutritional content, and was in accordance with people's expressed wishes. The chef and catering staff were innovative in providing specific items requested by people, and in preparing and presenting food in an attractive way.

People told us that they were fully involved in every part of their care planning and treatment, and were confident that staff explained everything to them clearly. Care plans were stored electronically, and those for in-patients were reviewed and updated on a daily basis. The hospice employed their own consultants and doctors, as well as nurses, healthcare assistants, physiotherapists and other therapists to provide on-going treatment and support.

Summary of findings

There were robust systems in place to obtain people's views, which included formal meetings and the use of questionnaires. However, we found that it was a feature of the hospice to ask people for their views in relation to every aspect of their care, so that they were treated as individuals. The manager explained that the staff always tried to pick up on any little frustrations that people expressed and dealt with these immediately, so as to make people feel as comfortable as possible.

Patients, relatives and staff said that the manager was always available, and provided reliable and helpful support with any concerns or difficulties.

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?

Good

The service was safe. Staff were trained in safeguarding vulnerable adults and children, and knew the action to take if they were concerned that abuse might be taking place. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There were effective systems in place to manage general risks in the service and risks for individual people. Patients were enabled to take informed risks in line with their individual wishes, and were encouraged to retain their independence.

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. Recruitment for staff and volunteers was carried out with robust procedures to ensure they were suitable to work with vulnerable patients. Staff managed people's medicines safely and effectively, and were particularly concerned with ensuring effective pain management.

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

Is the service effective?

Good

The service was effective. Staff carried out detailed assessment programmes and ensured that patients were treated as individuals. The hospice provided comprehensive health care management for in-patients and patients in the community. This included formal appointments, drop-in services, and a 24 hour navigation telephone system, which prevented people from feeling isolated in the community. The hospice staff liaised with other health and social care professionals to enable patients to have the care and treatment they needed.

Staff training was provided on site, and there were processes to ensure that staff kept up to date with required subjects. Staff were encouraged to take further training courses to develop their skills and competencies.

The food was prepared and presented to a high standard, and people's individual dietary needs and preferences were adhered to. The chef was innovative in providing meals to encourage people with their nutrition.

Is the service caring?

Outstanding

The service was extremely caring. Staff were kind, friendly and welcoming, and carried out their duties in a calm and gentle manner. They ensured that people's individual wishes were taken into account, and did all they could do help people to carry out their 'wish lists' as well as meeting their individual needs. Patients said that they were always treated with dignity and respect.

Summary of findings

The staff showed care and concern for people's family members, and there were counselling and bereavement services for family members as well as for patients. The hospice provided facilities to enable relatives to stay with patients for as long as they wished, including overnight rooms and lounge areas.

People's end of life choices were discussed with them sensitively and appropriately. Their wishes were clearly recorded and were acted on accordingly. The staff enabled people to have a comfortable and dignified death. Staff and facilities were provided to support family members through their times of grief.

Is the service responsive?

Outstanding 

The service was responsive. Staff were given clear guidelines to enable them to carry out people's individual care needs. A 24-hour telephone service ensured that patients and carers felt supported at all times.

People's care and treatment plans were reviewed and updated regularly. Staff checked the care plans for in-patients every day, and adjusted them if people's care needs had changed.

People said their views were always listened to. Any concerns were taken seriously and were quickly addressed.

Is the service well-led?

Good 

The service was exceptionally well-led. The manager and senior staff led by example, and spent time listening to the views of patients, staff, and volunteers. Auditing procedures and different quality groups provided a framework for ensuring that on-going proposals for improvements were considered and carried out. Staff were confident that their views and ideas were listened to and taken into account, and said they felt supported in their different job roles.

The manager obtained the views of other health and social care groups and carried out benchmarking against other national hospice services. There were systems in place to provide innovative solutions, so that it was a continually improving service.

Pilgrims Hospice Ashford

Detailed findings

Background to this inspection

The inspection team consisted of three inspectors, one specialist hospice 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. The expert for this inspection had experience of a relative who had used hospice services. This was an unannounced inspection. The previous inspection took place on 19 November 2013, when no issues of concern were found. This inspection was carried out over two days, as the second day was used to visit the company's head office and view recruitment files.

Prior to the inspection we examined the 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 PIR included comprehensive details as to how the care was provided, and the on-going development of the service. We looked at previous inspection reports; and we reviewed notifications received by the Care Quality Commission during the past year.

We met and talked with 10 in-patients, 8 people attending the day hospice service, and 12 people's relatives and carers. We talked with a variety of staff, and observed others carrying out their duties. We talked with some visiting health professionals such as a GP; and with nursing staff, physiotherapists and occupational therapists employed by the service. The hospice had a large number of volunteers who assisted with different aspects of the work such as reception duties, gardening, and administration, and we talked with some of these.

On the second day one inspector visited the Human Resources department in Canterbury to view staff recruitment files; and a second inspector made phone calls to talk with patients and carers in the community; and three phone calls to social workers who arranged placements for people.

We observed staff carrying out their duties, such as staff assisting people with reduced mobility to walk short distances; and staff helping people with food and drink. We carried out pathway tracking by reviewing people's records and speaking to the people concerned.

We reviewed records in paper and electronic formats. These included: a list of hospice risk assessments, and two of the assessments in detail; eleven maintenance and servicing records; four staff recruitment files and staff training records; minutes for a User Forum meeting; twelve recently completed patient surveys, and the results of the previous patient surveys; eight care planning and treatment records; one week's staffing rotas; the complaints procedure; medicines records for individual patients and controlled drugs records; and audits for cleaning, infection control and controlled drugs management.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

In-patients and patients from the community told us that the staff always listened to them, and treated them with dignity and respect. One person said, "I use the day service and respite services. If ever I had a problem I would go to them, no one else, I cannot fault them." People told us that they felt safe in the hospice, and were confident in the care and treatment given by all the staff. The relatives of a very frail patient were very complimentary about his care. They said he required regular attention and checks for his safety, and they were very confident that he was getting excellent care and attention.

All of the staff had received training in safeguarding vulnerable adults, and received refresher courses to keep them up to date. A recent staff survey had 100% positive response to the statement "I know what to do if I suspect one of the people I support was being abused or was at risk of harm." Staff demonstrated to us that they understood the different types of abuse and were familiar with safeguarding policies and procedures. The senior social worker on site was the named safeguarding lead.

Staff had received training in the Mental Capacity Act 2005, and further training was booked for November and December 2014. Staff were very motivated about ensuring that people's individual decisions were listened to and were followed. If there was any doubt that people were unable to make complex decisions, staff were aware of the correct procedures to follow. They arranged 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. However, staff were aware that there were times when people may be temporarily incapacitated from making complex decisions, for example, after receiving pain relief. They were therefore careful to discuss issues with patients at times when they could fully enter into discussions, as far as possible. The manager had not found it necessary to make any applications under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to restrict anyone's liberty for their own safety.

The service had a detailed system for assessing risks for patients and staff. The entire team ensured that the patient was the main focus of their care, but also ensured that children or dependents were being cared for by the previously agreed family representatives or guardians. Special emphasis was highlighted on young family members so that they had a provision for pre-bereavement care to promote the safety of vulnerable children whose parents or relatives were at the end of their lives. Patients' individual risk assessments included assessing the risk of falls, environmental risks, mobility risks, and management of wound care. General risk assessments for the building and environment included risks of using electrical equipment, kitchen equipment, hoisting facilities and disposal of waste materials. We saw that risk assessments showed how risks could be minimised for people so as to promote their safety. There was evidence of thorough risk assessments for individual patients, with family and carer involvement.

Nursing and care staff were available to in-patients and people attending day care services throughout the day, and we saw that there was no undue delay in answering people's call bells. A senior nurse explained that the hospice had a system in place to carry out scoring of patients' dependency levels for one week each month. This entailed the nurses viewing and recording how long it took to carry out different tasks for individual people, such as assisting them with a bath, or helping them to walk from one place to another. This data was analysed to assess if there were sufficient numbers of nursing and care staff. A recent check had shown that it would be of benefit to in-patients if staffing numbers were increased, and this had been discussed and agreed with the trustees. The staffing numbers were adjusted accordingly. Additional staff were made available if there was anyone with specific needs who required extra staff. This was an excellent method of ensuring there were always sufficient numbers of nursing and care staff to attend to people.

We saw that staffing numbers usually included three nurses and four care staff in the mornings; three nurses and two care staff in the afternoons and evenings; and two nurses and one care staff at night. An additional health care assistant was employed for a 'twilight' shift from 4pm to midnight. This provided a consistent level of staffing throughout the twenty-four hours, with a suitable ratio of nurses and care staff. A nurse who had worked at the hospice for several years remarked, "The staffing levels for patient care are fantastic". Other staff told us that they did not have to rush people, and were always able to spend sufficient time with them.

We viewed four staffing recruitment files, and saw that robust procedures were in place to ensure that staff were

Good

Is the service safe?

suitable to work with vulnerable people. The procedures included taking proof of identity, two written references, interviews with two senior staff, Disclosure and Barring System checks, and viewing records for previous qualifications, and nurses 'PIN' number checks. We spoke to the head of recruitment about the processes for ensuring that applicants completed a full employment history. New staff were taken through a comprehensive staff induction programme which included basic training subjects. They worked alongside other staff until they had been assessed as being able to work on their own. Each staff member had a report and review meeting at the end of their probationary period; and staff told us that they had found the induction and probationary processes to be helpful and supportive. Patients told us that they were confident in the care that was given to them by the staff.

The hospice used a large number of volunteers to carry out different aspects of work such as reception duties, gardening, fund-raising and maintenance. Volunteers who worked on a regular basis had stringent interview processes and Disclosure and Barring System checks. Some volunteers came for only a few days experience, such as school leavers. The manager told us that these were individually risk assessed, and were not allowed to be left unattended with any of the patients. The volunteers provided the service with an additional caring and compassionate work force, which assisted in the smooth running of the service. A patient told us, "The receptionists are very helpful, lovely, friendly and welcoming."

The nursing and medical staff ensured that people had medicines prescribed and administered in accordance with their individual needs. Medicines were stored in a large clinical room, in suitably locked metal cupboards. A stock of medicines was ordered each week by the nurses, and were dispensed by the local NHS hospital pharmacy. There were clear procedures in place for receipt and disposal of medicines, and we saw that weekly stock checks were carried out. We did not see any out of date medicines, and the ward sister told us that the dates of all medicines were checked weekly.

We saw that medicines for intravenous use and for syringe drivers were stored separately to promote safety. (A syringe driver is a small, portable pump that can be used to give a continuous dose of pain relief and other medicines through a syringe). Controlled drugs were stored in separate cupboards which met the required regulations, and were recorded in different controlled drugs record books. We saw that these were accurately completed, and showed when stock checks were carried out. We noted that the drugs fridge was not locked and discussed this with the ward sister and the manager. The clinical room was kept locked, but floor cleaning was carried out by domestic staff who could have had access to these medicines if a nurse was not present. The ward sister took immediate action to ensure this fridge would be kept locked in future.

The hospice included a wide variety of equipment such as overhead tracking hoists, manual hoists, assisted baths, over-toilet chairs and grab rails. Staff training programmes ensured that staff were kept up to date with moving and handling procedures, so that people were assisted to mobilise safely. Records confirmed that there were suitable systems in place for keeping equipment clean and serviced.

The hospice was well maintained, very well presented, and clean in all areas. A volunteer told us, "The hospice is always spotlessly clean, and beautifully maintained. It is such a pleasure to come here." There was evidence of daily cleaning checks, and we viewed audits for cleaning and infection control. Toilets and bathrooms contained liquid soap and paper towels, and there were hand-gel dispensers placed strategically around the premises. Staff used personal protective equipment such as disposable aprons and gloves for specific tasks. Laundry was not carried out on site, as the hospice had a contract for this with the local hospital laundry services. However, a washing machine was available for people's own laundry if they wished to use it when they were in-patients. We saw that there were reliable systems in place for on-going maintenance of the premises; and servicing for systems such as the call bell system, fire alarms and hoist servicing.

Good

Is the service effective?

Our findings

The nursing staff ensured that people's needs were assessed, and that care and support was given in accordance with their needs and preferences. Patients that we spoke to included someone who had been recently admitted. They said that within one hour of their arrival they had been informed of staff names, been given a jug of water, had been given an explanation of the call bell, and had a doctor carrying out admission procedures. They said "It's not what I imagined –everyone is so kind and friendly". Another patient said that the communication she had experienced from staff was something that "Makes me feel confident in their competence and gives me a feeling of safety and comfort."

The staff were able to talk knowledgeably about people's care and how to provide support for their physical, mental, emotional and spiritual needs. The ethos of the hospice centred around ensuring that each person was seen and treated as an individual. A thorough assessment was carried out at the commencement of their referral to the hospice, and at each in-patient admission. 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. All patients were able to say that their care was effective in different ways. Their comments included: "I'm simply better now for being here"; "I love my day care here"; "It's great when we are here"; and "I look forward to coming here." One in-patient was having respite care to give her relative a break and she joked "I am here to give him a break, but it's more like a holiday and it must be good, because I feel better!"

Staff training programmes showed that essential training subjects were completed during the probationary period. This included subjects such as health and safety, fire safety, equality and diversity, infection control, manual handling and safeguarding vulnerable adults. The training included online computer courses, and face to face training. Training was allocated in accordance with staff's specific job roles. The computer system showed when training was next due, and was colour-coded to show if required training refresher courses had gone out of date. The manager told us that staff would be prevented from working if these subjects were out of date, so that patients were protected from receiving care from inadequately trained staff. A patient told us, "The staff always support me when I need to move, and I get such good advice from the 'physios' that I don't fall when I am here."

We saw that training was provided for other relevant subjects, and was set at the levels required for different staff functions. This included training in subjects such as the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards; end of life care; bereavement training; handling complaints; and clinical record keeping. Training for nurses included subjects such as use of syringe drivers, and managing blood transfusions. Volunteers received training in accordance with their duties, and most had a role profile and a named person to report to during their shift. There was a large training room on site, which saved staff travelling time to other venues.

Staff had regular individual supervision with their line managers, and we saw evidence which showed that these meetings were kept up to date, ensuring that staff were supported in their different job roles. Staff also had yearly appraisals. A health care assistant told us that they had clinical supervision in a group when they could "ask anything", as well as general staff meetings. This enabled them to develop their skills and have more understanding of people's nursing and care needs. A nurse told us, "We have good support at the hospice and excellent training"; and "We support each other as a team."

Day patients, in-patients, staff and visitors were impressed with the quality of the food. There was a standard menu every day, with several choices that could accommodate vegetarian and light meal requests. The catering staff visited all patients and checked their specific dietary needs and preferences and catered for them on a daily basis. One day-care patient said "I wanted the special today which was sausage casserole. I could not have the one everybody else was having as I have a certain medical condition; so the chef prepared a special sausage casserole with different ingredients just for me". Another patient said that just the breakfast had given her a significant boost and feeling of wellbeing. They said, "I've got my desire for food back again, after the simple yet wonderful toast and fresh orange juice this morning". The person was most impressed by the individual tray presentation, and the pleasant manner of the staff. "It's given me a lift, an incentive, when for the last few months I just could not care or be bothered,

or did not have the energy, whilst I felt so unwell". The person's friend said "She seems so much better already, her manner is brighter and she looks better and smiles, when only a few days ago she seemed depressed and down; and all because of decent food, well presented!"

We saw that there was individual attention to detail with all of the food's presentation, menus and ingredients used. These included several fresh locally sourced vegetables as well as some quality frozen supplies. The lunch time meal was very good in quality and especially well presented. It was provided in the correct portion sizes for different people. Some people needed their food mashed or pureed, and this was done to different consistencies for each individual person. There was a regular 'refreshing' service for water jugs for in-patients, and hot and cold drinks were offered at regular intervals.

We assessed health care management by talking with patients and staff and viewing documentation. The hospice used electronic storage for patients' records, which were password protected to maintain confidentiality. There were paper records at people's bedsides. We viewed three electronic records and six paper records. The records confirmed that patients were individually assessed after admission, and a plan of care was promptly devised in discussion with them. Care records were reviewed every day and updated as needed. We saw that there was a minimum of three entries per day for daily records, showing every aspect of care given such as washing and bathing; repositioning; nutritional management; medicines and pain relief; physiotherapy, and input from the medical team showing the care and treatment that had been delivered during each shift. These were detailed records, showing how personal care had been given, how people had been assisted with their mobility; and recording their moods, fears, and level of pain and how these had been addressed.

Risk assessments such as risk of falls were correctly completed. One record clearly documented that a patient had had a fall (with no serious injury), and the records showed that the doctor had been called and visited the patient, the family had been informed, an accident form had been completed, nursing observations were taken, and the person's medicines management had been reassessed. The care records included daily reports from health professionals. These included reports from palliative care nurses, the hospice consultant and doctors, physiotherapists, and occupational therapists, as well as nursing reports.

Care records included additional charts, such as for positional changes to prevent pressure area damage; fluid charts; pain management; and wound care. These charts accurately reflected the changes in people's individual health needs, and the action that was being taken to address changing needs.

The staff had a handover for in-patients at each shift change. A health care assistant showed us a handover sheet, which listed each patient in detail, and included details of their families, as well as their primary diagnoses, medical issues, and aspects of care such as their mobility and elimination. We attended a handover meeting, and found there was an expected patient death during the day. This was dealt with quietly and sensitively by the staff in the unit. The end of life care was highlighted at the handover meeting where staff discussed the patient's individual care in detail. Each staff member contributed to discussions and it was evident that these staff members really knew their patients and their individual care needs. The team highlighted the importance of a 'Do not attempt resuscitation' (DNAR) document that had just been completed for this patient. For another patient, there was evidence of detailed discharge planning where individual team members discussed the person's family care, equipment issues, and liaising with adult care services, continuing health care, general practitioners, Macmillan nurses, and district nurses. A staff member said "There is good care here and good supervision throughout and most importantly, there is time to give patients and families. No-one tells me off, if I just sit and talk to patients."

The hospice ran a superb range of additional services to support patients while they were living in the community. This included 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 with them and then decided if the person needed emergency admission or if they needed to see a community nurse or doctor at home. The hospice managed a team of community nurses each day to go out and visit people, and there were two teams to cover different geographical areas. There was also a 'hospice at home' rapid response team to

Good

Is the service effective?

carry out duties such as giving personal care for someone in the community, or sitting with them at night. This gave patients and their carers the reassurance that they were never left without care and support when they needed it.

Day services were provided on a separate floor of the building, and included multi-functional days. On the day of our inspection there was a 'drop-in' clinic aimed mostly for younger patients. Other days were aimed at older patients, so that people felt comfortable in their peer groups. All of the care was managed by a clinical team with volunteers assisting; for example, a volunteer might drive the patient to and from the clinic session. There was evidence of supporting the patient's well-being and disease management, with breathlessness clinics, carer support groups, and a gym; and physiotherapists and occupational therapists who designed individual programmes of care for each patient to keep them mobile and active. We saw that the day hospice was being used by patients during our inspection, and there was a good ratio of qualified and therapy staff in attendance. There was a breathlessness and fatigue management class in the morning and a relaxation class in the afternoon. The gym and hairdressing facilities were in use, and complementary therapies to promote people's sense of wellbeing. One person said, "I am so pleased to be able to get my hair done here today. It is an effort to come to the day centre, and it is so good to have what I need all under one roof."

There were several areas for families to relax and children's toys available. There was a hotel style room for overnight stays with en-suite facilities and tea/coffee making facilities. The hospice included a variety of lounges and quiet areas for families to chat together, or for quiet reflection; and a multi-faith chapel open to anyone. The hospice included a chaplain, a trained volunteer chaplain and counsellors, to aid people going through grief and bereavement. We witnessed strong evidence of pre and post bereavement care for families at a daily meeting for health and social care professionals; and there was a risk assessment for identifying family members who may be at risk. The staff also worked with people's GPs so that they were kept fully informed of changes in people's medical needs and emotional wellbeing.

People's needs were met through the specific design and adaptations in the hospice. In-patients were cared for on the first floor, and day services were on the ground floor. There was a passenger lift between floors. There was a wide variety of other equipment such as manual hoists, assisted baths, over-toilet chairs and grab rails. Records confirmed that there were suitable systems in place for keeping equipment clean and serviced.

All of the in-patient beds had an overhead tracking hoist which eased patient movements and prevented back injury for the nursing staff. The bed bays overlooked the gardens which had been recently re-landscaped after a successful bid to the Department of Health. The staff were very proud of the gardens and said that these were an integral part of the therapy for in-patients and day patients. They included a wild-life garden, a sensory garden, and space for people to walk quietly on their own. They had full wheelchair access, and included raised beds for people who wanted to take part in the gardening club. Clean, comfortable chairs were available for patients and families, and these had sun protection/parasols in place.

Outstanding ☆

Is the service caring?

Our findings

Everyone that we spoke to was very positive about the high standards of care provided. Day patients and relatives that we spoke to on the telephone expressed surprise when we asked them if they had ever had any concerns about the standards of care. People's comments included, "I think the hospice is par excellence and have all my needs in hand and I am very happy with everything"; "The service in the hospice is A1 in every way; the doctors, nurses and staff are all excellent"; and "Nothing is too much trouble."

We observed that there were call bells in every room, with obvious emergency buttons. Outside each patient bedroom there was a blue light which indicated to other clinical staff that that patient was being attended to. There was evidence of a privacy curtain and a do not disturb sign on the door of every room. People told us that their privacy and respect were "always" considered. Patients told us, "I am virtually blind, but I always get my talking newspaper and audio books when I come here, I used to love books and reading, so I'm happy"; and "I get my hair done by someone that knows what they are doing"; and "I get a lovely bath." Relatives who had spent a lot of time in the hospice said the patient had received "The best of support and attention" during their time in the hospice; and said, "We have only good things to say about the hospice, the staff are so caring and considerate".

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. One of the staff said that some people's wishes might not be deemed as wise in relation to their medical conditions, but the hospice helped them to fulfil their wishes as far as it was possible. A staff member talked with us about a patient who had been admitted as an in-patient on five separate occasions for respite care, and the hospice team had helped to fulfil his wish list before he died. The staff member said, "It was such a positive thing to see him ticking off his wishes and everyone getting involved." We talked with a relative who said that the hospice team had assisted him in getting married to the patient in the hospice chapel, and he explained they had carefully discussed Mental Capacity Act issues with them prior to the marriage. He said "Time is very short now and nothing is too much trouble –the staff go out of their way. We are having my wife's cats in tomorrow for a special treat."

We talked with a patient who was being discharged home in the morning and they told us how the clinical team had taught them to manage their medication; how to manage breathlessness attacks; and had arranged for carers to visit in the community. "Nothing is too much trouble – day or night here, you just buzz the nurse and she pops along, always smiling."

We viewed questionnaires which had been recently completed by staff and health professionals. 100% of replies agreed with the statements "People who use this service are always treated with respect and dignity by its staff"; and "The service makes sure its staff know about the needs, choices and preferences of the people they work with." A staff member commented "I would recommend this service to a member of my own family." Nursing and care staff were very motivated and enthusiastic about working for the hospice.

We found that attention was paid to details, so as to really care for people individually. A senior nurse told us "We like to think we spoil people here." A staff member told us about a person who had mentioned that they would "Like to taste lobster" before they died. The chef had sourced one through the local fishmonger and had specially cooked this for the patient. People's anniversaries and birthdays were celebrated on site, and space was made for families to have their own parties and celebrations together. There was a very supportive and caring approach to the wider family, as staff recognised that family support was extremely important for people's wellbeing. This included specialist bereavement counselling and support for adults and children.

It was noticeable that every person that we spoke to – including patients, relatives, staff and health professionals – spoke positively about the care and support given. Health professionals' comments included, "The staff are all very approachable and absolutely well trained. The social workers and nurses are amazing positive people. The staff will always call me with any concerns they have." And, "I get great feedback from the people who attend saying they want to be there and it is a pleasant experience for the day unit and respite. I have never heard a bad word said about it from the people who visit." Another person commented

Outstanding ☆

Is the service caring?

"One thing stuck out to me; there was a high level of individualisation to the service for patients and their families/friends. Every single person was given the respect of being "their own" and provision was always considered to cater for that. That is a very high level of customer service and satisfaction."

We found that nursing staff ensured that each patient was kept well informed about their state of health, and talked with their relatives in accordance with their wishes. People confirmed to us that they had been fully involved in their care planning and had been asked about their end of life wishes. Some patients had said that in the event of a sudden collapse they would not wish to be resuscitated.

We saw that appropriate forms for "Do not attempt resuscitation" (DNAR) had been properly completed. Relatives and friends were able to visit at any time, and were able to stay overnight if this was the patient's wish.

The hospice included its own mortuary with nine spaces. This meant that the hospice could provide care for families through the whole process. Relatives found it comforting to know that they would not have to go to another strange place to see the person after they had died, but could spend time on the premises. Bereavement and counselling staff were available to assist people, as well as a chaplain. There was a discreet entrance for the undertakers to remove bodies with sensitivity and respect.

Outstanding ☆

Is the service responsive?

Our findings

Many patients visited for day care prior to respite or in-patient care, and some told us they had been surprised by their first visit. One person said that they had not expected it to be such a relaxed and friendly environment, and it was "Not at all what they had expected." The manager told us that staff aimed to have detailed conversations with people so as to really engage with them, rather than just trying to obtain answers to a series of questions. Patients told us, "Staff are always pleasant, friendly and caring"; and "They are all so helpful and listen to you when you have a problem." The ethos of the service was to provide people with person-centred care which helped them to fulfil their hopes and dreams, as well as meeting their individual needs.

People were referred to the service by their GPs or hospitals, and were offered an appointment to visit the service. They were sent an information pack prior to admission. The manager said they always tried to put people at their ease, and encouraged people to visit just to look round initially. 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.

The hospice had clear systems in place for providing treatment from different health and social care professionals, and effective liaison services, so as to provide effective on-going treatment for people. For example, for a person who was severely ill but wished to go home briefly, the nursing staff had contacted the community nurses, the GP, and the counselling team, after full discussions with the person, their family members, and the medical staff.

Senior staff had a daily meeting to discuss in-patients and vulnerable community patients, to discuss their wider care needs and discharge planning for people receiving respite care. We saw that staff received training in communication skills, so that this enabled them to be more confident in their approach with people. The hospice employed their own medical consultant, and he worked with the palliative care team at the local acute hospital to assess patients, to review existing care plans, and to liaise with people and the hospice specialist nurses to arrange a hospice admission when this was indicated. A social services case manager told us, "The staff always call me with any concerns they have regarding someone who attends the day unit. They are very proactive at reporting any concerns to myself, and liaising with other professionals." We saw that 100% of health professionals who had responded to recent surveys felt that the service "Co-operates with other services and shares relevant information when needed."

The hospice included a 24 hour on-call telephone service which provided advice and direction from nursing and medical staff to support patients in the community. This meant that patients felt confident that they always had access to nursing and medical care and advice. The 24 hour navigation support system enabled patients and their carers to know that help and support was "Just a phone call away" (as one person said). Another person said, "We wouldn't be able to cope without the hospice. We use the day patient and respite services, they arrange everything and it is lovely. It is an amazing place." People were given 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. The staff always looked to carry out procedures or care plans in accordance with people's individual wishes. Health care assistants told us that they were given clear guidelines at the start of each shift as to who they were allocated to support, and were updated with any changes in people's medical or social situations.

When we talked with the chef, we found that there was a Research and Development project that was underway. The team were hoping to produce tailor-made dishes for the 'Hospice in the home' team. Some innovative thought had been put into this new direction, and public safety and hygiene was clearly uppermost in their planning in this respect. This would provide an additional care service to support people living in the community. All key components of an ambitious project were being considered including the aspects of transport, storage and cooking in the home. We saw that the kitchens were well run, safe, looked clean and hygienic, and staff were following good practices. The premises included a café for anyone's use, and this served snacks and meals during the day as well as hot and cold drinks.

Outstanding ☆

Is the service responsive?

We saw that the hospice provided people with a complaints leaflet entitled "Making a complaint – helping us to improve." This summed up the attitude of the staff, who said that "Any concern is an opportunity to improve our services. The manager told us that the hospice considered that "A complaint is any expression of dissatisfaction." Complaints were logged centrally and were followed up to check for any trends. The hospice had had three complaints during the past year, and two had been resolved within 28 days. We saw that any negative comments were taken seriously and acted on. This showed that the service learnt from these situations. For example, a patient had said that their air mattress was uncomfortable. The staff took action by checking that it was on the right setting; and checked that it was correctly maintained. When it was still reported as being uncomfortable, the mattress was changed for a different one. We found that the 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. 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. People told us that they could "speak to anyone" if they had any concerns. One said, "I can't see how anyone can ever complain, everything here is always so good."

Written consent was obtained from patients for specific treatments such as having a catheter inserted, or having a blood transfusion. However, staff said that they asked for verbal consent for every aspect of care and treatment before they commenced it. The hospice maintained an electronic 'Share my Care' register, which provided an overview of patients' preferences and decisions. The register included details such as if the patient was aware of their diagnosis; if they lived on their own; their preferred place of death (for example, at home, or in the hospice); and if they had made a decision about 'Do not attempt Resuscitation' (DNAR).

Good

Is the service well-led?

Our findings

The service was well-known in the local community for its strong values of individual care and putting people first. The service carried out an annual "Summer Fair" which had been attended by thousands of people over the previous few years. It was well-known in the local vicinity as a charity which provided specialist care and 'putting people first'. The service had a friendly and welcoming atmosphere, and we saw that all of the staff were calm and smiling throughout our visit. One health care assistant said "I love working at the hospice, it's like one big happy family. It's really rewarding coming to work as the team work is fantastic." We noticed that the manager and the senior nurse manager led by example. They were visible to staff and approachable; and this was verified by a nurse during our discussions. Staff told us that they felt supported, in that they were encouraged to take holidays and to go off duty on time, and were not encouraged to work over hours.

The service was very proactive in ensuring that patients, family members, staff and volunteers were actively involved in the development of the service. A 'Staff communication and consultation group' (SCCG) provided an opportunity for dialogue and an exchange of views between executives and staff members, for issues of mutual concern and interest. Staff were also encouraged to take part in an annual 'Help the Hospices' staff survey for the company. Their views were taken seriously, and formed the basis for action plans to bring about changes as a result of their input. The hospice provided staff with '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. However, all of the staff that we spoke to said that the manager and senior staff were very approachable, and they felt confident in talking with them and raising any ideas or concerns. A recent staff questionnaire had 100% positive response to the statement "My managers are accessible, approachable, and deal effectively with any concerns I raise." Staff were informed about and familiar with the whistleblowing policy, but those that we asked said that they had never needed to use this. We found that 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.

The hospice held 'Patient safety and quality meetings', and people involved in this forum developed an improvement plan. Topics included items such as the use of antibiotics, prevention of pressure ulcers, and catheter care. The improvement plan was shared with the operational team, and agreed actions were carried out as a result. The manager showed us that the hospice had a structured approach to audits with a yearly planner, which helped the management to gauge the performance of the hospice against regulatory standards. This provided a focus for their improvement plans. We saw that auditing procedures included subjects such as infection control; deep cleaning; controlled drugs; staffing; safeguarding; complaints; use of syringe drivers; pain relief, care planning; and advance care plans. Other weekly audits were carried out for topics such as cleanliness of the premises, hand-washing, and medicines management. This showed that there were processes for an on-going assessment and improvement of the hospice at all times. The hospice also maintained audits which showed their performance ratings against other hospices nationally. This provided them with an on-going challenge to be the best in relation to other services. The results were discussed at the local management team meetings to identify any issues or improvements which could be made.

We found that the hospice was accredited, and used information from many other organisations which assisted the management in monitoring different aspects of the hospice. These organisations included 'Dignity in Care'; 'The Gold Standards Framework'; 'Action on Elder Abuse'; the 'Social Care Institute of Excellence'; and 'Skills for Health'. This enabled the hospice to keep up with best practice and be informed about different models and ideas for improvements.

The hospice was in the process of assisting with the opening of a new centre in the town of Folkestone after two years of planning. This was the result of listening to people and discovering a way of meeting their needs more effectively. The management had identified that this area had a significant caseload of people in the community who required support. The centre was to provide people with a non-clinical environment to attend appointments with doctors, nurses, social workers, and therapists. It was not designed to replace therapies and treatments at the hospice, but to complement them, and to enable patients to visit somewhere closer to home. This demonstrated the determination of the hospice to provide relevant care

Good

Is the service well-led?

services for people, which were more easily accessible for them. A 'User Forum' was available for people to discuss proposed changes, and included patients, carers, and volunteers. We saw that the centre had been included as a topic at these meetings. Questions had been considered together, such as "Is access suitable for disabled clients and carers?" "Is it more convenient coming to this centre?" and "Are you happy with the opening hours?" Other topics discussed by the User Forum included changes in décor for the hospice, changes to information leaflets, and facilities within the hospice.