Sue Ryder

Duchess of Kent Hospice

Inspection report

Dellwood Community Hospital
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Duchess of Kent Hospice is a local service run by the Sue Ryder charity. The in-patient facility covers a catchment area in Berkshire West which includes Reading, Wokingham and Newbury and is located in Reading. The hospice service provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver physical, emotional and holistic care through teams of nurses, doctors, counsellors, chaplains and other professionals including therapists. The service cares for people in three types of settings: at the hospice in 15 beds 'In-Patient Unit', or in their 'Hospice day service' that welcomes up to 14 people per day, and in people's own homes through their community service. The service provides specialist advice and input, symptom control and liaison with healthcare professionals. Services are free to people and the Duchess of Kent Hospice is dependent on donations and fund-raising by dedicated staff and volunteers in the community.

The services provided include counselling and bereavement support, family support, clinical psychology, chaplaincy, an out-patient clinic, occupational therapy, physiotherapy, dietetics, befriending, complementary therapies and diversional therapies and a lymphoedema service (for people who experience swellings and inflammation usually to their limbs post cancer treatments).

This inspection was carried out on 1 and 2 December 2015 by two inspectors and a pharmacist inspector who was shadowed by a new CQC pharmacist inspector. It was an unannounced inspection.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager also managed the community services, the day hospice service on site and the two day hospices located at Newbury District hospital and Wokingham hospital.

People were kept safe by staff who were trained in the safeguarding of vulnerable adults and health and safety. They were able to fully describe their responsibilities with regard to keeping people, in their care, safe from all forms of abuse and harm. It was apparent from discussion with members of the management team that all health and safety issues were taken seriously to ensure people, staff and visitors to the service were kept as safe as possible. There were enough staff, on duty, to ensure people received safe care. People were given their medicines in the right amounts at the right times by properly trained staff. Recommendations were made in respect of fire drills and the use of as required medications in order to encourage improvement in these areas. The recruitment process was robust and the service was as sure, as possible that staff employed were suitable and safe to work with people who were cared for in the service.

People's human and civil rights were upheld. The service had taken any necessary action to ensure they were working in a way which recognised and maintained people's rights. The staff team understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues

which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager had made or was making the appropriate DoLS referrals to the Local Authority.

Clear information about the service, the facilities, and how to complain was provided to people and their relatives. People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent or refusal before they supported them.

People's health and well-being needs were met. Staff had built strong relationships with people and were knowledgeable about and knew how to meet people's needs. The service respected people's views and encouraged them to make decisions and choices. Food was nutritious and of good quality. Staff were appropriately trained to meet the needs of people in their care including end of life care. Staff knew each person very well and understood how people may feel when they were unwell or approached the end of their life. Overall the service was highly responsive to people's needs and were proactive when people's needs changed.

People's feedback was actively sought, encouraged and acted on. People and relatives were overwhelmingly positive about the service they received. They told us they were satisfied about the staff approach and about how their care and treatment was delivered. The staff approach was kind, compassionate and pro-active.

The environment was well designed, welcoming, well maintained and suited people's needs.

The service was well managed. Meeting people's needs was the priority for staff and the registered manager. The registered manager was described by staff as supportive. Emphasis was placed on continuous improvement of the service. Comprehensive audits were carried out about every aspect of the service to identify how it could improve. When needs for improvement were identified, remedial action was taken to improve the quality of the service and care. The service worked in partnership with other organisations.

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 is safe.

Medicines were given to people correctly by appropriately trained staff. People were assessed as competent to safely take their own medicines.
Staff were properly trained and knew how to protect people from abuse or harm. People felt they were safe being cared for in the service.

Any health and safety or individual risks were identified and action was taken to keep people as safe as possible. The registered manager made sure the staff team learned from any accidents or incidents.

Robust and safe recruitment procedures were followed in practice.

The environment was secure and well maintained.

Is the service effective?

Good

The service is effective.

Staff were trained appropriately and had a good knowledge of each person and of how to meet their specific support needs.

Staff understood how to uphold people's human and civil rights and took appropriate action if people did not have capacity to make decisions. People were encouraged to make as many decisions and choices as they could.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service is caring. People's feedback about staff and the

service was very positive.

Staff treated people with respect, kindness and dignity at all times.

Staff interacted with people positively, with patience, understanding and respect. They showed kindness with people when they faced challenging situations

The service and the staff were very flexible and responded quickly to people's complex and changing needs or preferences.

People were consulted about and fully involved in their care and treatment. The service provided high standards for end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

Is the service responsive?

Good

The service is very responsive. People described the service as excellent and where nothing is too much trouble.

People told us staff were amazing and highly skilled. Staff fully understood and anticipated people's needs which enhanced the quality of their experience.

The service provided person-centred care which was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them.

People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life.

The service took a key role in the local community. People, their families and friends were actively encouraged, enabled and supported to engage with events outside of the service.

Is the service well-led?

Good

The service was consistently well-led.

There was open and positive culture that placed people and staff at the centre of the service.

The provider, registered manager and staff followed principles based on person-centred care which resulted in an approach which supported working in partnership with people.

Staff felt supported, valued and included in decisions about how the service was run.

There was a culture of continuous improvement.

The service worked in partnership with other organisations to ensure they provided a high quality service.

Duchess of Kent 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 carried out on 1 and 2 December 2015 and was unannounced. The inspection team consisted of two inspectors and two pharmacist inspectors.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. The registered manager had not received a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However, the registered manager had anticipated our request for information and had collected relevant information which we looked at during our inspection.

We looked at the premises. We looked at four sets of records that related to people's care and examined four people's medicines charts. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff management and three staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and the activities programme. We observed a staff handover meeting and the administration of medicines.

We spoke with five people who were in the Inpatients Unit and four of their relatives. We received feedback from another relative following our visit. Six nursing and care staff were spoken with together with three community staff. In addition, we spoke with three volunteers, the service social worker, the Service Improvement Manager. Kitchen staff and the Professional Development Lead. We also spoke with a Diversional Therapist who worked in the day hospice and the In Patient unit.
We spoke with the registered manager and the ward manager at length. We received written feedback from two visiting professionals and the local safeguarding team.

At our last inspection in February 2014 no concerns were found.

Good

Is the service safe?

Our findings

People told us that they felt safe in the hospice. One person said, "Very much safe, absolutely. I didn't really know what I was coming to but I felt safe straight away". Another person told us, "I could not be safer. It is a very safe place day time, night time. You need more of them". (hospices). Two other people said, "I'm very safe here", and "Oh, definitely, I feel safe". One of the volunteers told us they were confident people were safe and had never seen anything that concerned them. A visiting professional told us "I have no reason to believe that people are unsafe or not well treated". They also said "I have never seen anything that would cause me to question anything, or that I was uncomfortable with". Another visiting professional told us "I have only visited the hospice twice but on neither occasion did I see anything I was uncomfortable with".

People were protected from any form of abuse or breach of their human rights by staff who were fully aware of and able to clearly explain their responsibilities with regard to keeping people safe. All care and ancillary staff had received safeguarding training so they could recognise any signs of abuse or distress and take effective actions. They were able to tell us what they would do if they had any safeguarding concerns. This included reporting issues to the appropriate authorities outside of the organisation, if necessary. One staff member spoken with provided an example of what they had done when they suspected that abuse was occurring between a family member and a patient of the service. They had reported their concerns appropriately within and outside the service which had resulted in a positive outcome for the person concerned. The service had a whistleblowing policy that staff were aware of. Staff were confident that the ward and registered manager would take any necessary action to protect people. Risk assessments were reviewed every month by a member of senior staff. There had been two safeguarding incidents reported in 2015. Appropriate action had been taken and they had been reported to the local safeguarding team who told us that the service had responded to the concerns in a robust and suitable manner.

People, staff and visitors were protected from harm by health and safety systems. Regular checks and tests were completed to promote safety in the home, for example annual moving and handling equipment tests had been undertaken on 7 October 2015. Therefore, people were protected from risk caused by faulty equipment. All electrical portable appliances had been tested in September 2015. Some areas of the home, such as the laundry and clinical store room posed a potential risk to people as harmful chemicals were stored there. Those areas were protected with a keypad lock so that people were not exposed to danger. Up-to-date maintenance certificates such as gas safety electrical installations and portable electrical appliance testing were not readily available within the service. These were kept by the maintenance department of Berkshire Health Foundation Trust who provided repair and replacement of equipment under a service level agreement between the hospice and the health trust.

We were provided with records which indicated that fire fighting equipment and emergency lighting had been tested throughout 2015. In addition, weekly testing of the audible alarm was undertaken using a programme of activating the eleven call bells on rotation. However, evidence of servicing for the fire alarm system on a quarterly basis could not be provided for the period since early 2014 when a complete refurbishment of the building had been completed. We were told that Berkshire Health Foundation Trust held these records. There was no evidence of a fire drill having taken place from the records we saw since

the refurbishment of the building in February 2014. This could place people at risk in the event of a fire because staff may not know how to undertake an evacuation. Following the inspection we received information from the registered manager that a fire drill had been arranged for the week following the inspection visit. This would be unannounced for the majority of staff at the hospice and would not involve the evacuation of patients. There was a fire risk assessment dated 30 January 2015 in place for the building. We received information from the fire authority that the service was broadly compliant with fire regulations. The service had emergency plans and checklists in place to assist staff to deal with any unforeseen emergencies. There was evidence that these plans were reviewed and updated on a regular basis.

The service ensured they 'learned' lessons from any accidents and incidents that occurred. Accident and incident reports recorded, in detail, the accident or incident, described what action was taken and any further action or learning needed. Records that were kept included, number of falls and pressure ulcers whether acquired or inherited and were monitored for trends and trigger factors. If necessary, individual care plans were reviewed and amended. Body maps and post falls monitoring forms were in place to assist staff to identify any ongoing issues for people. People were protected from falls as high-low beds were in use and, if needed, mattresses were left on both sides of the bed to minimise the risk of possible injury. Sensor mats were placed on people's beds and chairs where appropriate. Staff were monitoring the safety of people using 'Safe and Seen' charts.

People's care was delivered as safely as possible. Any necessary risk assessments were incorporated into areas of the care plan which might pose a risk for the individual. They described the risks and instructed staff how to support people safely. Identified areas of risk depended on the individual and included areas such as health needs, bathing, nutrition and relationships. The service used recognised assessment tools for looking at areas such as nutrition and skin health.

There were processes in place to ensure that residents received their medicines as prescribed. We saw that medicines were given on time and that the medicine administration records (MAR) charts were completed to show what medicines people had received. Medicines were stored securely in locked rooms or locked cupboards and access to medicines was controlled appropriately. The medicines refrigerator was not managed in line with the organisation's policy. Temperatures were not recorded daily. We saw temperatures recorded outside of the recommended range (2 - 8°C). This was acted on straight away by the hospice.

Medicines that require additional controls because of their potential for abuse (controlled drugs) were managed and stored safely within the treatment room. Stock checks were completed once a day. There was a comprehensive controlled drug policy in place and the processes were audited.
Most patients had medicines prescribed to be used as required. We did not see protocols in place to support the nursing staff to know when to administer these medicines. The prescription included a note indicating what the medicine was for but we could not be sure that the processes ensured that people received the most appropriate combination of medicines as required. The registered manager undertook to review how they document the protocols for the administration of as required medicines.

Medicine incidents were reported and analysed. We were told about two examples where an incident report had resulted in a change in practice. This demonstrates that the hospice was willing to recognise when things went wrong and make changes to improve the safety of the residents.

Staff were suitable and safe to work with people because the service had a robust recruitment procedure. These procedures included requesting and validating references, criminal records checks, ensuring candidates had permission to work visas and checks on people's identity. Application forms were completed and included a full past employment history. An explanation for any 'gaps' in employment

history was noted on the file.

People's care was delivered safely by a suitable number of staff. In the case of shortages staff worked additional hours or bank staff were deployed who were familiar with the service. At the time of the visit there were four nurse vacancies. We were told that ongoing recruitment was in place. Work force reports were maintained which included the number of sick leave hours etc. We saw the last report dated September 2015. People told us there were always staff available to help them if they needed assistance. They said that call bells were answered very quickly. There was a minimum of two nursing staff and four health care assistants during the day. Two nursing staff and one health care assistant were available during the night. This was reviewed on a daily basis according to the needs of the people being cared for. We were told by the ward manager that a formal tool for scoring dependency levels was being investigated and considered to provide evidence and to support the number of staff on duty at any given time. The staff team were supported by a range of ancillary staff, senior managers and the registered manager. Rotas for the previous month showed that the staffing levels did not drop below those stated as minimum. The service had an on-call facility which provided telephone support and emergency staff cover, as necessary.

Good

Is the service effective?

Our findings

People told us they received excellent care from skilled staff. One person said, ''Staff are appropriately trained. There are always people ready to help you. They work in pairs so you have the feeling there are enough of them. It is really reassuring. You see doctors here every day. Most of the time there are two doctors in the room and they really took their time". Other people spoken with commented, "I would go to local authorities if I was neglected, but I've got no reason to do that at all. I ring the bell and they are here within minutes", and, "Staff are really wonderful. Nothing is too much for them. I think they are brilliant". One of the relatives said, "The staff to patient ratio is so high that everyone gets good care", and "You could not have better care than this". He added "The manager and health care assistants have 14 patients but they always have time for you". A health professional commented, ''I am usually able to speak to the person I need on the phone quickly even consultants. I am always phoned back when necessary".

Staff showed us a robust process for the supply of medicines on discharge from the hospice. Residents received a medicines aide memoire to help with taking medicines at home and a discharge letter was written by the doctor. The hospice had a process to enable self-administration of medicines. One person told us, "The changes in meds are always explained to me in the way I understand".

People's health and well-being needs were met by staff who helped them to stay as comfortable and free from pain as possible. Each person's healthcare needs were described in their care plans. We were told that the care plan layout and content had been reviewed to ensure that relevant and up to date information about individuals was readily available to staff. This record was supplemented by an electronic record which detailed daily progress and interventions, ward rounds by the hospice doctors and admission information. There was an approach to individual care that took account of the person as a whole, their family and friends and the aspirations they might have for their care and life goals. Staff told us that information about people's individual needs in respect of pain management was sufficient to enable them to provide the most appropriate care for each person.

People were supported by staff who understood consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). The registered manager told us that most people who were cared for in the service retained capacity. She had submitted one DoLS application to the local authority. People's capacity was reviewed on an individual patient need on admission and throughout people's stay. The care staff had received Mental capacity Act 2005 and DoLS training. Staff had a very good understanding of what a deprivation of liberty was, what constituted restraint and when a DoLS referral might be necessary. They recognised that people's capacity may vary depending on circumstances such as time, mood and well-being.

People were encouraged to make decisions and choices for themselves. People's consent to care was obtained and was noted in their care plan along with other relevant areas such as information sharing. Staff gave people time to make decisions for themselves and used the methods described in their care plans to support them to make choices.

People told us the hospice was always warm, clean and comfortable. One relative described the facilities as "very clean". A visiting relative told us "The hospice has always appeared clean and hygienic". The service had undertaken extensive refurbishment of the building which was completed in early 2014. The facilities provided were spacious and included a range of communal and meeting rooms. People had individual rooms with en suite washing and toileting facilities. Each room had direct access to the courtyard garden. The garden was well maintained and recently had raised beds for use by wheel chair users installed by volunteers. Specialist bathing and mobility equipment was provided as necessary.

People told us that the food was, ''good''. The menus were well balanced and varied. Relatives told us the service provided food in the way their family members preferred. One person said, "It is nice to know the pattern of mealtimes. It is also easy for my husband to order food. It is nice to have that choice of food". Food was provided for both the inpatient unit and the day service. Individual preferences, special diets and any allergies were catered for by a system which involved care staff alerting the kitchen staff each evening in preparation for the following day. However, the system was sufficiently flexible to meet the needs of newly admitted patients. There was a three week rolling menu which was not revised often due to the seven day average stay for each patient. The kitchen facilities were seen. We saw that kitchen staff had received healthier food training which included regular updates. Various checks were undertaken such as fridge and freezer temperatures, cleaning schedules and delivery temperature checks and records were seen to confirm this. Records to demonstrate that food temperature probes had been appropriately calibrated could not be provided on the day of the visit. We were told that the current menu had been reviewed by a dietician. We saw a certificate issued by the local Environmental Health Department which had awarded a five star (maximum) rating for the safe handling of food which was dated 16 June 2014.

The registered manager told us that the provision of meals was an area under review and development. The current arrangements included a 'chill and heat' system of providing food which was sourced from an external contractor. It was felt that this arrangement did not provide sufficient choice or flexibility. There had been some changes to the current arrangements such as providing freshly made cakes for the various groups that the service hosted for families, carers and interested parties. It was planned that the provision of only freshly prepared meals was implemented over a determined period of time. Nutritional assessments, weight, food and fluid charts were completed for individuals, if necessary.

The service employed a range of healthcare professionals including a team of doctors who worked across all services and visited people in the in-patient unit, the hospice day service, at home, in out-patient clinics or in two district hospitals. There were weekly ward rounds which included people and weekly multi-disciplinary meetings where psychological needs and discharge planning was discussed. One of the doctors was always on call at weekends and overnight for advice with a consultant in palliative medicine consistently available for further advice if needed. There were community nurses who visited people in their homes and provided a service to the in-patient beds which were located in two local district hospitals. There was a lymphedema team, therapists, psychologists, a social worker and family and spiritual support staff. A fund raising office was on site which was staffed by a dedicated team of fund raisers. In addition, the service enjoyed the service of a team of volunteers who provided a range of support to people and their families. The volunteers where supported by a dedicated volunteer co-ordinator who met with them individually on a regular basis. All new volunteers where provided with an orientation programme and mandatory training.

People were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and to the care of individuals. The staff told us that they received all the training that was required to work effectively and to provide the best quality of care. Staff told us there were enough staff to care in the way people needed and at times they preferred. We observed staff were available to help people at various times depending on their needs and wishes.

Training was delivered by a variety of methods which included e– learning, classroom based and external trainers. We were provided with a training matrix which covered staff employed throughout the three sites and the community which totalled approximately 137 in number. A wide range of training was on offer from mandatory training for all staff such as fire safety awareness, equality and diversity and moving and handling of inanimate objects. There was specific clinical practice training such as medication, resuscitation and pressure ulcer training for relevant clinical staff. Other training provided included post incident management, lone working, therapeutic interventions and supervision and appraisal which were undertaken by relevant staff according to their role and responsibilities. We spoke with the Practice Development Lead who had responsibility to ensure that all professionally qualified staff had access to appropriate training and development. A list of all nursing staff registered with the National Midwifery Council was maintained, updated and monitored.

Senior members of staff told us that new members of staff shadowed them for two weeks as a routine. That period of time could be extended if a new staff member was not sufficiently confident in their role. Staff told us they used formal channels of communication, for example a communication book and handovers, but also spoke face to face in order to ensure that information was passed effectively between shifts. We observed a staff handover which involved relevant updates on each persons needs which were detailed. The incoming staff had ample opportunity to ask questions and to seek clarification about tasks that needed to be undertaken. This system ensured that the continuity of care was maximized for individuals. The volunteers told us the communication between them and staff was satisfactory and that they were always aware of what was happening on the previous and current shifts.

All members of staff were supported through regular supervision meetings at least four times a year with their line manager. This had been more robustly implemented recently and consideration was being given to include set topics and areas for discussion. Three members of staff spoke highly of the opportunities they were provided with and found the one to one meetings and appraisals useful. They enabled them to identify their training needs and to contribute to the improvement of the service. Staff felt supported to meet the needs of people and offer what they described as, ''excellent care''. We were told that most staff had completed an appraisal this year. There were regular recorded team meetings for qualified and unqualified staff on the inpatient unit. Records to support this were seen. The ward manager told us that the separate meetings were being reviewed and it was likely that they would be arranged together in order to support collaborative working.

Good

Is the service caring?

Our findings

We received numerous positive views about the care the service provides. People described staff as, "excellent". One person said, ''The carers are very good, marvellous. You couldn't wish for anything better' and "They even bring me to the meetings with the consultant and relatives. They always ask me about my opinion". Another person told us, "I'm treated with dignity and respect". Relatives we spoke with told us, "The service is excellent, very good, very attentive, very clean. Could not be any better". And another said "With Duchess of Kent you can put brilliant again, again and again". Other comments from relatives included, "I think that the service here and kindness of staff are fantastic. Nothing is too much for anybody' and, 'The care, the treatment, the dignity from volunteers and everyone including the cleaners is brilliant". Another relative contacted us after the visit and said, "My father received the most wonderful care and attention at Duchess Of Kent".

Staff were proud of the care provided. Quotations from staff included, "Everyone who works here has got a drive and passion to provide the best quality of care", and, "I think it's probably the best place people would end their life". Volunteers told us, "I enjoy being with the patients. I feel privileged being with them", and, "People are treated with dignity and respect you can really feel it". A visiting professional told us, "Patients and their families give positive feedback for the care they receive at the Duchess of Kent hospice. I have never had a negative comment".

People were supported by a kind, caring and committed staff team. There was a warm and homely feel to the service in the in-patient unit and the hospice day service. There was a social atmosphere where people were encouraged to chat if they wished and were listened to. Staff were calm, smiling and engaging. They were observed listening to people and responding to them in an attentive manner. Their approach was kind, patient and respectful. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully. Physical touch was used appropriately to give people comfort.

Staff had developed very positive working relationships with people. They were knowledgeable about people's needs and were able to clearly describe how to support people with their varying needs. All staff knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal needs. Additionally, they described how they made sure that people were supported by the staff member they were most comfortable with, particularly for intimate tasks, wherever possible. People were assisted with their personal care needs in a way that respected their dignity. These included closing doors and asking people about their personal needs discreetly. All staff had received dignity in care training.

People were given choices and supported to make as many decisions as they were comfortable with. These included choosing meals, activities and where they wanted to spend their time. Staff described what they were doing and why and people were asked for their permission before care staff undertook any care or other activities. Staff encouraged people to keep their independence and control as many areas of their life as possible, for as long as they were able. Care plans described how staff should encourage and support

people to do as much for themselves as they could. People told us that staff helped them to do as much as they could for themselves. People's emotional, cultural, life choices and spiritual needs were noted in their care plans. Staff received equality and human rights training. People's end of life wishes were recorded and clear detailed plans for end of life care were in place. Do not attempt resuscitation (DNAR) forms were in place where appropriate and when people chose to have them.

Each person's wishes were at the centre of the service. People were supported at the end of their life to have a comfortable, dignified and pain-free death. A relative told us, "I never knew that places like this exist and that this level of care was available for people who are dying". Many compliments seen described the care people and their relatives had received at a time of great sadness and distress. At the staff handover we observed that the discussion of individual's changing needs included recognition of the emotional states of people and their relatives. Ways to assist people in the most appropriate way for them as individuals was well understood by the staff team. As staff demonstrated great understanding and empathy, people could be confident that their individual needs were met and responded to in a sensitive manner.

People were supported to maintain relationships with people who were important to them. People told us that their friends and relatives visited regularly and were welcomed to the hospice. There were no restrictions on times or lengths of visits. A relative told us they visited whenever they wanted and at whatever time they wanted. They told us they were, ''always made welcome and looked after''. There was regular weekly carers group which was led by a volunteer and was described as working very well.

Attention was paid to people's spiritual needs and chaplaincy support was available to people 'of all faith and no faith', which meant it was accessible to all. There was a quiet sanctuary room where people could go to be alone or to be with others in order to meet their spiritual needs. Names of the deceased were written in a memory book and their relatives were free to come on the anniversary of their death to pray and remember their loved ones.

The service provided emotional support for families that was continual and beyond the provision of care for people. The Duchess of Kent Family Support service was available to families at all times. Between five and six weeks following the death of their relative, each family received a letter about the bereavement service and what it could provide. They were asked what kind of support, if any, they might find helpful. The level of support was flexible according to individual needs. The bereavement service organised 'Family and Friends Sundays' on a quarterly basis where people who had lost their relatives could express and talk about their experience. This helped support relatives who wished to remember their loved ones and find comfort in the company of others. The service provided a space specifically designed for families where they could meet with their relatives in private. The area was equipped with a TV, puzzle boxes and toys for children.

Good

Is the service responsive?

Our findings

There was an extensive collection of feedback from people and relatives who expressed how responsive the staff had been to people's needs. People told us that the way staff responded to their needs was, "Brilliant", and "Nothing is too much trouble". People told us that staff were always available, without question if they needed anything. There was a pro-active approach to meeting peoples needs where staff were constantly checking to see how people were. During the visit staff were observed anticipating and responding to people's requests and needs quickly and positively. One person told us that, ''staff are very responsive and attentive''. Staff, whatever their role, worked with each other as a team to minimise the time people had to wait for requests for attention or assistance to be met.

The admission procedure to the in-patient unit ensured that people received a management plan in relation to their symptoms, emotional and spiritual support, pain relief and specialist care. Initial assessments had been undertaken to identify people's support needs and care plans had been developed outlining how these needs were to be met. People's wishes were at the centre of their care planning. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. For example, they knew when a person preferred a late breakfast, a shower in the morning rather than the evening, or if they preferred to take a nap on top of their bed at certain times of the day.

The provider delivered considerate and person-centred care and support that had a positive effect on people. Staff were able to demonstrate their understanding of how to give people personalised care. People had detailed individualised care plans which described their needs, personal histories, preferences and choices. The care given to people followed the care described in their care plan. However, people told us the staff were very flexible and always listened to them if they wanted things changed or done a different way. The constantly changing needs of people were assessed on a daily basis or more frequently in order to address them appropriately.
People were provided with information about the service and what they could expect. There were a range of information leaflets available and we were told and shown folders that would contain all relevant information for people which were planned to be available in every room within two weeks.

People told us they were fully involved in planning and reviewing their care needs. People's care and support was planned in partnership with them. As people and staff worked as a team to ensure each support plan was unique and responded to specific needs, people felt valued and understood. Regular service user groups were held every six weeks.

People's care plans included strategies with regard to their pain and symptom management which were updated on a continual basis. For example, during ward rounds, doctors updated the care plans on a laptop computer to ensure nothing was missed. The updates included changes in people's health and how to respond when people experienced changes in their symptoms or pain levels. Discussions with people about their wishes and their consent about any changes in their treatment were recorded. This meant that when people's pain increased they could be confident that responsive action of their choice was taken by staff.

We were told that when a person was anxious because they were too unwell to participate in a family celebration or special event, staff provided them with options they might not have considered, such as bringing forward the event and holding it on the hospice premises. An example was provided for the celebration of Christmas Day which could involve the kitchen staff in providing an appropriate meal. Other examples involved the Diversional Therapist who could assist people with making quality momento's such as cards to commemorate family celebrations which could be treasured by relatives. Because staff demonstrated a sensitive and insightful approach to people's involvement that was practical and considerate of people's needs, they were able to gain an enhanced sense of psychological and emotional comfort.

People, relatives and staff were encouraged to comment on the way care was being provided. There was a robust complaints procedure in place. Staff, people and their relatives told us they would be comfortable to complain and would do so if necessary. One of the relatives explained, "Anything reported is immediately dealt with. That is the thing: they listen and provide re-assurance. The place is very well managed and you can't think about any improvements".

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

The arrangements for social activities were varied and met people's individual needs. A broad range of daily activities was available in the hospice day service. There was a Diversional Therapist who was assisted by volunteers. The programme of activities included art and crafts, quizzes, games, clay modelling and outings. People were consulted about what they enjoyed doing and were involved in the planning of the activities programme. People's interests and past and present hobbies were recorded in care plans. People staying in the In Patient unit were supported and encouraged to attend the day service activities where appropriate. Individual time and activities were also available to people in the In Patient unit in their own rooms according their choice and preferences. When people did not wish to join activities and they preferred to read, watch television or listen to music, this was respected. Following a request from one person who wished to help in the garden despite their limited mobility, the provider had arranged for the building of raised vegetable/flower beds to make gardening accessible to everyone. This work had been undertaken by a team of volunteers who had been work colleagues of a person cared for by the service. In addition, when people who were bedbound expressed their desire to spend some time in the garden, they were helped to be transferred to the garden in their beds.

We were told that transition between services and the community were undertaken in close communication and collaboration with other professionals involved with people's care. One visiting professional told us, "The hospice staff work collaboratively and have the best interests of all their patients at the heart of all they do. They are always ready to discuss patients' needs with us, and my experience is that they act appropriately". A relative told us of their experience, "Communication between here and the hospital is brilliant. I was apprehensive about how it might work, but it works really well".

Good

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. People and their relatives told us, "I think the way they run this hospice is so well organised. I just think it's fantastic what they do here. I would recommend it with the highest of praise", and, "The place seems to be well managed". Staff and volunteers told us that the registered manager was very approachable and would listen to their concerns and act upon them if needed. One volunteer told us, "The place is first class managed. The ward manager is absolutely genius". Another said, "The place is well managed". All staff spoken with including community nurses, specialist teams, care staff and nurses said they were well supported and managed by all members of the management team. They all said they had confidence in the way the service was managed. Staff praised the provider and the leadership team for their approach and consistent, effective support. All of the staff we spoke with told us that they felt valued working in the service, and felt motivated to maintain high standards of care.

The registered manager was registered in October 2014. They had particular experience and expertise in leadership, nursing and palliative care. In consultation with the provider, they had recently reviewed the service's registration with the CQC to ensure that it was accurate and up to date. The registered manager was responsible for the operational management of the inpatient unit, the day hospice and specialist community teams covering the area of West Berkshire. The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. The registered manager told us that a recent initiative involved her trying to spend a morning every two weeks on the ward in uniform. These informal visits were not pre-arranged and she just turned up and spent time with staff and people. They were designed to give her valuable insight into the running of the ward and any challenges faced by staff on a daily basis.

People, staff and other interested parties were listened to by the management team of the service. In September a programme of 'Real Time Feedback' was introduced. This involved a volunteer speaking to people and seeking their views using an electronic survey. The reports were immediately available and allowed the service to respond to issues without delay. The most recent feedback seen, which was included in the service newsletter provided an example of the replacement of a television which had been described as unsatisfactory. The electronic survey also included questions designed to answer the 'friends and family' test. That is whether you would wish your friends or family to receive care from the service.

The service conducted more formal 'patient surveys'. These included both people and their relatives. The survey results for the period April 2015 to September 2015 were seen where ten people and twenty seven relatives had provided feedback. Comments included, "Food was excellent" and, "Staff and volunteers have always done everything to make mum and the family feel welcome and comfortable".

The service maintained a (feedback) comments book which people and their relatives could use at any time. We saw entries which included, "We appreciate your kindness more than you could know", and "Everyone has made me feel so wecome, safe and comfortable". Quality assurance surveys were sent to people and their families regularly. The recent post of a Service Improvement Manager had been implemented. This

position was designed to enhance the experience of people using the service and their representatives. The post holder had commenced employment on 1st October and was already involved with a number of projects including revising the way that feedback from people was obtained, followed up and used to improve the service. Some projects already underway included improvement of the catering arrangements, the installation of a food vending machine for people and their visitors and linking fund raising activities more closely with user groups. A folder had been created for staff reference where all local learning from incidents and investigations were recorded.

Staff meetings in relation to the inpatient service were held approximately monthly and currently were held separately for professionally trained staff and care staff. This system was under review as it was felt that whole staff meetings would reduce divisions and maximise the engagement of all staff. Their content included training, reflective practice and discussions about new procedures. Staff told us they could discuss any issues during staff meetings and, ''have no need to hold back anything''. The provider organisation was rolling out a programme of performance management training which was starting with line managers. In parallel with this intiative the Sue Ryder organisation had provided guidance on expected standards, values and behaviours. It was planned that this programme would be embedded through the performance management training which would increase consistency of approach and formalise expectations for all staff.

The service's reviewing and monitoring systems ensured the quality of care they offered people was maintained and improved. The ward manager and more recently the registered manager regularly worked in the service alongside nursing and care staff. They monitored staff attitudes and values whilst working with them to ensure they were offering care to the expected standard. In addition, any challenges staff faced were noted and reviewed. There was a nationally determined quality monitoring programme in place which directed review of a range of determined areas on a rolling programme across all services throughout the country. Areas included medicine management, catheter care, falls risk management and safety engineered equipment. Audits and checks were completed locally at determined intervals on all aspects of the care being provided. Examples included a range of medicines audits, documentation, hand washing, beds and recruitment. Other audits seen covered Mental Capacity Act, slings, falls and hoist inspection dates. There were quality visits to the service undertaken by Sue Ryder staff arranged on a quarterly basis. The most recent visit was undertaken a week before the inspection visit but the report of the findings was not yet available. However, the report was sent to CQC within 48 hours of the inspection visit.

A risk register of issues was maintained where control measures and remedial actions were monitored on a monthly basis. Areas covered included, infection control, call bells, roof leaks and inadequately fixed hand rails. Remedial actions were recorded such as hand rails replacement programme and security doors to address risks posed to people who tended to wander. The risk register fed into a regular quality monitoring group where a wide range of issues was discussed. This was attended by representatives of all areas of the service including a member of the user group.

People, staff and visitors were aware of the accountabilities and responsibilities of the management team. The registered manager was given the authority to make decisions to ensure the safety and comfort of the people who stayed in the hospice and attended the day services. These included emergency maintenance and repair issues and ensuring staffing levels could meet people's immediate needs, safely. The service made sure there was a senior or experienced staff member on-call at all times.

We were told that the hospice and community staff related well to other services and health care professionals. We received feedback from outside professionals that the hospice worked co-operatively with them in the interests of people receiving care. One professional told us, "The hospice communicate well with the Community Nursing Service. We are generally able to seek advice on behalf of our patients".

Another told us, "The hospice staff work collaboratively and have the best interests of all their patients at the heart of all they do".

Records relating to people who stayed in the service were of a good quality and content. They were accurate and detailed. All records were kept securely and confidentially. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely. Care plans gave staff clear directions about how to meet people's needs safely and in the way they preferred. Records relating to other aspects of the running of the service were mostly well kept and up-to-date. It was noted that some staff signing sheets within care plans were not fully completed. The registered manager undertook to raise this at heads of clinical services quarterly meeting to review the system to ascertain its worth and update accordingly. Because the hospice had a service level agreement for general maintenance with the local health trust some records were not readily available in the service which related to fire equipment maintenance and checks. The registered manager undertook to review the arrangements for records retention and information provided following the inspection visit confirmed that most of these records were now available within the hospice.