Thames Hospice

Thames Hospice - Windsor

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 February 2016 and was unannounced.

We had last inspected this service in July 2013. That inspection had found the service had been meeting all the legal requirements in force at the time.

Thames Hospice - Windsor is a 17 bed inpatient unit delivering end-of- life care as well as assessment, care and treatment to people with life-limiting illnesses. People receive care and treatment at Thames Hospice when their condition is too severe for outpatient treatment and the symptoms cannot be relieved if they stay in their homes. People are also provided with care on a respite basis. At the time of our inspection 15 people were using the hospice service.

The registered manager has been in post as Director of Patient and Family Services for 10 months and has been the Registered Manager from 9 December 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were safely stored. However, we were not assured that medicines were always stored within their recommended temperature ranges, or appropriately ordered. We did not see that people had experienced any negative outcomes as a result of these shortfalls.

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

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

There was a robust recruitment process and staff had undergone induction when they commenced their employment. Checks were carried out on all staff at the service to ensure that they were fit and suitable for their role. These included interviewing applicants and undertaking criminal record/barring checks and character references. Staff told us that they received support and supervision from their line managers. They understood their roles and responsibilities, as well as the guiding values of the hospice.

People said that there were sufficient staff available to promptly attend to their needs. Staff displayed patience in their interactions with people and relatives. They did not rush people and were ready to give

support to them and their family members. Staffing levels were flexible and suited people's individual needs.

Staff had been given training in safe working practices. They were provided with any personal protective equipment such as disposable gloves and aprons that were needed to keep them safe while handling potentially harmful substances but also to stop germs being passed on . Effective systems were in place to monitor and prevent cross infection at the service.

The hospice provided a relaxing, comfortable, clean and attractive environment. There was a quiet reflective area in the sanctuary and well-maintained gardens where people could spend their time.

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

The staff and volunteers were trained to provide the specialist care people required. A holistic approach to care was promoted within the service. It assumed that staff should look after each individual and their family rather than simply attempt to treat the person's medical condition. People's health and well-being were closely monitored so that they could receive the right care at the right time.

Staff were aware of people's individual needs and the support they and their family members required. We saw that people were provided with care by staff who were kind and compassionate. People and their families spoke very highly about the service.

People were supported to express their views, expectations and wishes regarding all aspects of their care. Each individual had a plan of care which covered their support needs and personal preferences. We saw the care plans were evaluated on a daily basis. This meant staff were provided with up- to-date relevant information. People were supported to take part in therapies and treatments to help them maintain their physical and emotional well-being.

We saw evidence that the delivery of the end-of-life care involved promoting sensitivity, dignity and respect. People's wishes and expectations were taken into account, noted and acted upon.

Thames Hospice - Windsor had established positive contacts with other professionals who ensured effective delivery of specific care to people whenever they needed and wanted it. The service was responsive to people's needs and continually looked for ways to improve. Feedback was used in a constructive way to enhance the quality of the service.

There was a strong management team who listened to and supported staff and volunteers working for the service. There was a clear clinical governance structure in place that involved staff at all levels to establish and maintain the best possible care for people.

There was an open culture and people were kept informed of changes that might affect the service. Staff and managers gave people opportunities to express their views and concerns and provided support to reduce people's anxiety.

The registered manager used the findings from the quality audits to take action to improve the service. The

management team adopted a variety of methods to assess and monitor the quality of the service. These included satisfaction surveys and care reviews.

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.

Risks to people were assessed and appropriate steps taken to minimise any possible harm to people without restricting their independence.

There was a sufficient number of staff on duty to meet people's assessed needs. Staff members were recruited in a way to insure people's safety. All checks were carried out prior to prospective staff starting work. Staff knew how to protect people from the risk of harm and abuse.

Medicines were safely stored. However, we were not assured that medicines were always stored within their recommended temperature ranges, or orders for controlled drugs were compliant with the legislation. Nonetheless, we did not see that people had experienced any negative outcomes as a result of these shortfalls.

Is the service effective?

Good

The service was effective.

Staff of all levels had access to ongoing training to meet the diverse individual needs of people they supported. Staff members were suitably trained to provide the specialist care people required.

Staff encouraged and supported people to eat and drink sufficient amounts of appropriate food and fluids. Professional advice was sought if people experienced any problems with eating and drinking.

The hospice environment was suited to the individual needs of people using the service.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

People and their relatives told us that staff treated them with exceptional kindness, care, dignity and respect at all times.

People were involved in the process of planning their end-of-life care, and their wishes and expectations were recorded and acted upon.

Positive, caring relationships had been developed between people who received care and staff. Staff interacted with people positively, with patience, understanding and respect. They always showed kindness to people when facing challenging situations.

Is the service responsive?

Good

The service was responsive.

People and their family members were involved in making decisions about their care and support.

People said staff always responded to their suggestions and concerns.

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

The service used a range of tools to obtain feedback from people using the service, relatives and professionals. Such information was acted upon to ensure the care was person-centred and in response to people's needs.

Is the service well-led?

Good

The service was well-led.

There was an experienced registered manager in post who was considered approachable by people. The manager was aware of each individual's care needs and preferences and shared this knowledge with staff.

Staff and volunteers were motivated, valued and supported by their colleagues and management.

There was a quality monitoring system in place which ensured care was delivered in a structured way. The system involved questionnaires, audits and analysis of incidents.

Thames Hospice - Windsor

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 was 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.

We inspected Thames Hospice – Windsor on 9 and 10February 2016. The inspection was unannounced which meant that staff and the provider had not been informed about our visit.

The inspection team consisted of five members: two adult social care inspectors, a pharmacist inspector, an expert-by-experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is someone who has up-to-date knowledge and experience of working in a specific field. The specialist advisor who participated in this inspection had extensive knowledge and experience in palliative care. Palliative care is a holistic, multi-disciplinary approach to providing patients with relief from the symptoms of a life-limiting illness such as pain and stress.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales. The PIR was used as a prompt to follow-up a specific areas on inspection, and support our findings.

During the inspection we observed how staff interacted with people using the service. We spoke with four people who were provided with care and support by the service. We interviewed the chief executive officer, the registered manager, the human resources officer, the clinical educator, and the pharmacist. We spoke with inpatient staff, including five nurses, six health care assistants and one volunteer.

Good

Is the service safe?

Our findings

During our inspection we observed positive and considerate interactions between staff and people. Reception staff and other staff members remembered to ask each person arriving at the hospice to identify themselves and sign a book to note who they had come to see. This ensured the safety of people who were at the hospice.

Each person visiting the service was shown the way or accompanied by staff to ensure they arrived safely at the place of their destination. Key locks were used to access all doors to patient areas. This prevented any unauthorised access and therefore helped to maintain the safety of people and staff.

No safeguarding alerts had been raised by the service since the last inspection. We saw procedures were in place for dealing with allegations of abuse. We noted staff had a good understanding of what types of concerns they should report and how they should report them. Staff members said they would not hesitate to report any concerns they might have about care practices. Training records confirmed all staff had received recent training on safeguarding vulnerable adults. This meant staff had the necessary knowledge and information to ensure people were protected from harm and abuse.

People's records included risk assessments which were personalised, reviewed regularly and adjusted to any changes in people's condition or risk. The assessments related to skin integrity, moving and handling equipment, and environmental risks. Each person and, when appropriate, their families and carers, were consulted about their care. This contributed to promoting people's independence, choice and rights. Staff were knowledgeable about the care needs of people cared for at Thames Hospice - Windsor, including associated risks and, if needed, any additional support people might require.

Staff were suitable and safe to work with people as the service had robust recruitment procedures in place. These procedures included criminal record checks and checks on people's identity. References were requested and validated. The service also insured candidates had visas and permission to work in the United Kingdom when these were required. Application forms included full employment history of each prospective staff member. An explanation for any 'gaps' in employment history was noted in relevant files. Line managers were involved in the process of short listing and interviewing candidates. Every newly employed staff member was supplied with a specific handbook providing guidance on their role. A range of checklists together with interview records were used to ensure that all the required information was obtained. A record of nurses' registration was checked, maintained and monitored. There was a robust disciplinary policy and procedure in place, and there was evidence that these had been used appropriately.

A large number of volunteers supported the service in various areas, performing reception duties, working in the shop and fund-raising. The recruitment of volunteers was undertaken separately and included a comprehensive interview processes together with criminal record/barring and vetting checks.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room only accessed by authorised staff. Medicines that required additional controls because of their potential for

abuse (controlled drugs) were stored securely. Medicines refrigerator temperature records provided assurance that medicines requiring refrigeration remained within the recommended temperature range. However, staff told us that the treatment room got "hot" and similar records for that room were not kept. Therefore the service could not provide assurance that these medicines were stored within their recommended temperature ranges and maintain their effectiveness. The registered manager took immediate action. An air conditioning system was installed in the room to ensure the recommended temperature was not exceeded.

Medicines including oxygen required in an emergency were available. Records indicated regular checks had been undertaken in accordance with the service protocols. A particular kind of medicine that may be required in an emergency to reverse the effects of sedatives was not available. It meant that it was not possible to reverse the effects of sedatives when needed and people's health could be compromised. Staff and management told us that they had agreed to keep this medicine. However, they were finalising the policy and educating staff to be competent in the use and administration of the medicine.

Controlled drugs were administered from stock rather than obtaining them on an individual prescription. The service's requisition book did not fully satisfy the requirement of the Misuse of Drugs Regulations 2001 with regards to the information required when ordering controlled drugs. Although we identified these shortfalls, there had been no adverse impact on people using the service. The registered manager took immediate action to address the issues relating to the management of medicines.

All the people we spoke with told us they received their medicines regularly and they were observed whilst taking them. People told us they were involved in making decisions about their medicines and about pain control. There were specialised guidelines in place regarding the administration of medicines. Staff competencies were assessed on an annual basis. We found that medicines were given on time and the medicine administration records (MAR) charts were completed to show what medicines people had received.

All accidents and 'near-misses' were recorded in an accidents and incidents folder. The folder detailed all the investigations carried out, their outcomes and lessons learnt. For example, a trend for an increased number of falls on Friday nights had been identified. Therefore, extra staff had been allocated to work on Friday nights to reduce the potential risk of falls. A quarterly report regarding adverse incidents was made to the Governance and Health and Safety Committee after being analysed by the Incident Review Panel.

We looked at how the service was being staffed. We did this to make sure there was a sufficient number of staff on duty at all times to support people using the service. There was a range of staff employed by the service, including doctors, nurses, physiotherapists, an occupational therapist, maintenance personnel, catering staff, domestic workers and volunteers. In addition, a family support team consisting of social workers and bereavement counsellors was also available. As the registered manager and staff told us, effective systems were in place to ensure sufficient numbers of staff with relevant skills were deployed to keep people safe.

At the time of the visit there were two qualified nurses and three health care assistant vacancies. We were told that ongoing recruitment was in place. Sickness absence was recorded and we were told that overall this was low in number. There was a minimum of seven staff members in the mornings and five staff in the afternoons. Of these, there were at least two qualified nurses on duty during the day. Two nursing staff members and two health care assistants were available during the night. This was reviewed on a daily basis according to the needs of the people being cared for. Staff told us that when additional staff were needed to meet the needs of people, the service was very responsive in arranging additional cover using bank staff.

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 people's needs and wishes. The staff team were supported by a range of additional staff, senior managers and the registered manager. Rotas for the previous month showed that the staffing levels had not dropped below those stated by the provider as a minimum.

The service had a bank of staff to use for short notice absences and to cover holidays. We saw there were on-call arrangements for senior nursing staff, medical staff and directors for evenings and nights. There were facilities for on-call medical staff to sleep overnight on the premises, if required for the close monitoring of specific medical situations.

The service took action to reduce potential risks relating to Legionella. All taps and showers were regularly flushed including those that were not in regular use to ensure that water was flowing through the system. Staff also ensured correct water temperatures were maintained to avoid systemic contamination of the system.

We found the environment safe and secure. Organisational risk assessments had been completed for various scenarios, for example, fire, flood and the engagement of agency and/or temporary staff. Disaster recovery plans were in place for failure of such utilities as gas and electricity. Moving and handling equipment, namely the lifts, hoists and bath hoists used within the service, were well maintained in line with the manufacturer's instructions. Recorded checks were made on bedrails, nurse calls systems, fire safety equipment and hot water outlets to make sure these were in working order and safe to use.

An infection control policy was in place. Entries seen were up to date with evidence of regular review. An Infection control lead was identified and seen to be an active part of the audit team. Follow-up actions were clearly identified and acted on when necessary. The laundry area was clean and well organised. A colour coding system for the safe handling of soiled and fouled linen was in place in order to prevent the spread of an infection. The staff were aware of the policies and protocols in place and were able to describe how they adhered to them. We observed staff follow the policies and protocols in practice; for example, they used disposable gloves and aprons or colour-coded mops.

Good

Is the service effective?

Our findings

People told us the staff had the skills to provide them with the support that they needed and expected. One person remarked, "The staff are really wonderful. They know what they are doing."

People were cared for by staff who were appropriately trained to meet their needs. All new staff were subject to a training needs analysis which identified any gaps in their training at the commencement of their employment. Staff were trained in the areas relevant to their role and in the care of individuals. Staff told us that they received all the training that was required to work effectively and to provide the best quality of care. We spoke with the Clinical Educator who provided a range of material which demonstrated the training and support that was provided to all levels of staff. An annual education and training programme was developed in order to provide a comprehensive overview of all the training the organisation provided to staff at all levels. The Registered Nurses had received degree level education in the form of end-of life care modules or post graduate certificates in palliative care for the Senior Nurses. This was made possible through working with Health Education England and Oxford Brookes University to fund and provide these courses.

Training was delivered by a variety of methods which included e-learning, classroom based activities and input from external trainers and was based on current best practice. The Care Certificate had been introduced in April 2015 and some staff were undertaking modules leading to the certificate. The Care Certificate is a set of 15 standards that new health and social care workers need to complete during their induction period. We were provided with a mandatory training matrix which covered all staff employed throughout the two sites and the community teams. A wide range of training was on offer for all staff including volunteers, such as fire safety awareness, equality and diversity, moving and handling, and infection control. There was specific clinical practice training available in medicines, resuscitation, symptom control and pressure ulcers for relevant clinical staff. In addition, all qualified nurses had received verification of expected death training.

Other training provided included safeguarding of vulnerable adults, documentation, record keeping, management of medicines and mental capacity. People were supported by staff who had been appropriately trained. Training was up-to-date and staff had received further training specific to the needs of people they supported, for example diabetes or dementia.

Collaboration had been undertaken with one of the local universities which specialised in health, social and community care training courses. A four-day specialist training programme concerning end-of-life care had been developed for all the health care assistants at the hospice. At the request of other services in the local area, training had been held for staff working for care homes and domiciliary care agencies. The training had proved to be particularly successful and had been very well received. There was also a programme providing syringe driver training for care home staff and, in addition, study days were arranged. The study days covered such topics as tissue viability and professional practice for patients safety.

All staff received induction into the area of the service within which they were employed to work. Staff told

us that they felt well supported and could always ask their colleagues or senior staff for guidance and advice.

We observed a staff handover which involved relevant updates on each person's needs which were explicit and detailed. The newly employed staff had opportunities to ask questions and to seek clarification about their tasks to perform. This system ensured that the continuity and integrity of care for people were maintained.

All members of staff were supported through regular supervision meetings with their line manager. The system for staff nurses and health care assistants was less formal, with meetings that were called 'catch up' sessions with their line manager. The staff told us they found it to be important for building emotional resilience as caring for people in the last stages of their lives could be rewarding but stressful. It meant that people received professional care from staff who were emotionally prepared and motivated to deliver the best quality service possible. More robust supervision arrangements were being planned for these staff groups. The service was actively recruiting a senior qualified nurse to drive improvements which would involve formal recorded quarterly meetings for all staff of the inpatient unit.

Staff spoke highly of the opportunities they were provided with and found the catch-up meetings and appraisals useful. Both the meetings and the appraisals 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 provide high-quality care. They were always able to contact their more experienced colleagues and managers if they had any concerns or doubts regarding the care and support delivery. All staff completed annual appraisals. Annual appraisals for qualified nurses were timed to coincide with the revalidation of their Nursing and Midwifery Council registration. There were regular recorded team meetings for various groups of staff including the inpatient unit, community team, heads of service and volunteers. Each group of staff could share their experience and provide support to other members of staff so that the needs of people could be met more and more effectively.

Additionally, the hospice organised Schwartz Rounds for their staff members. Schwartz Rounds are an evidence-based forum for hospice staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which they feel comfortable sharing their stories and offering support to one another. Staff told us that Schwartz Rounds helped them to reduce the level of stress. It also gave them the sense of being supported as they knew they could rely on their colleagues for help and advice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff had received training in the MCA and Deprivation of Liberty Safeguards (DoLS). Staff members had a thorough knowledge of their roles and responsibilities in relation to this legislation. They were motivated and encouraged to make sure that people's individual decisions were listened to and followed in all aspects of care delivery. We observed staff ask for patients' permission before giving any care. If there was any doubt about people being unable to make complex decisions, staff were aware of the correct procedures to follow. In such events, arrangements were made for people and their next of kin or representatives to meet with

relevant staff and social workers. Then a decision on people's behalf and in their best interests was made. Staff were aware that there were times when people might be temporarily unable to make complex decisions, such as after receiving pain-relieving medicine. Staff were therefore careful to discuss issues with patients at times when they could fully enter into discussions, if possible. At the time of our inspection there were no applications in place to deprive people of their liberty.

People's care records contained do-not-attempt-resuscitation (DNAR) forms where appropriate. These had been signed by people who had been assessed as having the capacity to make this decision for themselves. The doctor had discussed this decision with each person concerned and their relatives, so that everyone was aware of the person's wish and its consequences. When a person lacked the capacity, the doctor sought to identify person's wishes, preferences, beliefs and values by talking to those closest to the individual and/or the person with Lasting Power of Attorney (LPA) or an Independent Mental Capacity Advocate (IMCA) before making a DNAR decision.

People told us they enjoyed the food provided by the hospice. They said they received varied, nutritious meals in sufficient amounts. One person remarked, "Food choice is lovely". Another person stated, "Fantastic food, with alternatives, if I don't want the menu, to try and overcome the lack of appetite".

Care plans contained detailed information about people's preferences concerning both food and drink. Assessments of people's nutritional requirements were also included in the care plans. These assessments were monitored daily. Where there had been changes to a person's care needs, care plans had been updated. Menus were reviewed seasonally, with lighter meals available in the summer months. We observed that people were supported to eat and drink according to their individual needs and preferences. On the day of the inspection, we noted that people were asked what they would like to eat and drink. They had meals in the privacy of their rooms, brought to them by staff if they wished so. Protected mealtimes introduced by the provider allowed staff to focus on assisting people and helping them with foods and drinks.

We saw staff updated the cook with people's choices and they discussed alternative ideas for the nutrition of people suffered from loss of appetite. Staff made suggestions to help people decide what they might like if they did not want what was on the menu. We spoke with the cook who told us they tried to suit people's wishes at all times. For example, the cook had recently made a jam and coconut tart especially for a person who expressed such a wish. The person had appreciated the cook's effort and had later sent them a 'thank you' card. Some peoples' families had handed in 'like lists' which were always taken into account by the cook. The kitchen staff were aware of people's dietary needs and preferences and were able to provide specialist diets as needed, for example gluten free or dairy free diet. Monthly food testing helped to ensure good quality of food.

The hospice was purpose- built, fully accessible for people with disabilities, with all clinical facilities on the ground floor. The service was equipped with all the equipment necessary to meet people's clinical needs. Moreover, the registered manager told us every effort was made to ensure the service was as homely as possible. People told us that they were satisfied with the accommodation.

Good

Is the service caring?

Our findings

People spoke very highly of the care and support they received at the hospice. One person told us, "All of the staff have been absolutely fantastic". Another person stated, "Staff are amazing, very caring to me and my mum. The level of care from every member of staff has been so high. Even though they are so busy, they are constantly checking that I am ok and telling me stories to help me get through. They are always giving me emotional support when I am down or having a tough time".

The service had policies in place to maintain and promote people's privacy and dignity. We spoke with staff to check their understanding of how to treat people with dignity and respect. Staff gave examples of how they worked with people trying to recognise and accommodate to their individual needs and preferences. They asked people and their relatives about their likes and dislikes which were then incorporated in the care plans. One staff member told us," I try to build a rapport with patients so that they feel comfortable with me".

We saw throughout our inspection that care, consideration and compassion were high in the culture of everyone working for the service. We saw staff and volunteers were respectful and polite to all the people receiving a service or visiting the hospice. Staff demonstrated a caring and compassionate approach. They talked to us about the care and support they provided to people, their relatives and friends, but also talked about caring for their colleagues. All staff understood the need to spend sufficient time with people and their loved ones, taking time to listen to them and respond to their needs without rushing.

We saw letters and 'thank you' cards sent by relatives after the death of their family members. Each message showed that the senders appreciated the care and attention their family member received. One of the cards contained the message "I need to express my gratitude to you all for the excellent care, love, compassion and support you all delivered to my lovely sister". Another card said, "Thank you for love and care you have given to me, whilst my stay at Thames Hospice. You all do a great job!"

We saw in people's care records evidence that they were involved with and were at the centre of developing their own care plans. This demonstrated people were encouraged to express their views about how their care and support was delivered. Relatives and staff told us that people were given information and explanations about their condition and life expectancy if they needed it. They said it was carried out by the most appropriate staff and in a sensitive manner.

Staff used different methods of communication to make sure that people received and understood each piece of information. Staff used written words, pictures, word boards, and translators where appropriate. Where necessary, people used lightwriters, text-to-speech devices. A person who cannot speak types a message on the keyboard, and this message is displayed on two screens, one facing the user and the other facing the communication partner.

Staff had received training in promoting equality, maintaining diversity and human rights. This meant that the care was person-centred, with people's needs in respect of their age, gender, race and religious beliefs

respected and satisfied. There was a sanctuary room accessible at all times for people to reminisce, contemplate or use as a quiet room for meeting their families. The sanctuary room was also used for weddings of people or their relatives, wedding anniversary celebrations or spiritual services. The sanctuary room was used to organise Christmas parties for people suiting their taste and wishes. For example, people's favourite foods were served and everyone who wished to wear Christmas jumpers.

Staff spoke fondly of and were knowledgeable about people they cared for. They showed a good understanding of the individual choices, wishes and support needs of people within their care. All staff were respectful of people's needs and demonstrated a sensitive and compassionate approach to their role. Staff told us they enjoyed their work because they sincerely cared about the people they supported. One staff member told us, "We give people a very good care. 99% of the time we are on top of it."

Staff demonstrated their understanding of the importance of making sure people and their families were supported. The service recognised the significance of family during this difficult time. One person said, "The freedom visitors get is brilliant. They can come anytime so my son can come after work until 11pm."People's family members and friends were able to visit without restriction. In addition, family members were able to stay at night and accommodation was available for this purpose.

Bereavement support was available to people and their families or friends. This provided emotional support to those who required it. A pre-bereavement, post-bereavement and counselling service was offered to all people and their families as appropriate. Families of people who passed away got initial support from the service for the first two weeks. After six weeks, they were transferred to the counselling team. They could then have individual counselling or join the "Stepping Stones" bereavement support group, or use both. Each person accessing counselling was seen as an individual. Counselling was available to access even up to a year after the death of a loved one and the counselling support could be provided for up to two years.

There was also a chaplaincy service available to offer support if required. It aimed to meet multi-denominational spiritual needs of people and their family members.

People and relatives told us that medical and nursing staff always discussed treatment options with them. People were involved in making decisions about their treatment plans. They said they were able to take time and ask questions about the proposals and they felt they were listened to by all staff. The complementary therapy team offered therapies which helped people and families relax and relieve any anxieties. People were offered a range of treatments, including holistic back massage, reflexology and therapeutic touch. The service was tailored to people's needs and highly appreciated by them. For example, one person had been provided with the information about benefits of relaxation techniques. In further discussion it had emerged that lavender had been the person's favourite smell. The person had stated they would really appreciate being able to smell this as it reminded them of the wonderful times spent with their grandmother. As a result, the smell of lavender had allowed the person to relax more deeply than they had been able to relax for a very long time. The person had been very keen to continue using the relaxation technique.

We attended a multidisciplinary team (MDT) meeting where staff discussed patients' treatment plans and progress. The MDT meeting helped to assess and evaluate people's physical, psychological, social, spiritual and information needs. We saw that such discussions were followed by action plans. One action plan, for example, concerned reducing the anxiety level and delivering support in controlling panic attacks. Where appropriate, the MDT meeting also focused on the assessment of the needs of families and friends of people, and the support they might need.

Staff actively sought people's views on their end-of-life care. Records demonstrated that people's needs and

preferences regarding their individual care were regularly reviewed and responded to. This included planning bereavement support to family and friends. Staff communicated with other health care professionals to ensure people's care was consistent and their needs were satisfied. People also had access to specialist equipment and support when needed, according to their changing needs.

Good

Is the service responsive?

Our findings

People and their relatives told us the staff were responsive to their individual needs. One person told us, "The staff always listen to what I need".

The care observed was given in a personalised manner, and it reflected the needs, wishes and aspirations of the individual person and their relatives. The approach of nurses administering medicines to people was highly responsive. We saw that other qualified staff shared the same attitude. One of the nurses told us, "'I get to speak to and interact with every resident during the process and acquire a lot of knowledge that can impact on changes".

A referral process had been developed to effectively share relevant information when people moved between the services, for example from hospice at home to day services. The care files of people using the service showed that an assessment of their needs was completed by medical and nursing staff on admission, including risk assessments. People and their relatives had been actively involved in the process of assessing risk where appropriate. We saw that information had been obtained from other services including GP's, hospitals and district nurses. The assessments were comprehensively completed and included details of people's specific needs and choices. The assessment took account of each person's physical, psychological, social and spiritual needs. Areas assessed included dependency, communication, clinical, spiritual and cultural needs.
The service was flexible and responsive to people's individual needs and preferences. Thames Hospice accepted admissions seven days a week for those people in the community with rapidly changing needs. Moreover, the service provided 24 hours consultant and senior nursing advice to people on the in-patient unit and to people and clinicians in the community.

Detailed care and treatment plans were drawn up in response to the identified needs and preferences of people, with clear guidance for staff to follow. Care plans were reviewed on an on-going basis every day. Staff maintained accurate records of what had been achieved and noted any variations to the person's agreed care plan. For example, one person had been given additional medicines and support to deal with a particular health issue that had arisen.

Doctors and nurses told us that people's decisions changed along with the progress of their illness. Therefore, each week during multidisciplinary team meetings each person's condition was discussed, as well as their response to the treatment they had received and further treatment options. This was done prior to people being consulted and asked for their consent to future treatment. As a result, people remained fully informed about their state of health and available treatment options. This allowed people to voice their concerns and wishes so that these could be responded to effectively. The multidisciplinary meetings also enabled a range of health and social care professionals to review people's needs and plan their care and treatment in an integrated way. The meetings with agencies involved in delivering the care package were also used as means to manage the transition of people between services.

The service used an electronic recording system which enabled information to be shared amongst health

professionals in different agencies when the person provided consent to this. The system meant there was less need to duplicate assessment information and health professionals would be able to easily access the information when planning care and treatment.

The staff were aware of the potential impact that people's conditions posed to their mental health and well-being. Services were offered to people to help reduce the risk of depression, anxiety and social isolation. These included access to the psychological support services, complementary therapies and community support groups.

The service provided a wide range of complementary therapies used to reduce discomfort resulting from pain. Examples included reflexology, reiki, aromatherapy and physiotherapy. People and their relatives told us they valued the availability of alternative therapies. One relative commented, "What a terrific service the Thames Hospice provide, along with all the alternative therapies and the care and genuine feeling of being valued". The service also facilitated people's access to psychological support. Each person had an advanced care planning assessment and end-of-life care plan in place. Planning in advance ensured people received the care they wanted when they were nearing the end of life, and their relatives and partners were given appropriate help and assistance.

Care and support was responsive to the diverse needs of people. Spiritual support was available to all people and their relatives; there was a sanctuary room in the hospice that people of all beliefs could access. The environment could be adapted to display only religious objects of people's individual faith. A suitable environment was available for people to practise their faith.

Staff and volunteers helped people maintain their social life and contacts with their families. There were facilities available that allowed family members to stay overnight at the hospice. Staff told us that people's relationships with their loved ones were an integral part of the delivered care.

Information on how to make a complaint was contained in the welcome pack that was provided to people when they commenced using the service. The manager explained that they tried to detect any minor frustrations that people expressed so that these could be dealt with promptly. There had been only one formal complaint since the last inspection and we saw that the provider had investigated the matter and responded to the complainant in a timely way. People told us that they were confident relevant action would be taken to address their concerns if needed.

People and their family members had opportunities to voice their views. This was achieved, for example, through completing questionnaires and surveys. These were provided by the service or by an external organisation, such as The Association for Palliative Medicine of Great Britain and Ireland (APM). The feedback from the survey of patient experience carried out in 2015 was positive. Comments received included, 'Your lovely care and support was crucial', 'The care provided was over and above what was expected' and 'You were all amazing.'

The provider constantly sought feedback to enhance the service. There was a board in the corridor where people and their relatives were presented with information regarding upcoming activities, catering and occupancy. They were also asked to share their opinion on the service provided to people by leaving their comments on the board. For example, a relative complimented "lovely staff and volunteers" who were "making a big difference to my mum". There was a feedback token system in place where people could use tokens in order to express their opinion about other treatment therapies, such as physiotherapy, occupational therapy or lymphoedema service. The results of the feedback were analysed and changes implemented if required.

People told us that staff valued their opinions and that they were encouraged to express their views freely. The registered manager regularly analysed the gathered feedback and acted upon it. People's comments on how to improve the service had allowed the registered manager to discover how much music and docking stations were important to people. The docking station is a device in which a laptop computer, a smartphone, or other mobile device may be placed for charging, providing access to a power supply and to peripheral devices. As a result, docking stations had been purchased and were used by people to help them relax.

Good

Is the service well-led?

Our findings

There was a registered manager in place. 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. The registered manager had been in post for ten months. We found the registered manager to be very knowledgeable about the service. We observed how enthusiastically they spoke about the hospice and people who use it. All of the managers and staff we spoke with at the hospice were very dedicated to providing care to people. We found that they believed in the philosophy and values of the hospice, which were promoted and displayed prominently for all to see. Throughout our inspection we saw many examples of staff practising these values for the benefit of people using the service and their family members. The Board of Trustees were involved in the management of this service. They were responsible for directing the affairs of the charity and ensuring that Thames Hospice met its strategic objectives.

There was a clear management structure at the hospice. Staff were aware of the roles of the management team and they told us the managers were approachable and were present regularly at the hospice. Staff told us that they genuinely enjoyed working at the hospice. One staff member said, "I feel very privileged working here," and "When I first started here it was very different from my previous experience of care, staff all know what they are doing and there is no rank and file difference." Volunteers were also well motivated and well-supported in their role. They stated that the registered manager and regular staff were "very appreciative" of their work.

All the managers we spoke with maintained regular contact with staff and people who use the service. As a result, they demonstrated an excellent understanding of the care provided. Senior staff acted as a role model for their less experienced colleagues and promoted the values of the service in all aspects of their work.

The hospice had clear visions of the service explained to staff and volunteers through their induction programme and training. There was a positive culture at the hospice where people felt included and consulted. People and their family members told us they felt staff not only offered to care for the person receiving treatment but also for family members. We found the culture of compassion, caring and kindness to be embedded within all staff and volunteers working for the hospice.

All staff told us they felt supported in their roles without any exception. They also informed us that there were different arrangements in place to provide them with the support needed to do their work. Staff confirmed they could access clinical supervision to support them within their nursing role where they were able to reflect upon their practice. They also said there were times when staff needed a particular kind of support due to the emotional nature of the-end-of life care they provided to people. The service tried to address that need in various ways. Staff told us support was provided from an approachable and available management team, through regular one-to-one meetings, and from a coherent and caring team. We were also told that staff could use the counselling service and the chaplain was also available to them if required.

People, relatives and staff were very complimentary about the management of the service. At the time of our inspection we observed the whole staff team co-operating effectively in an integrated manner to meet the needs of people.

Systems were in place to monitor the quality of the care provided. These included audits in such areas as: general health and safety, management of medicines, assessments of nutritional needs, human resources, inpatient unit patient personal belongings, infection control, access to computer networks and sanctuary usage. The audits identified most of the issues relating to administration and storage of medicines. The audits of medicines management failed to identify the problem of storing medicines in uncontrolled room temperatures. However, immediate action was taken by the manager and we did not see that people had experienced any negative outcomes as a result of these shortfalls.

We found evidence that the service had gone above and beyond their duty whilst supporting their local communities. An external audit of the hospice was carried out by ethnic groups to ensure that the particular needs of their communities were met. The findings of the audits were analysed and staff were informed at staff meetings about their outcome and any actions they needed to take to make improvements. The analysis of the audit was followed by an action plan. The plan outlined Thames Hospice's actions to make the access to their services as equal as possible for various ethnic minorities. The issue was being tackled by meeting faith leaders to introduce a sanctuary room into the service and ask them about their guidance and advice regarding its use and decoration. The hospice ambassadors attended different religious groups to make the hospice known to the wider community. Even though the current plan was still in the course of its implementation, it had already resulted in the recruitment and employment of a full- time community consultant. This means that the service took the current needs of the community into account and aimed to accommodate to the diverse needs of the people living in the area.

Regular meetings held on a monthly basis kept staff informed and up-to-date, reinforced the values of the organisation and their application in practice. Staff told us these meetings were useful and they were able to contribute to the service development and improvement by sharing their ideas. Staff also stated that they were encouraged to raise their concerns if they had encountered any difficulties. In such cases, the registered manager worked with them to find solutions. For example, staff had raised their concern about the TV sets installed for people in the bays. These often broke down and did not provide good quality pictures and sound for the people. The registered manager acted on it immediately by installing brand new TV sets.

The service went the extra mile to recognise and award the effort of their employees. The hospice awarded their staff and volunteers during a biannual 'Make a Difference Awards Ceremony'. The awards were always different and kept secret until the ceremony commenced. Staff and volunteers were able to nominate colleagues for their distinguished merit. Depending on the category of the award, the successful nominees were awarded for patient-centred care, customer focus and providing support to frontline services or colleagues in other teams. This initiative was received well, improved the team morale and commitment, and was welcome by staff and volunteers as a genuine recognition of their efforts. People also benefited from being cared for by well-motivated staff who knew that their dedication was appreciated and who were encouraged in their endeavour to provide best quality care.

The hospice had strong links with the local community which were maintained through fundraising and social events. There was a range of information for the public which was available in the reception area as well as in other local facilities such as the Thames Hospice charity shops. The hospice recognised its responsibility to ensure that its services met the needs of all sections of the local community and continued to learn. The hospice had developed services and built relationships with the local groups so that this aim

could be achieved. As a result, a chain of British supermarkets had allocated a member of their staff to work at the hospice for six months. The member's skills included know-how in project management which had been utilised by the clinical teams of the hospice. This meant the service worked in partnership with other organisations to make sure people were provided with a high quality service.

There was a strong emphasis on continually striving to improve. The hospice was constantly benchmarking their service against other services in the country. They took a part in the FAMCARE Audit. 27 hospice inpatient units (IPU), 15 home care teams and 10 hospital support teams had taken part in the audit. The audit had showed that Thames Hospice had received more "very satisfied" responses in comparison to the average across the IPU sample from 27 participating hospice IPUs. Thames Hospice - Windsor had also participated in a benchmarking project managed by Hospice UK, which is the national membership charity for organisations providing or supporting hospice care across the United Kingdom. The benchmarking project had collated data from 108 hospices. The results of the project had shown higher bed occupancy and lower number of pressure ulcers, falls and medicine incidents at Thames Hospice - Windsor than the average in the other hospices taking part in the project. This illustrates how the service was going above and beyond their duty in order to ensure they provide the best quality of care. The FAMCARE audit provided the service with information about the areas in which the service could improve as well as helped them acknowledge the areas in which the service was proficient. This enabled the hospice to keep up with best practice and be informed about different models and ideas for improvements.

The service also excelled in providing education and undertaking research to identify and share best practice. The hospice had links with the University of Southampton and had taken part in the research into compassion fatigue amongst hospice staff. The research proved that fatigue, stress, sadness and the associated decrease in morale and work performance are the consequences of caring for those who are suffering. These conditions may not only negatively affect the retention of staff but also influence patient satisfaction and patient safety. The registered manager was aware of the research and understood the issue of 'burnout' and 'compassion fatigue', hence the chaplain support and Schwartz rounds offered to staff. Schwartz Rounds are an evidence-based forum for staff from all backgrounds to come together to talk about the emotional and social challenges of caring for people. The aim is to offer staff a safe environment in which they can share their stories and offer support to one another. Addressing the compassion fatigue in a proper manner at Thames Hospice – Windsor proved to have a positive effect both on recruitment and retention of highly effective nurses. As a result, people benefited from high quality care provided by staff who were familiar to people and who had developed rapport with them. Other consequences for the whole service were increased staff morale and productivity, a reduced time of sick leave, lower turnover rates, and higher patient and family satisfaction.