Board of Trustees

The Heart of Kent Hospice

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Heart of Kent Hospice is a local charity that provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families in the Maidstone, Aylesford, Tonbridge and Malling area. They deliver physical, emotional and holistic care through a multidisciplinary team that includes doctors, nurses, physiotherapist, occupational therapist, volunteer complementary therapist, counsellors, a social worker, a chaplain, a care manager and administrative, catering and housekeeping staff. The service is supported by a large group of volunteers. Services are free to people and the Heart of Kent Hospice is largely dependent on donations and fund-raising by volunteers in the community.

The service cares for people in two types of settings: at the hospice in a 10 beds 'Inpatient Unit', or in their own home with the support of a community palliative care team. In addition, the Heart of Kent Hospice provides a day therapy centre, 'Magnolia Place', which is open three days a week, where people can access advice, support, and take part in individual and group therapeutic activities. A weekly Drop-in Centre and a dementia café provide an environment where people and their families can receive support from the team as well as talk to others facing a similar situation.

This inspection was carried out on 08 and 09 February 2016.

There was a manager 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 was on extended leave and had not been in post since July 2015. The Chief Executive Officer had appointed the Deputy Patient Services Director as acting manager until the registered manager's return, to ensure continuity of management. The acting manager had been in post since August 2015.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns in regard to people's safety. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

There were sufficient staff on duty to meet people's needs and arrangements in place to ensure there were always enough staff to meet people's needs during any short notice absence.

There were recruitment procedures in place which included the checking of references. New recruitment systems were being set up, however as these improved recruitment systems were not yet embedded and needed to be sustained over time, this is an area for improvement which we will review at our next inspection.

We found improvements were needed in regard to the secure storage of medicine, competency checks for

nursing staff and records of administration of medicine. We have required the provider to take action to ensure that people receive medicines that are appropriately stored, documented and delivered by competent staff.

There were members of staff who took the lead in a speciality such as dementia, motor neurone disease, renal impairment and infection control. They offered specialist guidance to other staff so people could be confident about staff particular expertise.

Essential mandatory training was provided although the system for the monitoring of staff training was not effective. This meant that people could not be confident that staff had been appropriately trained. There were plans in place for a new system to monitor all staff training. However, this improved system was not yet implemented. This is an area for improvement which we will review at our next inspection.

Care staff competency about their role was not regularly checked during their induction, and not all members of care staff received regular one to one supervision sessions to support them in their role. We have required the provider to take remedial action.

People were fully involved in the planning and review of their care, treatment and support while in the Inpatient Unit. Staff delivered support to people according to their individual plans.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered in accordance with the Mental Capacity Act 2005 requirements.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences, restrictions and reduced appetite.

Staff knew each person well and understood how people may feel when they were unwell or approached the end of their life. They responded to people's individual communication needs and treated them with genuine kindness and respect.

People and relatives were consistently very positive about the quality of service they received. They told us they were extremely satisfied about the staff approach and about how their care and treatment was delivered. People told us, "They provide outstanding care, the staff are exceptional", "This place is amazing; the staff are amazing; the care is amazing; there is no other word to describe it" and, "The staff go above and beyond the call of duty, they are so dedicated and passionate about what they do." Staff approach was kind, compassionate and pro-active; they were skilled at giving people the information and explanations they needed in a sensitive manner. They often went beyond the scope of their duties to meet people and their families' needs.

Clear information about the service, the facilities, and how to complain was provided to people and visitors. 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 feedback was sought and acted on. Audits were carried out to identify how the service could improve and action was planned as a result. However some of the action plans had not yet been implemented and new monitoring systems were not yet in place. As new monitoring systems were not yet embedded and needed to be sustained over time, this is an area for improvement which we will review at

our next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Practices regarding the storage, administration of medicines and regarding staff competency checks were not in accordance with current controlled drug legislation.

Consistent and robust recruitment procedures were not followed in practice and needed improvement.

Staff knew how to recognise signs of abuse and how to raise an alert with the local authority if they had any concerns in regard to people's safety.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Essential mandatory training was provided although the system for the monitoring of staff training was not effective. Not all staff received one to one supervision to be supported in their role. Not all care staff were subject to competency checks to ensure they were competent to carry out their role.

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

The acting manager understood when an application for DoLS should be made and how to submit one. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

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?

Outstanding ☆

The service was outstandingly caring. People's feedback about the caring approach of the service and staff was overwhelmingly positive. They told us, "They provide outstanding care, the staff is exceptional" and, "The staff go above and beyond the call of duty, they are so dedicated and passionate about what they do."

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. They were skilled at giving people the information and explanations they needed in a sensitive manner. People valued their relationship with the staff team who often performed beyond the scope of their duties and pre-empted people's emotional needs.

Staff communicated effectively with people and treated them with utmost kindness, compassion and respect.

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

Is the service responsive?

Requires Improvement

The service was not always responsive to people's individual needs.

There were no records to indicate that people were routinely invited to take part in 'advance care plans' (ACP) in the community and supported during the process. This meant that people may have less opportunity to consider decisions about their treatment and options ahead, before they came into the Inpatient Unit.

People's needs were assessed before support was provided in the community and as soon as they came into the Inpatient Unit for respite of for a longer stay. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in accordance with people's care plans.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was led by an acting manager in the registered manager's absence with the support of a Chief Executive Officer appointed in May 2015 who had been in post for nine months prior to our visit. The acting manager had identified and carried out several improvements to the service since they had been in post. Audits had been carried out to identify how the service could improve and action was planned as a result. However some of the action plans had not yet been implemented and new monitoring systems were not yet in place.

The staff told us they had confidence in the current leadership.

There was a culture that focused on people and people were placed at the heart of the service.

The Heart 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 carried out 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 08 and 09 February 2016 and was unannounced. The inspection team consisted of three inspectors, one pharmacist inspectors and an expert by experience. The expert by experience who supported this inspection had experience in palliative care.

The acting manager had completed 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. Before our inspection we looked at the information provided in the PIR, records that were sent to us by the provider, acting manager and the local authority to inform us of significant changes and events, and at our previous inspection reports.

We looked at the premises and equipment. We looked at ten sets of records that related to people's care and examined 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 recruitment, training and management, and records relevant to the storage, ordering and administration of medicines. We looked at checks that were carried out concerning the monitoring of the safety and quality of the service. We observed a 'ward round', a multidisciplinary meeting and the administration of medicines. We sampled the services' policies and procedures.

We spoke with the Chief Executive Officer, the acting manager, the medical director, the Community Team Manager and five Heads of departments such as Facilities, Catering and Hospitality, Human Resource, Family Services and Education.

We spoke with one specialist doctor, an occupational therapist, the (IT) Information Officer, six nurses including one bank nurse and one student nurse; two healthcare assistants, the ward co-ordinator, the Receptionist/Administrator, a member of the maintenance team and a member of the housekeeping team.

We consulted two people who stayed in the In-Patient Unit, four of their relatives and three volunteers. We also spoke with people who attended Magnolia Place, four of their relatives and two people who received support in their own home from the Community Team. We contacted three GPs who referred people to the service, one manager of a local care home where training had been provided and we sought their feedback.

At our last inspection on 02 May 2014 no concerns were found.

Requires Improvement

Is the service safe?

Our findings

People in the Inpatient Unit told us they felt safe living in the service. They said, "There is enough staff around ready to help" and, "I feel safe here because I feel I am in good hands." " A relative told us, "I know this is the safest place for my relative to be at this time." A relative of a person who was supported by the service in the community said, "We have total confidence in the staff."

Staff training records confirmed that only clinical and medical staff had received training in the safeguarding of adults and children, and these members of staff were scheduled to attend refresher courses. There were plans to provide this training for all staff in all departments of the service from April 2016. However all the staff we spoke with knew how to identify abuse and how to respond and report internally and externally. Staff knew how to access the safeguarding of adults and whistle blowing policies. These policies included clear explanations concerning what constitutes abuse and potential signs that a person is at risk of abuse. It included information about how the service would work in partnership with the local authority in order to manage safeguarding concerns.

There were sufficient staff to meet people's needs. When people asked staff for help, staff were available to respond without delay. Staff confirmed that they would be able to stay with someone for their final moments "as long as needed." Staff rotas indicated some deficits from the levels that were identified by the medical director as necessary, and a care worker told us, "The biggest challenge here is covering the shifts when staff are on annual leave or sick". However people and relatives we spoke with told us that staff were in sufficient numbers to meet their needs. The acting manager showed us how steps had been taken to increase the number of bank nurses available to cover any unexpected shortfalls in staffing. There were six bank nurses and eight bank care workers who were called to cover staff at short notice when necessary. The Head of Education and Development was the acting manager for the Inpatient Unit. The In-patient Unit Manager was not carrying out their duties as in-Patient Unit manager and had been offsite for some time. There were no vacancies at the time of our inspection and a nurse had been recruited to start shortly.

The community team supported approximately 480 people with a life limiting illness to remain at home. Its staffing comprised of a manager, six clinical nurse specialists including one specialised in dementia and another who visited care homes and three associate nurse specialists. They were the first point of contact for people and their families that were referred to the Hospice by their GP, district nurse or hospital consultant. Two people who were supported by the community team told us, "They always turn up when needed and without any delay" and, "There are enough of them, they always make sure we see the same familiar faces too." The provider had appointed 12 key staff since our last inspection that included a medical director, a dementia nurse specialist, a nurse practitioner, an occupational therapy lead, a physiotherapist, a social worker, a welfare advisor, a counsellor and an information officer. This ensured that staffing levels were maintained to meet people's needs and keep them safe.

We found that three out of five nursing and healthcare professionals' files we looked at did not contain a full employment history with explanations for any gaps in employment. The application form for applicants only requested details of last ten years employment instead of full employment history. Three files included a

blank induction form that had not been completed. Two others did not contain an induction form to evidence their induction. None of these files included a photograph to identify the member of staff.

The Head of Human Resource had started working at the service three weeks before the inspection and had introduced a monitoring system to ensure a robust recruitment process was followed and that staff criminal checks had been carried out. The HR department staff were also carrying out an audit into all staff files to identify any missing data, and reported to the CEO and acting manager who were requesting line managers to collect the information, so that all staff files could be appropriately documented and completed.

This checking system had identified that some staff had not completed probationary reviews or appraisals. An effective monitoring system in regard to recruitment and related documentation had not previously been in place when the registered manager had been in post. The Head of HR and the CEO told us they were looking into purchasing an integrated HR system to monitor all aspects of recruitment more effectively. As new recruitment systems were not yet embedded and needed to be sustained over time, this is an area for improvement which we will review at our next inspection.

There was a detailed disciplinary process in place that clearly outlined the steps that would need to be taken if it was necessary to address staff performance issues. Appropriate steps had been taken by the provider to keep people safe and ensure good standards of practice were maintained.
This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Individual risk assessments were carried out for people in the community and in the Inpatient unit to identify how risks could be minimised. For example, a person who was at risk of respiratory difficulties was provided with an inhaler as prescribed and encouraged to use specific breathing techniques. Another person who was at risk of falls was checked at regular interval and their bed was lowered when they were unattended. Staff were aware of the risks that related to each person. Control measures to minimise risks to people included the provision of specialist equipment and instructions to staff to work in pairs when necessary. Staff ensured that people had their call bells within easy reach so that staff could respond when they needed help.

Comprehensive environment risks assessments had been carried out over the last four months to identify possible hazards in each area of the premises and establish how risks could be reduced for people, visitors and staff. This included the risks about the possibility of acquiring an infection, falling, bruising, tripping, slipping or scolding. Appropriate measures were identified and taken to minimise such risks. Dates had been scheduled to review and update these assessments. A further risk assessment with details of remedial action in regard to using the minibus had also been carried out in December 2015.

Contracts were in place for the regular servicing of equipment such as hoists and lifts. The premises were well maintained and although there was no system to track and monitor how repairs were carried out within the hospice, staff spoken with confirmed that they were able to get repairs made when they reported them. The acting manager told us a monitoring system for repairs and maintenance will be introduced shortly.

We spoke with staff at the hospice about how medicines were managed. We saw peoples' own medicines were kept securely in lockers in their own rooms.

Appropriate arrangements were in place for ensuring medicines were not used past their expiry date. We saw detailed, clear records of medicines which had been ordered and received by the hospice. Emergency medicines and oxygen cylinders were available, in date and stored appropriately. Waste medicines were

stored securely and disposed of appropriately.

Controlled drugs (CDs - medicines which are at higher risk of misuse and therefore need closer monitoring) were kept in locked cabinets. We saw written evidence that staff conducted balance checks of controlled drugs and that ordering processes and records were appropriate. High strength preparations of CDs were kept separately from other strengths to help prevent incorrect selection. Disposal of expired medicines and patients' own CDs was undertaken appropriately.

Blank prescription forms (FP10s) were stored securely but there were no processes in place to allow their use to be tracked in the hospice. This is important in preventing misuse of prescriptions and the hospice should take action to ensure that such processes are in place in the future.

We saw that temperature records for the fridge in the clinic room were not always completed fully. We also saw that temperatures were sometimes higher than the recommended 8oC with no evidence of action taken. Medicines requiring refrigeration need to be kept between 2oC and 8oC to ensure they are safe to use.

Prescribing was undertaken by in-house doctors along with an in house consultant. A range of medicines were prescribed for people on admission to the hospice to ensure they always had access to appropriate medicines whenever they needed. Prescribed medicines were also screened by a pharmacist twice a week.

On two occasions, we saw trained nurses safely prepare a syringe driver for a patient (a portable pump which allows medicine to be administered by slow release over a period of 24 hours). Staff also had good access to up to date resources which they may need for medicines administration, including guidance on the use of syringe drivers. Staff told us they had been assessed to ensure they were competent in the use of syringe drivers but the hospice did not hold any records of this.

Staff were able to clearly explain information patients are given about unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms). We checked prescription and administration charts for three patients. We found that these were not always completed fully and in line with the hospice's own procedures. For example, reasons for missed doses were not always recorded. As records were not completed appropriately, people could not be confident that medicines were administered as per their prescription.

The shortfalls we identified in respect of the temperatures of medicines storage; and of MARs not being fully completed indicate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had effective processes in place to enable patients to take out medicines when on day leave and provided oral syringes for liquid medicines. A full audit on medicines management had been undertaken in January 2016 and we were able to view an action plan made to address issues which had been highlighted by the audit. The services manager was beginning (February 2016) to put in place ways of communicating required changes to practice through a "practice change log" which was available for all staff to view. Alerts issued by the Medicines & Healthcare products Regulatory Agency (MHRA) were acted on.

The premises were clean and well maintained. There was ample supply of personal protective equipment available for staff and it was noted that staff were wearing gloves and aprons when needed. Cleaning schedules were in place and regular deep cleans were being carried out. Staff washed their hands

appropriately, and guidance about hand washing was on display throughout the service. Alcohol gel was available outside every room and used by staff and visitors. There had been an infection control audit carried out on 28 January 2016. This had been completed by an external consultant to ensure that an accurate benchmark was obtained from an independent source. They had identified some areas for improvement and these had been actioned. For example, it was identified that there was no clinical waste bin in the treatment room. Steps had been taken immediately to address this issue.

Regular health and safety meetings were held at the service and these were used to identify actions that needed to be completed. For example, records of a meeting in January 2016 showed that a need for additional training and support in Infection control for the lead nurse and Housekeeping team had been discussed. As a result, this had been implemented, The training matrix system listed 24 members of staff due to receive training in infection control. This system did not identify whether this was original training or a refresher course. However all the staff we spoke with told us they had received the training and were knowledgeable about how to manage a possible outbreak of infection as they described the appropriate steps they would take to prevent a person's infection from spreading to others. Seven members of clinical staff were scheduled to attend emergency first aid training by the end of March 2016. As the training matrix system did not identify whether this was original training or a refresher course, we checked three nurses' knowledge about first aid and they demonstrated a high level of competence and confidence.

The premises were secure and systems were in place to ensure that visitors to the service signed in on entry. There were alarms on the external doors and this ensure that the security of the premises was maintained. There was a clear plan for emergencies and staff knew where this was located. There was a business continuity plan in place that provided staff with guidance concerning how to maintain the service in case of an emergency.

Regular checks of fire protection equipment and fire drills were carried out and appropriately documented. A list of first aiders and location of first aid boxes was displayed. First aid boxes were checked and replenished regularly. A comprehensive fire risk assessment of the service had been carried out by the Facilities manager in November 2015, which acknowledged that 'occupants in the Inpatient Unit would be at variable stages of ill health ranging from fairly mobile independently to needing assistance to move at all'. The provider explained that as people's status regarding their level of mobility may change within a very short time, the service had a group evacuation plan for people in the Inpatient Unit rather than individual plans. Staff were aware of this group evacuation plan.

Requires Improvement

Is the service effective?

Our findings

People told us the staff gave them the care they needed. Two people who stayed in the In-Patient Unit said, "I feel I am in the best hands possible, I have total confidence in the doctors and the nurses, everyone have the skills that are needed to do that kind of job" and, "It is wonderful that when I ring the bell the staff come almost straight away and I always receive attention." A person who attended the Day Therapy Centre said, "The staff are very understanding, sympathetic and very supportive both at the hospice and away from it." A GP who referred patients to the hospice told us, "We have close contact with the hospice team with many of our palliative patients; communication is excellent by fax, or personal liaison on the phone in urgent cases; intervention is timely and their expertise is invaluable in managing our patients; they often help in giving a coordinated response liaising with district nurses, family, and social services in providing a patient centred response to care. They have provided a role in education to our team when attending our palliative care meetings." Another GP who gave us their feedback commented, "They have always been able to provide telephone advice when needed" and, "Communication is good and timely and I know I can always ask for advice regarding management of patients, at home or at local nursing home."

Staff knew how to communicate with each person and understood their individual needs. One person was not able to communicate verbally and was not fluent in English. One of the doctors had showed them a picture book in order to communicate and had requested a relative to interpret when this method was not fully effective. A person with a neurological condition had been provided with a 'Possum System', which is an assistive technological device that enables them to communicate with their chin. Another person with Parkinson's disease had a hand-touch pad and a light-touch call bell to enable them to express themselves and call for help without difficulties. During a ward round, the medical director and a nurse were kneeling by the bed to ensure they were positioned at eye level to facilitate effective communication with a person who was unwell. All members of staff used a gentle tone when they spoke with people and used appropriate touch to communicate their empathy. There was a book in the ward office used by the acting manager and staff that ensured a two-way communication.

Staff shared information about people's care following a 'ward round' in the In-patient Unit. We observed a ward round where the medical director talked with each person on the In-Patient Unit and discussed their options with them. They then discussed with a team of two doctors and two nurses to plan the best way forward to manage people's symptoms. There was a system of frequent and scheduled staff handovers throughout the day to ensure continuity of care between staff shifts. There were daily 'Referrals meeting' and weekly multi-disciplinary meetings to review each person's care and treatment to ensure it remained appropriate and discuss how to support people in the community who might be admitted to the hospice. We observed a multi-disciplinary meeting. A comprehensive team attended including the acting manager, the acting Inpatient Unit manager, the chaplain, the medical director and a doctor, three nurses, one physiotherapist and an occupational therapist. A range of options to present people, such as referrals to external healthcare services or access to other residential services, was discussed with the team's active participation. The doctor was updating people's care plans on a laptop during the meeting. This system ensured effective continuity of care and that staff were knowledgeable about people's individual care, treatment and relevant updates.

There were members of staff who took the lead in a speciality such as learning disabilities, dementia, motor neurone disease, lung disease, heart failure, renal impairment and infection control. These members of staff could offer specialist guidance to other staff. This meant that people could be confident that staff had access to expertise that could enhance their knowledge and delivery of care.

Essential mandatory training was provided although the system for the monitoring of staff training was not effective. The training matrix was managed by the hospice's Receptionist/Administrator who told us that staff were expected to book themselves in when they needed refresher courses, and that this often did not happen. They told us, "There is confusion because many members of staff were told training has to be done by the end of the financial year in April, although many may need to have the training before that but there is no way to establish when." There was a 'waiting list' for essential training that listed 22 members of staff waiting to be trained in infection control, 19 staff in moving and handling, and 24 in fire safety. The training matrix did not indicate whether staff 'waited' for their original training or a refresher course. This meant that people could not be assured that staff had completed the training necessary to carry out their role.

Training that was specific to people's needs was provided. For example, nurses received advanced training in communication skills, symptoms management, cannulation (inserting a "tube" into a patient's vein so that infusions can be inserted directly into the patient's bloodstream) and venepuncture (inserting a needle into a vein, usually to obtain blood). Additional 'Bite size' training sessions on a wide range of topics relevant to care were regularly provided to care and nursing staff. For example, a MacMillan nurse clinician had come to talk to staff about secondary breast cancer. A member of the local mental health team came to talk to staff about behaviours that challenge. A nurse told us, "These sessions may only last half an hour but they are so interesting, it gives us more insight into what people go through." There were workshops and study days for staff, which included incidents reporting, palliative care, duty of candour, dementia, neurological conditions, respiratory disorders, catheterisation, benefits of Tai Chi and of acupuncture. These were implemented and were scheduled a year ahead.

Clinical training was provided although the system for the monitoring of staff training was not effective. Clinical training was monitored by the Head of Education and Development who had been the acting Inpatient Unit manager over the last two months. They told us that training such as symptoms management, advance care planning, resuscitation, syringe driver (portable pumps that are used to provide a continuous dose of medicine through a syringe), and verification of death were completed within six months of clinical staff starting their post and updated every two years. However there was no documentation to verify this. Clinical staff were expected to book themselves in for training and there was no monitoring system to alert the manager when staff were due for their refresher course.

The provider and acting manager had discussed the need for all training to be completed and appropriately logged at the last monthly management meeting and we were told that this will be implemented by the end of March 2016. There were plans in place for the monitoring of all training to be merged in future to get an overall accurate picture of the training that staff had completed. However, this system was not yet implemented. This is an area for improvement which we will review at our next inspection.

Training on palliative care was appropriately provided by a specialist nurse to approximately ten local residential and nursing homes and provided. A manager of a care home where staff had received training, support and guidance told us, "This training was invaluable and enabled us to be much more effective in the way we provide end of life care to our residents."

All the staff we spoke with told us they had not received regular one to one supervision sessions, although two staff told us, "We do get a lot of informal supervision because we talk amongst us" and, "The nurses are

great I just go to them for help and support and they give it." The medical director and nurses told us that informal group supervision often took place in the ward office where the clinical team be briefed and obtain support from each other. They told us, "We discuss difficult situations, our response and how we feel about these; we support each other."

The provider and Head of HR were not clear whether supervision was being undertaken or not as they assumed that it was down to the managers to carry it out and monitor it. Since they were in post, the acting manager had supervised the head of Family Services Team, the Therapies lead, the Head of Education and development, the Community Team manager, the Dementia specialist nurse and the clinical specialist nurse who visited care homes. These supervision sessions were appropriately documented. Although the Therapies lead had supervised each member of her team, other members of care staff were not receiving regular one to one supervision sessions. As a result, people could not be confident that all care staff were effectively supported to carry out their roles.

Clinical supervision was not provided and the provider told us this had been discontinued two years ago. The provider and acting manager had set up a working group which was researching different models of supervision to identify the most appropriate way to deliver supervision and clinical supervision to staff. The provider told us that as a result of this working group, a supervision programme to include clinical supervision was scheduled to be implemented by April 2016. However all the care and nursing staff we spoke with told us they received informal supervision and were able to access guidance and support from their manager at any time.

Checks of staff competency during induction were not appropriately carried out to, including checks for staff who administered medicine to people. The acting Inpatient Unit manager told us that reviews of new staff competency were to be carried out three times during their six months' probation period. However there were no records to evidence that staff had received an induction to their role nor that their practice had been monitored to record their progress. Three staff files included a blank induction form that had not been completed. Two others did not contain an induction form to evidence their induction. There was a half-day corporate induction every three months for all staff of the service and volunteers. One member of staff said, "We listened to talks from people who worked in all areas of the business; it helped us see the bigger picture." The acting Inpatient Unit manager had provided the format to carry out competency checks in September and October 2015 to the Heads of department where care was provided. As a result, only a few competency checks had been completed and returned, such as for five nursing staff in the Inpatient Unit. None had been completed and returned for staff in the community palliative care team and this had not been followed up.

We were told that spot checks of staff practice had been carried out in the Inpatient Unit to check that staff were competent to carry out their role, however the Inpatient Unit manager had left and the documentation to verify this was not available. Competency checks had been carried out and recorded for volunteers who were provided with a 'competency passport' that enabled them to assist care workers after they had received appropriate training.

As care staff competency was not regularly checked, and as a system of regular supervision was not yet implemented, gaps in staff knowledge or competency may not have been identified and addressed in order to ensure safe and appropriate care for people. Therefore people could not be confident that good practice was effectively monitored and maintained. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS had been appropriately submitted and attention had been paid to people's mental capacity. When people had been assessed as not having the mental capacity in regard to a specific decision, meetings had been held to reach decisions in their best interest. This process had been followed for two people who had wished to return home. This meant that people could be confident that correct processes were followed by staff to protect their rights and act in their best interest.

People told us they were very satisfied with the quality of the food. Their comments included, "The food is excellent", "Always delicious", "The food is always freshly cooked with a speciality of fish and chips on Fridays" and, "The kitchen is open for eleven hours at a time." Staff had time to help people to eat and drink effectively and people were supported with eating and drinking when they needed encouragement.

There were chefs in attendance in the kitchen which was opened for a period of eleven hours daily, seven days a week. There was a cafeteria area where visitors could purchase freshly prepared food and snacks, drinks, home-made cakes and fruit. Dietary requirements forms were completed and displayed in the kitchen so kitchen staff were aware of any allergies or special diets. The Head of catering and hospitality had been in post for 18 months and had changed the way menus were devised and how the food was ordered. There was a system to collect people's feedback about food. Night staff asked people in the Inpatient Unit what they wished to eat and returned the menus to the kitchen staff each morning. As a result, there were three choices of meals and staff prepared alternative dishes when people wished to have something else. A person in the Inpatient Unit had wanted "Something cheesy" and the chef had prepared a cauliflower cheese which the person said she really enjoyed. This was requested three days running and provided. Staff said that 'smoothies' and milkshakes were also a popular request. A wine and spirits list had been introduced for people.

People were referred to other services and to healthcare professionals when necessary. For example, staff discussed at handovers possible referrals to the Family Services team, occupational therapy, physiotherapy and complementary therapies. This showed that staff responded effectively when people's health needs changed.

Outstanding ☆

Is the service caring?

Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were overwhelmingly positive. People told us, "The heart of Kent is truly the HEART of Kent", "They provide outstanding care, the staff are exceptional", "This place is amazing; the staff are amazing; the care is amazing; there is no other word to describe it", "The staff go above and beyond the call of duty, they are so dedicated and passionate about what they do" and, "A weight has been taken off my shoulders by the nurses in the remarkable way they have dealt with my family". A GP who referred people to the service wrote to us with their feedback that included, "I would thoroughly recommend them! I know patients are receiving excellent care, are very well looked after and cared for in a compassionate manner. All levels of clinical staff to admin are always professional, caring, helpful and welcoming, even when it's busy. The team are knowledgeable, caring and supportive. An excellent hospice providing an excellent service!"

There was a homely feel throughout the service and a social atmosphere where people were encouraged to chat if they wished, and were listened to. Staff were smiling and engaging; they stopped to listen to people and responded to them with apparent genuine interest. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they conversed with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names. Staff used appropriate touch when needed such as gently stroking a person's arm while they experienced some discomfort when such gestures of empathy were welcomed by people. They offered companionship to people who stayed in their bedrooms when they considered that people may not wish to be on their own. The staff responded quickly to people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected and staff communicated the updates with each other during handovers.

All the care and nursing staff we spoke with were knowledgeable and understanding about each person's individual history, preferences and needs. Staff were attentive to people's individual needs, focussed on what was important to people and paid attention to their emotional state. A relative told us, "The nurses do not just look after me; they also have gone out of their way to get to know my family personally". The nurses had found out the person's children names, age and personal interests, and had welcomed them in to have breakfast. They had engaged and conversed with the children and had given them a tour of the hospice so they could become familiar with their parent's new environment and be more at ease. When families visited, staff knew who they were and greeted them warmly.

People valued their relationships with the staff team and told us that they often went 'the extra mile' for them when providing care and support. As a result people felt cared for in an outstanding way and that they mattered. A person told us how staff had spent "Many hours" talking with her even after their shift had ended when she was feeling anxious. Visitors were welcome at any time and relatives were able to bring people's pets to visit their owners in the service, to bring them comfort and lift their spirit. Such measures ensured that people could retain and find comfort in routines that were familiar to them. A nurse told us, "We had a parakeet, several dogs and cats, and even caged budgies in people's rooms; they are after all also

a part of people's families."

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. They were extremely skilled at giving people the information and explanations they needed in a sensitive manner. One person in the Inpatient Unit said, "They managed to give me the worst news in the nicest, kindest way, with total respect, honesty and understanding." Their relative told us, "It is all about the way that they talk to you that makes you feel calmer inside."

Staff often performed beyond the scope of their duties, pre-empted people's emotional needs and supported each other as well as people and their families. One person had wished to ride in a Rolls Royce and this had been set up for them. Staff had organised an overnight stay and a meal at a local castle for a young mother and her children. A person who had bought a motorbike for their spouse had become unwell before they could give this present, and staff had organised its delivery at the hospice so this gift could be given by the person. A person had wished to eat in her caravan once more and staff had organised the caravan to be brought to the hospice so the person could eat fish and chips in it. There were blessings and weddings held at the hospice for people who were too unwell to return home. A member of staff told us, "We decorate the garden room and make it as festive as possible." Families were able to stay with their loved ones in 'Z' beds and reclining chairs. A relative told us, "I stayed a whole week at my wife's bedside and the staff became my friends, they checked on my wellbeing every step of the way and were there til the end to support me and give me strength when I thought I could not go on."

The relationships between staff and people receiving support consistently demonstrated dignity and respect at all times. A person told us, "The staff are respectful not only towards my body but also towards my feelings, they always help discreetly in embarrassing situations and go out of their way to make me feel at ease." A nurse told us, "We have a small window of opportunity to make sure we give the right care at the right time and create meaningful human connection with people and their families." Another nurse said, "We stay with people at the end of their life if they do not have families present, as long as it is needed, to make sure people do not feel alone." With such caring approach from staff, people could be confident that staff spent time with them when needed and had genuine concern for their wellbeing.

At a multi-disciplinary team meeting, staff had discussed options about how to support a person who was unwell to visit their spouse in a nursing home. They had also discussed a person who experienced difficulties with their environment and had explored options about how to help them stay in their home. Staff had accompanied a person to the chapel so she could have a quiet time to reflect after she had received bad news. The person told us, "This place is life-giving; the staff are like angels." A GP who referred people to the service told us, "Given their limited resources, they provide an excellent service and they do go the extra mile. One example was the medical director visiting a patient following their death on a Saturday morning; he came to our surgery and spoke with us to come to a solution to help the bereaved relatives, I felt this was showing a willingness to provide extra care and compassion." Staff and people described the medical director as, "Incredibly compassionate and understanding and, "Caring and using such a way to connect with people that inspires total confidence." As staff were pro-active and used a caring and compassionate approach, people could be confident their emotional and psychological needs were taken into account.

Family support was recognised by staff as vital to people's wellbeing and staff strived to meet the emotional needs of people's relatives and families. Where necessary, staff supported people and their relatives to regain their personal strengths, to help them cope and come to terms with illness or death. A relative had commented, "The Family services were simply amazing, many times I called them and they always managed to see me almost straight away; they went out of their way to see me even when they were so busy because they understood how I felt; they have helped me locate my own strength; I cannot find adequate words to

explain how extraordinary these people are, a real lifeline." The Family Services team offered a drop-in service for people and carers, where they could meet others and receive emotional support from counsellors and bereavement volunteers. People could choose how often to come and how long to stay for.

The Family Services team also provided a 'Stepping Stones' service, which is a group work that can be held at evenings for people who worked. Counselling and therapy was available for individuals, couples, families and children, during illness or after bereavement. Counselling was provided with children who were aged four and above, and for children under three, the counsellors worked with parents so they could support their children. Specialised reading material was provided to offer guidance during the bereavement process. Social work support was provided, that included psychological support, advocacy, and signposting for practical matters. The social worker worked closely with parents and local schools on how to support children. There was a welfare advisor who helped people with their entitlements and offered advice on a range of matters such as employment, housing, pensions, utilities and legal matters. Spiritual care played a vital part in the holistic care that was offered to people and their families. The chaplain supervised a team of five bereavement volunteers and provided ongoing daily support. There were four annual memorials remembrance services that included 'Light up a life' service where families and friends could get together and enjoy readings, carols and music. There was a sculpted memory tree where relatives and friends could place a copper leaf with messages for their loved ones. A relative told us, "This is a special gesture that helps us every time we come and visit the hospice." Families were invited four weeks after their loved one's death to attend the drop-in service and discuss the services available to see if they may wish to engage. The Head of Family services told us, "People stay with us six to nine months after the death of their relative; we review how they benefit from our services after twelve sessions and always extend when necessary, as our support always varies according to individual needs." Therefore the service provided emotional support for families that was continual, beyond the provision of care for people.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. This included the complaints procedures and a wide range of booklets and leaflets designed and written by the service, clear to understand and available in different formats. There was a booklet 'Making every day precious' that explained the nature of each service in the hospice to people, relatives and local care homes; there were leaflets on spiritual care, complementary therapies, the Family Support team and counselling, welfare advice, and a booklet about grief and bereavement which explained the grieving process, acknowledging how people may be feeling and giving advice about moving forward. A new 'Welcome leaflet' was in the process of being re-designed and feedback from a 'Hospice User Group' had been sought to that effect.

People and relatives were also signposted to other services and a wide range of leaflets was displayed in the service to that effect, including how to contact other charities, such as two local bereavement support services for children and young people through creative activities and therapeutic meetings. There was information from 'Dying Matters' available. The service had an updated website that contained clear, comprehensive information and that was user-friendly. The service produced a seasonal newsletter titled 'Reflections' where people could read about testimonies, the minibus being available for transport, diarised fundraising events, how to become a volunteer, updates about charity shops, and an introduction to their dementia care programme.

Specialist dementia care was provided as a response to the increase of dementia in the community and was led by a specialist dementia nurse. The specialist nurse told us how passionate they felt towards their role. They told us, "'I had a vision for dementia care and I was supported to deliver it" and their comments in the newsletter included, "It is so important that patients and families are referred to our service at an earlier stage so we can help co-ordinate their care and link in with other agencies to ensure they have the support

they need." There was a testimony from a carer who had been supported by the service in the community. They said, "When I met the dementia nurse, she just understood what I was going through and took problems out my hands so I didn't' have to worry."

People were given support when making decisions about their care and treatment and were fully involved with all relevant planning, from symptom and pain management to their end of life care.
They were proactively supported to express their views and staff were skilled at giving people face to face information and explanations they needed and the time to make decisions. The doctors had held a frank discussion with a person and had tactfully presented a range of options to the person, outlining the positive and negative aspects of each option. This included explanations of the medicines that were available and how pain could be managed. As a result, the person's ultimate decision was respected and the person remained in the hospice rather than undergoing further tests at the local hospital. They told us, "They say it like it is because this is how I want to be spoken with; there is no patronising tone, they are honest, to the point, but also very gentle."

When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. Each person in the In-Patient Unit had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered. People were supported at the end of their life to have a comfortable, dignified and pain-free death and their wishes were at the centre of the service. A relative told us, "My husband has planned every detail, and the staff know and understand what he wants." As staff demonstrated great understanding and empathy, people could be confident that their individual needs were met and responded to in a way that may exceed their expectations.

Staff were in turn supported by the management team if they experienced emotional difficulties due to the nature of their work and were also able to receive counselling. One member of staff told us, "This job is a privilege, and an amazing job, we need to remain as positive as possible to support people who trust us to be just that".

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that staff responded very well to their needs. People told us, "All the staff here know the way I want things to be done because we communicate very well" and, "When I became ever so upset the staff just knew what to do." A relative told us, "They have good activities here, it keeps people occupied and distracted, they do lovely things."

The doctors and clinical nurses followed a process based on the 'Gold Standards Framework' for their assessments. The Gold Standards Framework is a systematic, evidence based approach, developed to improve quality of care for patients with a life-limiting illness, adopted by all organisations providing end of life care.

People's needs were assessed before support was provided in the community and as soon as they came into the Inpatient Unit for respite of for a longer stay. We looked at ten records of people who received support either in the community or in the Inpatient unit. People had been asked about their physical condition, medical history, their symptoms, preferred place of care, whether they had documentation about their resuscitation status, and whether they had a legal representative.

There were no records to indicate that people were routinely invited to take part in 'advance care plans' (ACP) and supported during the process. These plans give people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to be their legal representative. There were blank ACP booklets provided to people, however the Head of Community Team told us, "We give them and people just don't fill them in so we don't use them." The staff we spoke with told us they did not spend time with people to support them with devising advance care plans. As a result, people did not have advance care plans when they were admitted to the Inpatient Unit after having been supported in the community. This meant that people may have less opportunity to consider decisions about their treatment and options ahead.

A form had been appropriately completed by a person who had expressed a decision in advance to refuse a certain treatment. Minutes of a multi-disciplinary meeting indicated an ACP had been thoroughly discussed and explained to this person by the medical director before they moved to a nursing home. However we were told that the documentation of ACP for people was not standard practice. The CEO, the acting manager and the medical director were aware of this shortfall and were in process of introducing a system of advance care planning that would ensure people's wishes were documented and also reviewed regularly as people's wishes changed. This was part of an improvement plan. As an ACP system was not yet implemented, embedded and sustained over time, this is an area for improvement which we will review at our next inspection.

Admissions to the In-Patient Unit ensured that people received a management plan of their symptoms,

emotional and spiritual support, pain relief and specialist care. Comprehensive assessments of people's pain were carried out. This identified the pain's site, character, intensity, and what increased or relieved it. There were honest discussions with people about what they could expect and how the services available may support them.

People's care plans included strategies with regard to their pain and symptom management that were updated on a continual basis. For example straight after visiting people in their rooms, and during daily professional meetings, doctors updated their care plans on a laptop computer to ensure nothing was missed. The updates included changes in people's health and about 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. People were offered different options of pain relief and were supported to make an informed decision. A relative told us, "The doctors understand how important it is to be pain-free." This meant that when people's pain increased they could be confident that responsive action of their choice was taken.

People's wishes were not appropriately documented during the assessment and care planning process. Staff were aware of people's care plans that clearly outlined how to manage people's illnesses and their symptoms. However there were very few details of people's likes, dislikes and preferences such as about their daily routine, whether they favoured a particular therapy, food, or had any specific requirements. There were daily logs where staff wrote when a person had declined to have a shower or liked to sit upright in bed for example. Staff were knowledgeable of people's likes and dislikes as they talked with people, and exchange information with each other at handovers. For example a member of staff told us, "This person likes to bathe late at night." As records were incomplete, new staff may be unfamiliar with people's preferences.

We discussed the lack of documentation in regard to people's likes and dislikes in their care plans with the acting manager. The acting manager was in process of introducing a system that would ensure people's wishes, preference and specific requirements were documented and also reviewed regularly as people's wishes changed. This was part of an improvement plan. As this system was not yet implemented, embedded and sustained over time, this is an area for improvement which we will review at our next inspection.

There were additional care plans that were updated hourly when people approached the end of their life, to monitor closely their comfort and respond to their changing needs. The care plans were centred on the individual, included food and drink, symptom control and psychological, social and spiritual support. Sensitive communication took place between staff and the person, and those identified as important to them. Therefore people's needs in the last hours of their life were met by well-informed staff who were knowledgeable about people's individual requirements.

The service used a 'dementia trolley' that included signage to transform any room in the Inpatient Unit into a dementia friendly environment.

There was a range of activities available within the hospice. A staff member commented that activities within the hospice were 'good and about to get better' as there were plans to increase the range of activities available. The service had recently won a competition to get some help with landscaping their garden and they had plans in place to develop accessible horticulture facilities through putting in raised beds. Special events were held within the day centre and this had included chocolate making, a visit from a magician and special events to celebrate Christmas. Plans were in place to introduce 'Tai Chi' as an activity. There was a timetable in place which included therapeutic art, an exercise group, relaxation and reflection time run by the service's chaplain. A staff member we spoke with about activities described to us why it was important

that they were planned around people's interests. They told us 'We ask what their interests are, get a sense of what other activities may suits them and make them individual." There was a dementia café which was well attended. The hospice had recently purchased a minibus and people had enjoyed outings to a museum in Maidstone and a local boat trip at a nearby lake. Staff were also providing activities for people in their rooms if they were not able to access the day centre. For example, people would be supported to create memory boxes if they wanted to do so. As visitors were welcome at any time of day or night, and as they were enabled to remain overnight with their family members if they wished, social isolation was reduced.

Links with the community were actively sought and maintained through a series of fundraising events and challenges. These included sponsored golfing days, marathons, fun runs, moonlight walks, countryside walks, fire walks, bike rides inland and abroad, skydiving and trekking in the Sahara desert. A relative who was taking part in these events told us, "These really brings the whole community together and makes our bond with the hospice even more special." Such events improved people's experiences as they were actively included and connected with their local community. There were approximately 600 volunteers supporting the service, 14 shops and the café. Two volunteers told us, "This hospice is marvellous, it is vital for the community and does so much good, it is an honour to support them" and, "We have made so many friends with patients, carers, their families, this hospice has brought so many people together."

Annual surveys were used to gather people's views of the services provided, the staff approach, the environment, and the food. The last survey had been carried out in December 2015 and sought feedback about the results showed consistently high levels of satisfaction with the service. Some of the feedback had led to the complaint procedures being displayed more prominently, such as on a notice board 'You said, we did' that showed new furniture had been purchased. Comments cards were available in the reception areas.

Four complaints had been received by the service since our last inspection. The logs of responsive action taken in regard to two complaints dating 2014 did not include the results of any investigations carried out, which may have meant that no lessons had be learnt from these complaints under the previous management. However, further logs in January 2016 under new management showed an appropriate documented response which indicated responsive action had been fully undertaken.

Requires Improvement

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people, which staff promoted throughout the service. People's feedback about the way the service was led was mixed, with some describing it as "Well managed", "There seems to be several teams that do their own things but they do it very well", "There has been quite a few changes of staff lately and a lot of new staff on board so it needs time for it all to settle." A relative told us, "The new acting manager seems to be on the ball." Staff told us, "The new manager is very brave, she is a 'do-er', she has stepped in to organise the staff and she has her work cut out" and, "We don't really know what is happening as there are so many changes and we are not sure whether the temporary manager is here to stay or not." The Chief Executive Officer (CEO) told us that the provider was shortly to clarify their position regarding a permanent arrangement for the management of the service and that staff would be informed as soon as possible.

Five directors including the acting manager, a medical consultant, a finance and central services director, an income generation director as well as the Head of HR were overseen by a CEO who had been in post for nine months. The acting manager had also been in post for approximately seven months and oversaw the Inpatient Unit, the Community Team, and the Outreach services such as Family services, Day Therapy service, Training and Education, Therapy services and four specialist nurses who were leads in dementia, nursing homes, hospital A & E, and enablement. She was closely supported by the CEO in order to devise new monitoring systems and see them to effective implementation. To this effect, the acting manager had created a 'live action plan' that set clear steps of how to improve the service.

This improvement plan was comprehensive and included checks and programmes regarding audits, team meetings with all departments, medicines management, policies, the environment, incidents reporting and complaints, mental capacity assessments and safeguarding, nutrition and hydration, wound care, staff training, supervision and appraisals and 'compassionate leadership'. This addressed how to support staff through changes, improve the manager's visibility and internal communications. Each section of this plan had a review date to monitor the progress and an estimated completion date.

A report had been produced following a visit from one of the trustees from the hospice. This report highlighted areas were improvements could be made and demonstrated that the trustees were taking a close interest in what was happening within the service. For example, there were plans to ensure that trustees were regularly visiting the hospice to ensure good governance and support for the staff who managed and ran the service. There was a governance committee in place as part of the board of trustees which looked specifically at concerns relating to the overview management of the service.

The acting manager had achieved a considerable amount of improvements since she had been in post. Working groups had been created to oversee the development of a 'Hospice at Home' model, the improvement of the referrals system using a new computerised system, how to introduce case reviews at multi-disciplinary meetings, and how to re-introduce clinical supervision to all clinical staff. An audit and research group had been created in September 2015 to maintain an audit time table, approve additional audit proposals, and set dates for audits to be carried out, review them and write an action plan to meet any

identified shortfalls. The clinical management team met with the audit and research group monthly to discuss outcomes of audits, review policies, key performance, safeguarding, and the 'Patient Safety Thermometer' which was a record of incidents and accidents. The Head of Training and Education had set up a workshop 'Walk through audit' as a refresher for staff about the auditing system. This workshop was ongoing to ensure all staff were able to attend. The acting manager told us, "Audits must be done properly and the process to implement them in each department takes time but this is a work in progress and we are getting there; once all improvements are clearly identified we can get on with monitoring the systems effectively." However, the audits that had been carried out had not identified all of the breaches in regulations that we found. New monitoring systems were in process, however as these were not yet implemented, embedded and sustained over time, this is an area for improvement which we will review at our next inspection.

The acting manager had carried out an audit to check whether a mobility and safety care plan had been written for all people admitted in the Inpatient Unit, their time frame for completion, and whether they had been reviewed after any incidents such as a fall. As a result, staff were reminded to complete these care plans within a time frame; people's cognition, visual impairment and fear of falling were introduced as part of the assessment; sensor mats had been purchased.
An audit about infection control in January 2016 had identified four shortfalls and all had been remedied without delay. As a result, waste disposal equipment had been purchased, and a new system to record cleaning schedules had been implemented.

The provision of 'Bite size' training sessions on a wide range of topics relevant to care had been introduced to care and nursing staff by the acting manager. A member of staff told us, "This is a good idea and the format means we get really useful information within a short period of time; this allows us to learn and also get on with our job."

The acting manager took part in a monthly meetings, as well as weekly informal meetings, during which objectives of the organisation and its contingency plan were discussed. These meetings were appropriately recorded. Every six weeks, the acting manager attended a 'Hospice User Group' that included supporters of the hospice. This group had taken an active participation in writing the hospice booklet on bereavement, and had requested new chairs in Magnolia Place. This had been implemented.

Action had been taken to drive improvement in staffing levels to ensure people were cared for by specialist staff and 12 key staff had been recruited since our last inspection. This included the appointment of a medical director, a dementia specialist nurse, a full time occupational therapist and an A&E nurse who will assess all palliative cases in the local hospital A&E to help prevent hospital admissions.

A programme to up-skill and train volunteers to enable them to assist care workers and give direct patient care had been recently implemented. This innovative service development was closely monitored to check that this benefitted people, their families and the multi-disciplinary team. A volunteer told us, "This is extraordinary work, we have had excellent training and always work alongside the staff; we have our special uniforms and we feel part of the team." A person who stayed in the Inpatient Unit told us, "This is a brilliant idea; why not tap into such a valuable resource when the volunteers want to help." The outcomes of the acting manager's evaluation in regard to this programme were due to be submitted for presentation at the Palliative Care Congress 2016.

Staff forums were held quarterly at the service to ensure that staff were engaged with developments within the service and made aware of developments within the sector. These included 'Questions and answers' sessions. For example, the acting manager had provided a topic relevant to care to each head of

department for them to discuss with their individual team and report their findings to the forum. This provided an opportunity for staff to think about current practice and identify how this could be improved. Staff surveys were carried out, although the last survey was carried out two years ago. The CEO and acting manager told us that an annual staff satisfaction survey will be introduced. However, staff were able to voice their views in other ways. For example, there was a comments and suggestions box in three locations in the hospice, available to people, staff and visitors. These were emptied weekly although this was seldom used. A member of staff told us, "If we have a problem or a suggestion to make, we just go and talk with our head of department or with the acting manager." The CEO had created a workshop attended by 17 staff to discuss their views on the Assisted Suicide Bill. Staff views were listened to and informed the creation of a statement about the hospice position on this issue on their website. Staff in the Inpatient Unit had been consulted about redecoration schemes at monthly team meetings and their views had been acted on.

The service participated in a project set up by the National Palliative and End of Life Care Partnership, which is a group of national organisations with experience of, and responsibility for, end of life care. Its members had come together to produce a framework to improve palliative and end of life care for local action between 2015 and 2020 and had set six ambitions. The medical director sat on its committee and the acting manager told us how the service was committed to achieve set goals, such as ensuring each person had fair access to care.

People's feedback was sought and acted on. The service had taken part in a service evaluation of 52 specialist palliative care services led by the Association For Palliative Medicine (APM) in August 2015. This addressed people's levels of satisfaction in Inpatient Units, community teams and family support teams. In addition, annual satisfaction surveys were carried out by the hospice inviting people being cared for in the Inpatient Unit and their relatives to give their feedback. The results were analysed to identify how the service could improve. The last survey took place in December 2015 and included comments such as, "A wonderful unit", "the service and the staff are faultless" and, "First care and attention from all at the hospice, and I feel the attention given is real and personal." Some people said they were unaware of the complaints procedures and as a result, the complaint procedures were displayed more prominently in the reception area.

A new electronic record system had been introduced to store and update data about people's care that was still in its development and improvement stage. Archived records were kept for the appropriate period of time in accordance with legal requirements and disposed of safely. All records relevant to people's care were kept securely and confidentially. However the documentation regarding staff training, Advance Care Planning, people's individual likes and dislikes, complaints logs and recruitment was not appropriately completed. The failure to maintain accurate complete records is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. Medicines were not properly and safely managed. This is a breach of Regulation 12 (1) and (2) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Documentation regarding staff training, Advance Care Planning, people's individual likes and dislikes, complaints logs and recruitment was not appropriately completed Systems and processes were not established and operating effectively to ensure compliance. This is a breach of Regulation 17 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Lack of staff competency checks. Staff did not receive appropriate support, training, supervision as is necessary to enable them to carry out their duties. This is a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.