Kirkwood Hospice

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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?	**Outstanding** ☆
Is the service responsive?	**Good** ●
Is the service well-led?	**Good** ●

Summary of findings

Overall summary

This inspection took place on 7 September 2016 and was unannounced. The service was last inspected on 26 November 2013 and at that time the service was meeting all the regulations we inspected.

Kirkwood Hospice provides treatment for people who have advanced, progressive life-threatening illnesses such as cancer, neurological diseases, advanced heart and lung disease and end stage kidney failure. They provided 'in-patient care,' for up to 16 people. People are admitted to the in-patient unit for symptom control and medicine reviews and to support people and their families with their illness and treatment plans. The average length of stay at the hospice was seven days. There were 11 people using the in-patient hospice beds at the time of this inspection.

The service had a registered manager. 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.

People we spoke with told us they felt safe at Kirkwood Hospice.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse. The provider had safe recruitment and selection procedures in place.

There were enough staff to meet people's needs in a timely manner and medicines were managed in a safe way for people.

Staff had received an induction, supervision, appraisal and specialist training to enable them to provide support to the people who used the service. An effective overview of staff training and supervision was in the process of being developed to ensure staff were up to date with their training and development needs.

Staff were supported to maintain their professional registration where appropriate, reflect on and improve practice and share learning and expertise to support with the local community.

People's consent to care and treatment was sought in line with legislation and guidance.

Meals were planned on an individual basis and people could choose from an all-day menu. People's dietary requirements were catered for and people told us catering staff went the extra mile to meet their individual preferences.

A multidisciplinary team of healthcare professionals was available on site and effective liaison was evident between community professionals and the staff team.

The environment was clean and comfortable. It was also very well designed and maintained to accommodate people's individual needs and promote their well-being.

People who used the service told us all the staff were excellent, showed compassion and went the extra mile to involve them in decision making and to support them with their end of life wishes.

We saw staff were caring and supported people in a way that maintained their dignity, privacy and human rights. People gave us examples of how they had been supported with compassion and sensitivity.

Staff were passionate about enabling people to experience a comfortable, dignified and pain free death. We saw the service provided holistic support, which included the persons family and support network.

People were supported to be as independent as possible and people's cultural and religious needs were central to service provision.

People told us they were involved in their care planning and we saw they received personalised care that was regularly reviewed.

People were able to make choices about their care. Care plans detailed the care and support people required. From talking with people who used the service, their relatives and staff we were confident person-centred care was being delivered. Although some care records lacked information about personal goals a new project was being implemented to address this.

A range of activities were provided for people. Friends and family were welcomed to the service at any time.

Comments and complaints people made were responded to appropriately and any learning was reflected upon and implemented.

People using the service and their relatives told us they were very happy with the service.

The culture of the organisation was open and transparent and the registered manager was visible in the service.

People who used the service, their relatives, and staff were asked for their views about the service and they were acted upon.

The registered manager had a range of effective audits and quality assurance measures in place and was in the process of improving oversight of staff training and supervision.

The registered provider had an overview of the service and the board of trustees received regular reports to enable them to monitor and improve the quality and safety of the service.

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.

Medicines were managed in a safe way for people.

Staff had a good understanding of how to safeguard people from abuse. Robust recruitment practices were followed to ensure staff were suitable to work in the service.

The environment and premises were well managed and appropriate safety checks took place to ensure people's safety.

There were always enough staff to meet people's assessed needs.

Is the service effective?

Good ●

The service was effective.

Staff were provided with training to ensure they were able to meet people's needs effectively.

People's consent to care was sought in line with legislation and guidance.

There was a choice of meals and all preferences were catered for.

People had access to health and social care professionals as the need arose.

Is the service caring?

Outstanding ☆

The service was caring.

People told us the staff who supported them were very caring and went the extra mile to fulfil their wishes.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible and direct their own care.

People's religious and cultural needs were respected and person centred end of life care was delivered in line with people's individual wishes.

Is the service responsive?

Good ●

The service was responsive.

People were involved in the development and review of their care plans and their choices were respected.

People told us they knew how to complain and told us staff were approachable.

Is the service well-led?

Good ●

The service was well led.

The registered manager was visible within the service.

The culture was positive, person centred, open and inclusive.

The registered manager and registered provider had a system in place to assess and monitor the quality of service provided.

Kirkwood Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 09 September 2016 and was unannounced. The inspection was conducted by two adult social care inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The area of expertise of the expert by experience on this inspection was as a family carer. Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding team, the clinical commissioning group and Health Watch. The provider had returned a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing the support people received and the environment. We spoke with five people who used the service and six of their relatives or friends. We also spoke with two doctors, two care workers, three nurses, one social worker, the premises and support coordinator, a physiotherapist, a cook, the registered manager and the deputy manager. During our inspection we spent time looking at four people's care and support records. We also looked at three records relating to staff recruitment, training records, maintenance records, and a selection of the service's audits.

Good ●

Is the service safe?

Our findings

People we spoke with told us they felt very safe at Kirkwood Hospice. One person said, "I felt safe as soon as I came to the hospice", and another person said, "I felt safe and relaxed after the stressful time previously." A third person told us, "Nothing is too much trouble. If I have pain they bring an injection really quickly. There's no waiting it's amazing, they are so kind", and a fourth said, "When I buzz they are there, not immediately but very quickly."

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and understood the procedures to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One member of staff said, "I would have no hesitation in reporting anything that concerned me." This showed staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

We saw safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and the Care Quality Commissions (CQC) had been notified. This showed the registered manager was aware of her responsibility in relation to safeguarding the people they cared for.

The members of staff we spoke with understood people's individual risks and how to ensure risks were minimised whilst promoting people's independence. We looked at four care records of people who used the service and saw risk assessments were in place for a range of issues including pressure area care, choking, risks related to specific health conditions, mobility and falls. We saw risk assessments were reviewed regularly and were up to date. This showed us the service had a risk management system in place which ensured risks were managed without impinging on people's rights and freedoms.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed for each one. We sampled three incident reports and saw evidence each incident had been reviewed for the cause of the incident and measures had been put in place to reduce future risks to individuals who used the service.

We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they had an overview of the safety in the service.

We checked staffing levels. There were four nurses and four care workers on an early shift; three nurses and four care workers on a late shift and two nurses and three care workers at night. There were also medical staff and other staff in supporting roles such as, volunteers and therapy staff. Therapy staff included physiotherapists, occupational therapists, social workers and complementary therapists. We spoke with two doctors. One doctor told us, "We are both here four days a week. There are between two to four doctors here every day." The staff team helped to ensure people's physical, emotional and social needs were met.

Staff told us there was an 'on call' system for accessing out of hours medical cover. We spoke with two doctors who told us that there was always one doctor on call and a consultant to ensure people's medical needs were met. One member of staff said, "If we are busy or some patients need extra care then they get extra staff in to help. There is a staff bank we use." This showed the service had contingency plans in place to enable it to respond to unexpected changes and meant the service to people using it could be maintained.

Staff told us there were sufficient staff deployed to meet people's needs. One staff member said, "We have time to sit and talk to patients. We do have a good staffing ratio to provide quality care." We saw staff carried out their duties in a calm, unhurried manner. We saw appropriate staffing levels on the day of our inspection which meant people's needs were met promptly and people received sufficient support.

We looked at the systems in place for medicines management. Medicines were supplied by a local pharmacy under a service level agreement. The service was available Monday to Saturday during normal working hours; medicines were available from the local hospital pharmacy outside of these times. Medicines were stored securely with access restricted to authorised staff.

There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and we saw evidence that staff carried out routine balance checks.

Medical staff checked (reconciled) patients' medicines on admission to the service by checking with their GP. Medicines were given as prescribed and administration records were completed clearly to show the treatment people had received. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Medicines requiring refrigeration were stored securely and temperatures had been recorded. We found gaps in records on four days in August 2016, however, all of the temperatures that had been recorded were within recommended limits. The registered manager told us they would address the gaps in recording with staff.

'When required medication analysis' charts were completed by nursing staff for each administration, including homely remedies, detailing their reason for giving the medicine, the action taken, and the outcome, although some 'when required' administration records lacked details such as minimum dose intervals. The registered manager told us they would address this. Having a PRN protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

There were adequate supplies of emergency medicines and oxygen, and a system was in place to ensure these were fit for use. The service did not have access to a defibrillator and as no risk-assessment had been undertaken with respect to this the registered manager told us they would complete a risk assessment to address this.

Blank prescription pads were stored securely; doctors recorded when prescriptions were issued but there was no log of prescriptions received into the service as set out in national guidance. The registered manager told us they would address this.

Policies and procedures were regularly reviewed and covered all aspects of medicines management. Arrangements were in place to ensure medicines incidents were reported and investigated through the service's governance arrangements and staff we spoke with described an open culture with regards to reporting and learning from medicines errors.

We reviewed records which showed staff undertook medicines management training and checks of their competence annually. This meant people received their medicines from people who had the appropriate knowledge and skills.

The clinical services director told us the service did not routinely audit medicines management, but that they did undertake safety walk arounds every two weeks. They also held regular clinical governance meetings, however this system had not detected some of the minor shortfalls we identified during our inspection. The registered manager told us they would review medicines audit processes to ensure all areas were addressed.

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people. This showed staff had been properly checked to make sure they were suitable and safe to work with vulnerable people.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. A premises and support coordinator was employed and a schedule of planned maintenance ensured the environment was well maintained. Service contracts were in place for areas such as, fire safety, Legionella and electrical installations. A series of risk assessments were in place relating to health and safety.

Appropriate equipment was in place to meet the needs of people who used the service for example ceiling tracking hoists and profiling beds with air flow mattresses. Equipment had been properly maintained and serviced.

The staff we spoke with knew what action to take in the event of a fire. People who used the service had a personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported when the building needs to be evacuated. We saw staff training in fire safety was up to date and fire drills occurred regularly. This showed the service had plans in place in the event of an emergency situation.

There was a comprehensive cleaning schedule in place and all areas we viewed were very clean and hygienic. Staff had access to protective clothing such as, gloves and aprons and we observed staff washing their hands before and after contact with people to help prevent and control the spread of infection.

Good ●

Is the service effective?

Our findings

Staff were provided with training and support to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. This demonstrated that new employees were supported in their role.

Staff told us they regularly undertook training to enhance their role and to maintain their knowledge and skills relevant to the people they supported. A quality and education manager was employed and we saw staff had carried out training in safe working practices. Staff told us they had also received specific training to meet the individual needs of people who used the service such as palliative care, dementia care, wound care, diabetes and Motor Neurone Disease. One member of staff said, "I have also done a best interests assessor module."

Staff were involved in sharing good practice and practice education. A doctor told us, "We are involved in the nurses' education. We also do evening (training) sessions." Some staff told us they also worked at the local NHS Trust. One staff member said, "I share practice at [name of hospital] and then I pick up ideas from the hospital. They were using some really good falls equipment at the hospital, falls mats and sensor tags so we now have that equipment here."

One care worker told us they had completed nationally recognised training in health and social care at level three and they were being trained and supported to develop competencies to enable them to complete further tasks, such as monitoring blood pressure. The manager told us one care worker was being supported with time off to complete registered nurse training through the Open University.

We saw from training registers staff had attended courses in the last two months such as 'The last week of life', 'Posture, wheelchair, hoist and bath seat', training and, 'Dying with dignity: an Islamic perspective.' Mandatory training included safeguarding adults from abuse, infection control, food hygiene and use of safety belts. However, evidence to confirm which training some staff had completed was not always available at the hospice to provide an effective overview of staff training needs, as some staff kept their training certificates at home. The registered manager told us this was being addressed as all training was in the process of being recorded on their computerised management system to provide a more effective overview.

Competency assessments were carried out on a number of areas. Designated competency assessors had been appointed in areas such as moving and handling, syringe drivers and blood sugar and health monitoring equipment. This meant there was a system in place to check staff were following the correct procedures and delivering safe and effective care.

Staff told us they felt very well supported by the registered manager and the rest of the hospice team. Comments included, "[Name of manager] is very supportive", and, "We also turn to each other for support."

Staff we spoke with told us they received supervision and appraisal to monitor their performance and development needs. Staff supervisions covered areas of performance and also included the opportunity for staff to raise any concerns or ideas. The registered manager told us and our own checks confirmed that sometimes staff kept their own supervision records at home. There was no clear overview of staff supervision to ensure all staff received supervision in a timely manner. The registered manager told us this was also being addressed as all supervision and appraisals were in future to be recorded on their computerised management system.

Staff informed us clinical supervision meetings and debrief sessions were held for the staff. Nurses were supported with their revalidation with the Nursing Midwifery Council (NMC). Revalidation is the process which nurses must undergo to maintain their registration with the NMC. A clinical supervision news bulletin was produced which gave staff information on various aspects of clinical supervision. We read that a staff member had commented, "I love coming to clinical supervision! It's a relaxed place to discuss things which are hard to discuss on the in-patient unit. It's great to hear other people's ideas, views and thoughts and take those into account. It's reassuring to know it's confidential too as it makes me more prepared to discuss issues important to me."

'Champion' roles had been identified for staff who had a particular interest in certain areas. Wound care champions supported good practice in would care management in palliative care within the service and nationally through publications. Champion roles also included diabetes, Mental Capacity Act and Deprivation of Liberty Safeguards, nutrition, the discharge process, Motor Neurone Disease, spirituality and catheter care. One staff member told us, "Being a champion gets you involved. It helps us focus on our strengths and interests and share our knowledge which helps make sure that patients receive quality care which is based on best practice." In addition to the staff champions the hospice had appointed an Admiral Nurse. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope. Training was also provided to volunteers and the role of safety champions was being developed.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in hospices are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked the registered manager about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. The registered manager told us and records confirmed that two DoLS applications had been authorised by the supervisory body in line with legal requirements.

Staff demonstrated a good understanding of the MCA including how to support people with making decisions and choices. One of the doctors with whom we spoke said, "I have been involved in the mental capacity proforma and making sure that we can document best interests. We are very proactive in checking capacity." The social worker told us, "We have a resource pack for MCA and DoLS. They do now get it right with MCA. Before I would ask at meetings, 'Does this person have capacity? Have you done a mental capacity assessment?' but now staff are saying 'We've done a mental capacity assessment'."

We saw from people's care records that their mental capacity had been assessed and, where appropriate, best interest meetings had been held. This meant the rights of people who used the service who may lack the capacity to make certain decisions were protected in line with the Mental Capacity Act (2005) and guidance.

We saw people were asked for their consent before they received any support and the service acted in accordance with their wishes or in their best interests.

There were effective systems in place to facilitate communication amongst staff and between organisations. Staff used an electronic patient record system that connected information about people across a number of healthcare settings.

Staff met three times a day for a review and handover of patient care. We attended a staff handover meeting at the beginning of the afternoon shift. Information about people's physical and emotional condition was discussed and also the needs of their relatives and representatives. We heard one person's medicine had been increased via their syringe driver. A syringe driver is a small pump which releases a dose of medicine at a constant rate. The staff member also told the meeting, "Discussed end of life wishes [with name of person]. They do not want to die at home." This handover procedure helped ensure that person-centred care was delivered safely, effectively and in a timely manner. Staff at the service assessed people's needs and used a recognised tool (Palliative Care Outcome Scale or POS) to check people's progress and ensure the service provided was effective. This information was then analysed to evidence and improve the effectiveness of the service.

People we spoke with were complimentary about the food and the catering staff who they said took time to find out their likes and dislikes. One person said, "I would like the prawn cocktail and then when it came I didn't fancy too much of the sauce. So the lady said, "Don't worry." and returned with this separated so that I could put as much sauce as I wanted on. It was so kind. They go the extra mile." Another person said, "Nothing is too much trouble for them."

We checked how people's nutritional needs were met. People who used the service had access to an all-day menu and were able to request drinks and snacks at any time. A kitchen was also available for people and their visitors to help themselves to drinks and snacks or prepare their own meals. Chilled jugs of water were accessible at all times and changed regularly during the day.

We saw there was a wide choice of menu and the likes and dislikes of each person were recorded in the kitchen. We saw the portion sizes varied according to the person's requirements and wishes and the meals were well presented and appeared appetizing.

The cook was knowledgeable about people's nutritional needs and about the fortification of food. She told us, "We had a patient who didn't want to eat because they had a sore throat and mouth so I made them some milk ice lollies as they are not as citric as the fruit ones." She also said, "We have someone here who requires Halal meat, however they have chosen to have a vegetarian diet whilst they were here, but getting Halal meat would not be a problem. I also make milk shakes with ice cream, fruit and cream and we also do Fortisip jellies (nutritional supplement). If we can build up a patient we will." This meant people were supported to ensure they received sufficient nutrition and hydration to meet their needs.

People were supported to access health professionals as the need arose. One staff member said, "We have consultant-led ward rounds three times a week." A wide range of therapies were available in addition to medical and nursing care. These included complementary therapies such as aromatherapy and massage.

This helped ensure that people's needs with regards to relaxation and general wellbeing were met.

Two social workers were employed who were registered with the General Social Care Council. Part of their role was to provide information and advice about finances and assist people with planning for their future as well as providing emotional and psychological support. This demonstrated the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were being met.

The premises were designed to meet the needs of people who used the hospice. People could usually choose to stay in a shared bay or a single ensuite room. The physiotherapist said, "The bays work at bringing some patients out of themselves, but of course if a patient's condition deteriorates, being in this area would not be as beneficial and we would look to move them to a single room if this is what they wanted." Single rooms had pull down visitor beds. The physiotherapist told us, "The [visitor] beds are so important, relatives appreciate being able to be near to their relative at all times." Room temperatures could be controlled by people using the service.

Each of the individual rooms led out onto private verandas which had their own power supply. The physiotherapist told us, "Having the power supply means that patient's beds can be taken outside and they can access the sunshine and fresh air. The beds themselves can be adjusted so they are chair shaped."

There were tea and coffee making areas for people and their relatives to use. There was also a children's play area which was well stocked with games and activities. A quiet room, used for prayer and refection, was an integral part of the building which people and their relatives could use at any time.

There was a smoking room in the hospice which people could use. Staff and visitors could not use this room. Other than the smoking room, the hospice was a smoke free site.

The service had been designed to provide a relaxing atmosphere with photographs and art works in communal areas. We saw an adapted bath was provided with a docking point for people to play their own music with relaxing lights. There were seating areas for people in the garden and patio areas. This meant the design and layout of the building was conducive to providing a personalised, homely but safe and practical environment for people who used the service.

Is the service caring?

Our findings

People we spoke with told us the staff were very caring and went the extra mile to make them comfortable and anticipate their needs. One person said, "They second guess what's needed. She (staff member) bought me a warm cushion as she knew I was developing discomfort. I didn't have to ask she just knew." Another person said, "I feel safe here, the quality of care is excellent. I can see a doctor when I need to." Another person told us, "The staff are kind. I've been given my personality back." And another said, "The night staff are really attentive, keep popping in but don't disturb you." One person told us their dog was allowed to visit and said, "You can't do that anywhere else can you?"

Staff spoke passionately about ensuring people's needs were at the forefront of everything they did. One staff member told us, "I love it here." They were also able to describe how they went above and beyond to meet people's needs in a person-centred way. One staff member said, "If things are happening at the end of shift times, staff will often stay or pop in at weekends." Another staff member said, "The comments and cards we get from families are testament to the care we provide." We read a sample of thank you cards which had been received. We saw that relatives were extremely complimentary about the care and compassion which staff had shown their loved ones.

Staff gave us examples of care and compassion which they had demonstrated when helping people accomplish their last wishes which gave people a sense of achievement, happiness and peace before death.

The physiotherapist told us one person had wanted to go to the beach but were too ill to go. Staff had built a small beach hut and beach area in the garden so the person could still get the "seaside experience." This was confirmed by our own observations. A member of staff told us, "It's just the little things like this. We have had weddings here and parties – we make things happen." The physiotherapist said, "We had a lady who wanted a sleepover with her daughter and wanted a movie night. We didn't have a DVD so we went to buy one and went to get popcorn", and, "We had a choir come in and one of the patients was too poorly to get out of bed so we wheeled her bed around to where they were singing so they could hear."

The social worker told us, "One patient had a DoLS in place; however, this did not mean that they couldn't go out, there were conditions we needed to put in. He wanted to go home, so we organised a volunteer driver and we took him home and he actively directed us – his face was a picture. When he got to his home, he wanted to come back to us, he'd been back (home) and he'd seen. I was so pleased I went and saw his reaction. We can still make things happen."

People were supported to make choices and decisions and their wishes were acted upon. The cook told us, "At the end of the day, we can go home and have whatever we like, but they can't, so if someone says, 'I want a fillet steak,' I have been known to phone my husband up and ask him if he is passing a butchers to bring in a steak so I can cook it for them (the person)", and, "They can have whatever they like. I've just done a picnic for this afternoon for a patient and her family. We have also done weddings and buffets here." We saw the picnic which had been prepared consisted of an Indian and Chinese snack selection, sandwiches, a fruit platter and cakes.

We saw positive interactions between staff and people. We spent time at an exercise class and observed that the staff member was positive and encouraging with both people who were attending, using humour to encourage people. The staff member said, "They would be a 10 on Strictly Come Dancing."

Many people at the hospice were very poorly and we did not want to intrude on people at this critical time in their lives. We saw that people looked comfortable and well cared for.

Staff were aware of people's spiritual and religious needs. There was a spiritual care co-ordinator who was available to people who used the hospice and their families. One staff member said, "We had one patient who is a Muslim and his room was facing the wrong way so we changed his room prior to admission. We are always mindful of cultural needs. [Name of spiritual care coordinator] is taking the staff around a Mosque. We have good links with all spiritual leaders and churches." This meant people were supported and enabled with their individual spiritual and cultural needs.

Staff informed us that pets were welcome at any time. They recognised the importance that pets had on people's lives and the positive benefit seeing their pets had on the patient. One staff member said, "Pets are welcome any time. Pets are so important to patient's well-being."

People told us staff were attentive to their communication needs and people had access to community languages as needed. There was an information room at the hospice with leaflets giving people information about a variety of areas such as finance and support for carers. The social worker told us, "We now have an agreement with social services so we can access interpreting services quickly. Before this, [the interpreting service] was difficult to access quickly and so when I met with the CCG and social services, I said, 'How can we do things differently?' We now have direct access to community languages."

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We saw a nurse helped clear a person's lunch tray asking permission to move their personal belongings. She chatted with the patients and it was evident by their conversations that there was a good rapport between them.

We saw staff were respectful of people's privacy; they knocked on people's doors and asked permission to enter. One person told us, "This morning when I had a bath for the first time in a long time they were kind and covered me with a towel to stop any embarrassment that was nice, less embarrassing. I didn't mind then whether it was a man or a woman helping." Staff told us they kept people covered during personal care and closed curtains and doors. As the bedroom doors opened directly into an area with staff passing, the registered manager had ordered dignity curtains for the doorways to enhance the privacy of people's bedrooms.

People were encouraged to do things for themselves. One person who used the service told us, "The staff were very kind and worked with me to get to be able to be transferred; I have lost use of my legs. We tried several different ways to assist with helping me move out of the bed and eventually decided the hoist was going to be best. This was my decision. It saved my dignity. Staff listened to me and then helped me to make decisions." We spoke with a physiotherapist who was helping to develop and implement the new rehabilitative palliative care approach at the hospice. She said, "There is a change of practice and focus. It's all about rehabilitation and about promoting independence. Instead of tucking up people in bed, it's now about enabling people to do what they want." This showed people using the service were encouraged to maintain their independence skills and direct their own care.

The service followed the five priority principles contained within the 'One Chance to get it Right' report.

These included recognising the importance of effective communication between people, staff and their representatives, involving people in their care, exploring the needs of people's families and ensuring that people had an individual plan of care. The service had been proactively involved in developing and used a regional 'Individualised Care of the Dying Document' (I-CODD) which was a personalised plan for end of life care for people in the last few days of life. A guidance document about the ICoDD which stated, "Using the I-CODD document helps staff to meet these individualised needs and guides them to delivering the best care they can at this time." This ensured people's individual needs and wishes were met at the end of their life.

Staff cared for the whole family. They supported people to visit their home and go out on trips with family or friends. 'Share and Care Group' sessions were held. The social worker told us, "These are not only educational, but provide a social support system for relatives. We discuss things like moving and handling, nutritional and pressure area care. It's about supporting families to care for people in the best possible way and it provides a safe, comfortable environment for people (relatives) to ask 'How do I do this?'" Carer's Retreat sessions were also held where relatives were able to relax and take part in pamper activities as well as receive information.

Carer's assessments' were carried out by staff to ensure the needs of carers were considered and support could be provided to them by the service. We read that one relative felt supported whilst their family member was at the hospice; however, they were anxious about how they would cope once their relative returned home. We noted that staff had discussed the relative's emotions with them along with options and the support available. Hospice staff did home visits to support carer's before and after admission to the service if required. This showed a holistic service was provided taking into account the needs of and providing support to those most important to the person using the service.

People and relatives were involved in people's care. "Family meetings' were carried out. Staff explained that these provided an opportunity for people and their representatives to discuss medical information and future plans. We read that one person had stated in a recent meeting, "Pleased that not all doom and gloom."

Families and visitors were welcomed to the hospice at any time in line with the wishes of the person. Leaflets were available to inform people and their representatives about the service. We read the leaflet which stated, "We do not have any set visiting hours or limits on the number of visitors."

There was an annual memorial service known as 'Light up a Life' to remember people that had died. This provided an opportunity for friends and relatives to come together and remember loved ones.

Staff were aware of how to access advocacy services for people if the need arose.

Good ●

Is the service responsive?

Our findings

One person who used the service said, "I am able to take control of my situation and plan for the time I have left with my family. It has taken the stress away, helped my [relative] as well. We can enjoy the time together, have quality time." Another person said, "They listen to people. They put you at ease."

Through speaking with staff and people who used the service we felt confident people's views were taken into account. We saw evidence people and their representatives had been involved in discussions about their care and people we spoke with told us they were involved in every aspect of their support. This meant that the choices of people who used the service were respected.

Each person had a care plan in place which aimed to meet their physical, emotional, social and spiritual needs. We saw care plans did not always clearly document people's personal goals and preferences; however, from our observations and speaking to people who used the service, staff and visitors we were confident person-centred care was being planned and delivered to meet people's needs and preferences. The registered manager told us the average length of stay at the hospice was seven days and care records sometimes focused on specialist clinical care to manage pain and other symptoms, as well as emotional and psychological assessment and support. We saw some personal information was recorded, for example in one record, "Very proud of grandchildren," And psychological information such as, "Worried about family."

The hospice was planning to pilot a more enabling model of care which included more person-centred documentation. The registered manager said, "There is a change in patients' profile. Patients are living longer and if we are taking away people's independence it is not helping them to self-manage. Part of the enabling service is to help them live at home and have a good quality of life with meaning." We noted the registered manager had written a paper on this new model of care entitled 'Rehabilitative Palliative Care – Enabling people to live fully until they die.' This stated, "The aim of rehabilitative palliative care is to optimise people's function and well-being and to enable them to live as independently and as fully as possible, with choice and autonomy within the limitations of advancing illness."

Care plans we saw for specific health conditions and areas such as pressure area care were comprehensive and reviewed on a daily basis. Daily records were also kept. They detailed the care people received, including personal care, pain management, pressure area care, food and fluid intake and the person's well-being.

We saw people were supported to achieve their goals and desired outcomes. The social worker told us, "We have a discharge pathway; it's all about person-centred and individualised planning. We organise planning meetings and we ask the person what is important for them and who they would like to attend this planning meeting, it isn't always their relatives. The patient may say they want to go home. We will then follow up with a home visit with the occupational therapist, social worker, district nurse and anyone else involved. We will action plan everything and say who is going to do what."

Sessions to help people with a specific disease or condition were held at the hospice. These included the 'Breathe Better' and 'Braveheart' courses for people with chronic respiratory conditions and heart failure. An evaluation of these courses was carried out. We read the 2015 evaluation report for the Breathe Better course. This stated, "[Person] says he does feel better as he now has awareness around how to control his panic and anxiety", and, "[Person] feels he has achieved his goals of walking around and helping more at home. Confidence is the biggest improvement."

The hospice had a dementia care strategy. The social worker told us, "We needed to be dementia ready." The social worker showed us a dementia kit and said, "We use a digital clock. We tend to put this in people's room before they come in so they do not think we are doing it especially for them. We also have this bear which is relaxing when you stroke it. The call bell system can be really confusing so we have a buzzer which has only one button so that people don't need to think about which button they need to press. We have red tape which we put anywhere which directs people like around the toilet or on their door handle. It's much more dignified way of doing this."

Staff spoke with good insight into people's personal interests and we saw they were given opportunities to pursue activities of their choice. An activity coordinator was employed as well as a complementary therapy team. The physiotherapist told us, "There is a grow group which is a gardening group which [name of occupational therapist] runs. She brings the garden to the patients so even the most debilitated can join in, feeling the soil and plants – it's so inclusive." We saw from relatives meeting minutes that 'HOOT', a creative arts group came into the service regularly to provide singing sessions.

People we spoke with told us staff were always approachable and they were able to raise concerns any time. We saw there was a complaints procedure on display and in people's care files. Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw where people had raised concerns these were documented and responded to appropriately. Specific time was also set aside to capture the learning from any complaints and plan improvements to the service. Compliments were also recorded and available for staff to read.

Good ●

Is the service well-led?

Our findings

People who used the service and their family members we spoke with told us they were very happy with the service. One person said, "It's a wonderful place to come and die."

Staff told us that morale was good and they enjoyed working at the service. Comments included, "I think we are really lucky to work here. This place feels really special. We are a really tight knit team," and, "This is the best place on earth to work."

The registered manager had worked at the hospice as a registered nurse for around 14 years prior to becoming registered manager around two years ago, which meant they had an in-depth knowledge of the needs of the service.

Staff told us the management team were supportive and they would act on any concerns. One staff member said, "If I had any concerns about anything I would feel able to report, but I haven't had to."

The service promoted a positive culture that was person-centred, open, inclusive and empowering. The registered manager said they operated an 'open door policy' and people were able to speak to her about any problem any time. People we spoke with confirmed this.

The registered manager told us they felt supported by the registered provider and could call them for support at any time. She said, "It's the hardest job I have ever had, but the best one ever. Everyday someone makes me proud." The registered manager told us their vision for the service was widening access to all sections of the community and implementing the rehabilitative palliative care model that was being piloted.

The service was very involved in the wider community and 54 people had recently attended a tea party at the hospice held for carers from the community. On the day of our inspection an open day was also being held welcoming people to visit the hospice and take part in various activities.

Hospice staff worked with external organisations such as the local university. The physiotherapist told us, "I do teaching with the undergraduate students. They come here to get an idea of what it is like." The service also worked in partnership with a number of other organisations, such as the Yorkshire Ambulance Service and LOCALA (the local provider of community health services) to support their staff to follow best practice in end of life care and improve outcomes for people. They also had an out of hours helpline. Anyone could access this help line such as care home staff for advice and guidance. This work supported people in the local community and enhanced community links and understanding.

The registered manager told us they met with an external network of managers to share good practice. Sub groups met regularly in areas such as medicines management, clinical governance and infection control to ensure good governance and continuous improvement, for example changing the way liquid medicines were monitored. This meant the registered manager was open to new ideas and keen to learn from others to ensure the best possible outcomes for people.

The manager told us that the hospice was open to all people regardless of their background and they were involved in a project to work more closely with people experiencing homelessness. The physiotherapist told us, "We want to extend our reach into different groups. It's been really successful. We work with the respiratory team at the hospital so we are opening the hospice to respiratory patients. Sixty per cent of the 'Breathe Better' patients have now accessed the hospice."

We saw from records individuals and their representatives had been consulted on every aspect of their support and their views were recorded. Future Forum meetings for people using the service and their relatives to feedback and plan improvements were held regularly by the social worker. Recent issues discussed included whether the community team should wear a uniform and people considered the issues around privacy this might create. Improvements suggested by the future forum that had been implemented included a new smoking shelter, ground coffee, photo boards with staff names on and to stop using ticking clocks in patients' rooms. Also discussed were the hospice priorities included in the 2015-2016 Hospice Quality Account report, implementing the new enabling approach project and hospice enabled dementia care. This meant people who used the service, and their representatives were asked for their views about the service and they were acted on.

A computer tablet was available in the foyer for people to provide instant feedback and volunteers supported people to use it if required. We saw notice boards around the building requested feedback.

A series of meetings were held regularly with staff such as a property meeting, learning forum and regular staff communication meetings. Topics discussed included staff training and development, individual people's needs, health and safety, the providers' policies and building maintenance. Actions from the last meeting were discussed and goals were set from the meeting. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people using the service.

An annual staff survey was completed and this was reviewed and disseminated to staff by the management group. We saw a communication group had been established in response to some staff feedback about communication within the organisation. This demonstrated action had been taken in response to staff feedback to improve the service for people.

The registered manager completed a weekly safety walk around looking at different aspects of the service and we saw actions identified had been followed up and completed by the relevant person, for example a review of nursing notes had identified an unsigned consent form, which had then been addressed. A person using the service had complained about people being able to see in to their bedroom window when seated outside on the patio and so a garden trellis was moved to improve privacy. We saw audits were maintained in relation to premises and equipment such as mattress and water temperature checks.

Complaints and incidents were formally analysed for any learning and improvements that could be made to the service through learning forums and a learning from incident form that was used. We saw this information had been used to improve the quality and safety of the service, for example clarifying mental capacity assessment and best interest recording on admission to the service.

A quarterly clinical quality report was produced by the clinical governance group and submitted to the board of trustees covering areas such as analysis of incidents and accidents, infection prevention and control, health and safety, admissions policy, audit results such as a 'dignity audit' and the real-time patient and carer feedback strategy. The registered provider demonstrated they continually strived for improvement using their strategic plan, which was reviewed annually, as well as using their 'Quality account' to set and share their priorities with all stakeholders.

Trustees completed regular quality visits to the service including checking complaints or incident records and talking to people and staff. This demonstrated the senior management of the organisation were reviewing information to drive up the quality of the service