

Princess Alice Hospice

# Princess Alice Hospice

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This inspection was carried out on 12, 13 and 27 September 2016 and was unannounced.

Princess Alice Hospice serves the adult population of part of Surrey and West London. The Inpatient Unit (IPU) can care for up to 28 highly complex people at any one time, it does not offer long-term in-patient care. There are four elements to the Hospice at Home service. The Hospice at Home team is usually the first point of contact for people living at home. Patients are triaged and the Rapid Response team visits people who need immediate symptom relief and support; the Night Response team provides this service after hours. The Night Nursing team provides family and carers with an overnight break and will stay by the person's side from 10pm to 7am. When a person experienced a significant change in symptoms whilst at home, which might necessitate a hospital admission the hospice implemented the Enhanced Support service. The service had a dedicated Patient and Family Support Team and Day Services.

The hospice has a large multi-professional team consisting of medical staff, nurses, social workers, therapists and chaplaincy supported by people facing volunteers. There are approximately 800 people on the community caseload at any one time and capacity to support 24 inpatients where outstanding care and holistic support was offered to those whose illness towards the end of their life necessitates admission to the hospice.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

Princess Alice Hospice is an outstanding service. It is focussed on the individual needs of the people and families who they support, at the time they need it in a way and place that best suits them and their whole family. The hospice ensured that everyone received good quality, personalised end of life care regardless of diagnosis, age, ethnic background, sexual orientation, gender identity, disability or social circumstances.

People and carers spoke overwhelmingly of the positive support, guidance and healthcare interventions people had received. They were full of praise for the staff in terms of their kindness, compassion and knowledge about end of life matters. People and their carers viewed the staff as experts in their knowledge and skills when supporting people with complex health needs at the end of their life. The hospice was an accredited training centre and offered end of life care training opportunities for their staff and other health and social care professionals. Through this training and other service developments the hospice had enabled people to receive end of life care closer to home and reduced the need for hospital admissions.

People and carers spoke of a service that was tailor-made for them and their families saying that staff went 'the extra mile' with empathy and compassion. Throughout their end of life care people and their families were kept involved and encouraged through creative risk taking to remain living at home at the end of their

life. People's informed consent was embodied into all work that was undertaken at the hospice and people who did not have capacity to consent to their care and treatment had their rights protected under the Mental Capacity Act (MCA) 2005.

The various departments within this hospice worked well together so that people had a seamless experience of moving from one department to another as the need arose. The end of life and bereavement support provided was tailored to meet the needs and wishes of each family member with sensitivity and compassion. The hospice was supportive of family's spirituality. They strived to offer spiritual support that went beyond faith support and staff were sensitive to individual spiritual needs and thought of ways to meet these needs when people experienced difficult times.

Staff were involved in the development of working practice, listened to, empowered with training and supported to offer excellent end of life healthcare and support. The management team promoted a culture of openness and excellence. They listened to people, carers and staff, involving them in the running and development of the service. They actively sought out their views and used feedback as an opportunity to improve and develop the service. There was a kindness and warmth about the management team that made them approachable to everyone and people knew them by their first names and told us they were visible and solved matters raised.

Governance of the service was of a high standard and robust quality assurance systems were in place that showed people were right to have confidence in this local hospice. The hospice worked innovatively in partnership with many local and national organisations to develop local services for their community and to inform and improve practice in the adult hospice sector. We saw how this partnership working had enabled young people to access appropriate adult services when they became too old for children's services and for people to receive prompt specialist support to enable them to die at the place of their choice

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was outstandingly safe.

The provider had a high level of understanding of their wider safeguarding responsibility to keep the children of people who used their services safe from abuse and discrimination. The hospice had a dedicated children's and young people's social worker and children had been supported creatively to remain safe from harm.

There was a transparent and open culture in the hospice that encouraged creative thinking and innovative ways to manage risk and keep people safe so that they could remain living at home. Staff had an enabling attitude and had through positive and creative risk taking encouraged people to take ownership of the end of their life.

Recruitment processes for new staff were robust to ensure they were suitable to work with vulnerable people.

Medicines were administered safely. Processes were in place to ensure that people received their medicines as prescribed. Trained staff were responsible for looking after and giving people their medicines.

**Outstanding** 

### Is the service effective?

The hospice was exceptionally effective.

The hospice contributed to the development of best practice in the hospice sector and offered accredited training opportunities to ensure staff would know how to provide people with high quality end of life care.

People's rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Where people lacked mental capacity families and other professionals were consulted when decisions needed to be made about people's care and treatment.

**Outstanding** 

The hospice placed a strong emphasis on the importance of eating and drinking well. Staff and hospitality volunteers went out of their way to meet people's food preferences and to encourage people to eat for as long as their health allowed.

### **Is the service caring?**

The hospice was exceptionally caring.

People and their families were supported by kind and compassionate staff who went the extra mile to ensure people continued to have life enhancing experiences.

People and their families were involved in planning their care which included what they would like at the end stages of life and staff found innovative and creative ways to make this a reality for people.

Support was offered to bereaved families and contact maintained if this was what the family wanted. The spiritual needs of people and their families were supported in whichever way they wanted taking into account what gave them meaning and hope.

**Outstanding** 

### **Is the service responsive?**

The hospice was outstandingly responsive to the needs of people and their families.

The hospice worked innovatively and in partnership with other agencies to respond to the needs of the people and families in their local community. For example the hospice had developed their Enhanced Support Service. This was to ensure when people experienced a significant change in symptoms, which may have necessitated a hospital admission, they would receive specialist support to enable them to remain at home.

The hospice ensured that everyone received good quality, personalised end of life care regardless of diagnosis, age, ethnic background, sexual orientation, gender identity, disability or social circumstances. For example the hospice had worked with two local nursing homes to improve the service provided to people at the end of life including those living with dementia.

Complaints investigations were thorough and the hospice used complaints to challenge their practice and improve the service provided for people.

**Outstanding** 

## Is the service well-led?

Outstanding 

The hospice was outstandingly well-led.

There was excellent leadership. The registered manager had developed and sustained a positive culture encouraging staff and people to raise issues of concern and to be actively involved in improving the hospice.

The values and aims of the hospice were visible throughout the service and clearly demonstrated by the staff. The provider also had a clear strategy for developing and improving the service over time.

The service worked in partnership with other organisations to make sure they were following current best practice and providing a high-quality service. They strived for excellence through research, consultation and reflective practice. We saw evidence of the hospice sustaining their outstanding practice and improvements over time.

# Princess Alice Hospice

## Detailed findings

### Background to this inspection

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

This inspection was unannounced and took place on 12, 13 and 27 September 2016.

The inspection team consisted of one inspector, a specialist advisor with a medical background, an expert by experience and a pharmacist inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. We previously inspected the service on 09 December 2013 and no concerns were found.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sent questionnaires to staff and people who used the service to gain their feedback. We reviewed the PIR, previous inspection reports, notifications and all contacts we had about the service. A notification is information about important events which the service is required to send us by law.

During our inspection we spoke with the Registered Manager (also the Director of Patient Care and Strategic Development), the Chief Executive Officer, the Medical Director, Head of Quality and Patient Experience, Head of Operational Services, the chef, Housekeeping Assistant, Head of Housekeeping, a doctor, a trainee doctor, the IPU Ward Manager, Support Services Assistant, Specialist Nursing Consultant, Head of Education, Therapies/ Day Service Manager, Head of Volunteer Development, Senior Social Worker, Patient and Family support Manager, Chaplain, Medical lead for Research and Evaluation, Discharge and Family Liaison Facilitator, Practice Therapies Educator, two Hospice at Home managers, two Community Team managers, nine nurses, five care staff, seven volunteers and three members of the facilities team.

We spoke with 16 people that used the hospice services and four family members.

We reviewed a range of care records for five people including five medicine administration charts. We also

reviewed records about how the hospice was managed. This included staffing records, audits, meeting minutes, training records and governance records. We also attended the admissions meeting and two multi-professional meetings.

After our visit we also spoke with the manager of a provider service that commissioned the services of the hospice, a Carer Companion (also a bereaved carer), the dietician, and the manager of the nursing home involved in the Together 2 Care project.

## Is the service safe?

### Our findings

People and their relatives told us they had no safety concerns when people stayed at the hospice inpatient unit (IPU) and when they received support in their own homes. They said they would be confident speaking to any member of staff or the registered manager if they had any concerns. Staff and volunteers had completed safeguarding training as part of their induction and ongoing training. They were able to identify the procedures they needed to follow should they suspect a person in their care had been or was at risk of abuse. The registered manager was aware of their responsibility to report allegations or suspicions of abuse to the local authority and had not needed to report any safeguarding concerns relating to the hospice since our previous inspection.

The provider had a high level of understanding of their wider safeguarding responsibility to keep children and young people safe from abuse and discrimination. The hospice had a dedicated social worker for children. This ensured when staff had identified risks to children and young people whilst working with families, these concerns were addressed in accordance with local safeguarding procedures. A social worker told us child protection referrals were made if needed and staff supported safeguarding investigations to ensure positive outcomes were reached for families. When we attended the admissions meeting we saw how the admission team considered the safety and rights of the children of people referred for hospice care. This was routine as part of each person's proposed plan of care to ensure everyone in the family would be kept safe. During our inspection we were told of examples of young people helping to care for their ill parents. Staff worked with families and children's services to ensure care tasks performed by children were appropriate and undertaken in a safe manner. Staff had supported people to ensure legal arrangements were in place to protect their children's rights to safely remain resident in the UK following their death. Where young people were made homeless following a parent's death staff supported them to apply for the appropriate benefits and secure housing. Staff and their mix of skills were used to give them the time to develop positive and meaningful relationships with families to ensure their children and young people would remain safe.

Staff knew how to follow whistleblowing procedures and raise concerns anonymously if required and were confident that any issues raised would be addressed to keep people safe and to improve the service people received.

Risks to people's safety and staff supporting them had been identified using universally recognised screening tools, effectively managed and reviewed. These areas of risk included any potential hazards in the environment, risks when people were supported by staff to move or transfer, risk of falls, weight loss, choking and the development of pressure ulcers. Staff demonstrated that they knew what action to take to keep people safe in accordance with their care plans.

People identified at high risk of developing pressure ulcers were reviewed daily to ensure the arrangements in place to protect their skin from deteriorating remained effective. People who could not change their position independently were provided with air mattresses and air filled cushions to relieve the pressure on their skin. Records showed they had also been supported to reposition regularly to protect their skin from

pressure damage. One relative told us "I can see how many times they have turned her through the night and how many times they have given her morphine". People were supported to understand the risks and encouraged to take preventative action. One staff member told us "People are often very tired and do not always feel like being turned in bed but we explain how important it is and spend a bit of time with them to make sure they understand that they will have complications if they do not turn".

People at risk of falls had been assessed to ensure appropriate arrangements were put in place so staff would know how to support people to mobilise safely. People were provided with the necessary equipment to enable their care to be provided safely or to remain safely independent at home such as grab rails, slide sheets, wheelchairs and hoists. Staff had received training in safe moving and handling techniques and told us the hospice's physiotherapist supported them to ensure they knew how to use any new equipment safely. People's changing health and fluctuating strength meant their risks could change rapidly. We found risks to people were reviewed continuously to ensure their risk management plans would remain effective. For example, when a person at low risk of falls had a fall, they were moved to a room closer to the nursing station. They were also given a large call bell to support them to call for help so that staff would respond swiftly if they needed support to mobilise safely. They told us they were satisfied with the action staff had taken to ensure they would be safe and told us when they fell "Staff came quickly when I called."

The provider empowered staff to think creatively when problem solving. They encouraged staff to have the confidence to suggest innovative ways to manage risk and keep people safe so they could remain living at home. People with learning disabilities and elderly people living alone had been supported to fulfil their wish of staying at home until their death. One person with mild memory impairment lived alone and was unable to administer regular pain medicine. In discussion with the multi-professional team (MPT) the route of a medicine administration was changed to a pain patch that the district nurse team could apply every three days. This made it safer for this person to continue living alone as they wished. The hospice's welfare and benefits advisor worked tirelessly with relevant agencies to ensure a person who had not had hot water in their home for eight months could return safely to live at home with access to all utilities. One person's wife, who was also their main carer, had to unexpectedly leave home for a few days which meant the person was unable to use the stairs safely. Staff recognised this risk and the need for two handrails to be installed at their home to enable the person to use the stairs safely without the assistance of their wife. Despite the limited time available to organise and arrange this work the hospice's facilities team and therapies lead promptly made and installed the handrails. This enabled the person to stay at home and mobilise independently in a safe way.

We were told how staff had mitigated the risks relating to equipment and oxygen to enable a person too ill to live at home to return home for a visit on four occasions therefore greatly increasing their mental wellbeing. Staff had also found a creative way to fulfil another person's final wishes to be transported by their family using their own vehicle from the IPU after their death. Staff ensured the person's relatives and staff were kept safe when transferring the person from the mortuary trolley into the vehicle. Staff had an enabling attitude and had through positive and creative risk taking encouraged people to take ownership of the end of their life.

Staff understood each person's vulnerability to infection and took action to protect them from the spread of infection. We saw staff washed their hands prior to undertaking any procedures and when delivering care. Staff and visitors had easy access to hand washing facilities in the hospice. There were sufficient supplies of protective equipment such as gloves and aprons and staff used these appropriately. Records showed that regular cleaning and infection control audits had been undertaken to ensure staff complied with the hospice's infection control requirements. The hospice was well maintained and clean throughout the inspection. The chef told us, and records showed that the kitchen had achieved the top 5-star rating from

the local environmental health team every year for the past 6 years. This meant the hospice continued to maintain 'Very good' food hygiene standards.

Processes were in place to ensure safe management of people's medicines and people told us they received their medicines as prescribed. One person said "I take 24 tablets a day and they have told me about the side effects and what I take them for". Nurses were responsible for looking after and giving people their medicines, and we observed good practice in the preparation of medicines. Nurses received training and underwent competency assessments before commencing single nurse dispensing and administration of drugs (SNAD) in the hospice, and a risk assessment had been completed to identify and mitigate the risks associated with SNAD.

Appropriate arrangements were in place for ordering, receiving and disposing of medicines. Medicines were stored securely and access to medicines was restricted appropriately. Medicines were stored within the recommended temperature ranges to maintain their effectiveness. Expired and unwanted medicines were stored securely and disposed of appropriately.

Some people's medicines were given via a syringe driver. A syringe driver is a small portable pump that can be used to give a continuous dose of a painkiller and other medicines through a syringe. Suitable syringe drivers were in use when people needed medicines to be administered continuously. These were regularly serviced to ensure the equipment used was safe and fit for purpose

People's prescription and administration charts were completed appropriately and people had received their medicines as prescribed. We saw that people had access to 'when required' medicines, these are additional medicines such as painkillers which are not required on a continual basis. The Director of Patient Care and Strategic Development told us that the medicine charts would be reviewed as part of the forthcoming introduction of a new pharmacy service to ensure more comprehensive guidance on people's 'when required medicines' would be available to support administration of the most appropriate medicine when people needed them.

Incidents involving medicines were recorded and regularly audited within the service and changes in practice were made to reduce the likelihood of a similar event occurring again. For example, staff were encouraged to take the medicines trolleys into patient's rooms during medicines rounds, rather than preparing medicines in the corridor, to avoid distractions which might lead to errors. Staff were also proactive in alerting external agencies to concerns that may affect people's health and wellbeing. For example, a series of faulty giving sets which staff had found to leak were reported as a suspected problem to the Medicines and Healthcare Products Regulatory Agency.

Staff and volunteers had been required to undertake full pre-employment checks before they were offered employment and could work with people unsupervised. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Nursing and Midwifery Council (NMC) checks had been completed to ensure health professionals were fit to practice. The provider had used the interview process to demonstrate staff's relevant skills and experience and to support the registered manager to plan the induction for new staff. The provider had taken into account all known risks relating to each candidate's suitability when making recruitment decisions.

There were enough staff on duty in the IPU to meet people's needs and keep them safe. Staff were deployed effectively on the three days of our inspection. We observed staff regularly checking on people who remained in their rooms. People were supported in the day service area throughout the day and told us their requests for assistance were promptly responded to. One person told us "The response to the call bell is

within thirty seconds".

Staffing in the IPU was reviewed and adjusted daily to reflect the changing needs of the people using the service. For example, when one person became agitated an additional staff member was made available to ensure they would receive the individual support they required to stay safe. The ward manager told us the hospice had made the decision to temporarily limit the number of beds in the IPU while they recruit additional nurses to ensure people would continue to receive safe care. They continued to review the impact this might have on people. The service at times used agency staff when their permanent or bank staff could not complete overtime to cover sickness and annual leave. As the same agency staff were selected as much as possible, this promoted continuity of care for people as they were supported by staff who were familiar with their needs.

The hospice operated health and safety systems effectively to protect people from harm within the hospice. Regular audits and daily checks by nominated staff ensured that the environment and equipment used was safe and fit for purpose. The hospice had contingency plans to manage emergencies, for example; evacuation in relation to a fire or flood. The hospice was at risk of severe flooding in 2014 and effectively implemented their serious incident contingency plans.

## Is the service effective?

### Our findings

People and their relatives were highly complimentary about the skills and knowledge of staff. One relative told us "Honest this is the only place that I'm confident in leaving her at night and I can go home happy knowing she's being look after properly". People were supported by highly skilled staff who had completed training in end of life care tailored to their professional needs and to the individual needs of the people using the hospice services.

The hospice also contributed to the development of best practice in the hospice sector. They had developed the European Certificate in Essential Palliative Care and also ran several other accredited End of Life care courses for their staff and other health and social care professionals. The deputy manager of one of the nursing homes that had completed their Gold Standards Framework in Care Homes (GSFCH) through the hospice noted in their training feedback "Our unnecessary hospital admissions are down to zero, so if a resident is deteriorating, we don't automatically send them to hospital anymore." This training had ensured people were able to spend their last days in a familiar and comforting environment supported by staff that understood their end of life wishes. Nursing home staff spent time on the IPU as part of their end of life training. Hospice staff told us through working with the nursing home staff they had developed their understanding and skills in working with people living with dementia. One staff member told us "They have great skills and after working with them I feel more confident in my ability to speak with people with dementia and meet their needs".

The hospice offered 'train the trainer' workshops for domiciliary care staff to support the development of their organisations by becoming Gold Standards Framework trainers. The hospice's Hospice at Home staff also provided mentoring to staff from other care agencies to support their skills in providing end of life care. This meant that people being cared for by domiciliary care staff at home would also receive end of life care in accordance with best practice.

The hospice understood for people to have the best quality of life to the end they needed to feel valued. Staff and volunteers had been trained creatively to have meaningful conversations with people, offer reassurance and compassion. All staff and people facing volunteers had completed a communication course called 'Sage and Thyme' or an advanced communication course and staff told us how this had enabled them to notice people's distress, listen to their concerns and respond helpfully. The hospice used the nationally recognised practice of 'Schwartz' rounds to develop staff's capacity to understand and manage the psychosocial aspects of people's care. One staff member told us "The last Schwartz round really made me think what it must be like for people and their families if we as professionals sometimes feel helpless". The hospice had developed an innovative 6-month volunteering programme on the IPU aimed at 17-year olds which enabled young people to work towards the Care Certificate qualification. Young volunteers were required to evidence the requirements of this certificate through conversation and time spent with people. One staff member told us "We were initially a bit wary about letting young people help on the ward, but they have been fantastic and people really enjoy chatting with them. One young volunteer spent three hours giving an agitated patient a hand massage to soothe them and we did not need to give them any medication to calm them".

The hospice understood each person expressed their spirituality in a uniquely personal manner. To ensure more people had their spiritual needs met the hospice had introduced a 'Community Chaplaincy Listening Service' that visited people at home to offer support when they questioned their beliefs or wanted to return to things that were important to them earlier in their lives. The hospices had developed training courses relating to spirituality, which included, 'Making sense of decisions at the end of life', 'Faith, belief and ritual around time of death' and 'Exploring Mortality' and trained the chaplaincy volunteers to ensure they had the skills to meet people's spiritual needs without judging. Through this training more people and their families had been given the opportunity for personal reflection and to consider what a good death might mean for them.

The provider was mindful of the emotional challenges staff faced and believed a resilient, happy and valued team was essential to ensuring staff remained caring. The provider had supported staff through a wellbeing programme to develop their resilience to stress. This included a wellbeing week, a range of bespoke resilience training sessions, mindfulness courses, nutritional support, inclusion in the Community Choir and Pilates classes. Staff told us they felt this resilience work supported them to sustain their caring, energetic approach. We saw as a result people benefitted from highly motivated staff that were passionate to provide care that was kind and compassionate.

Staff were complimentary of the training opportunities they were provided. Their comments included "This is the best induction I have ever had", "We are encouraged to complete the clinical training on offer" and "I have had sufficient training for my role". A programme of ongoing training for care and clinical staff covered health and safety related topics and also topics relevant to the support needs of the people staying in the IPU and in the community. The provider had developed a competency framework for the nursing and care team to evidence staff had all of the skills needed to meet the needs of people.

Staff told us they felt supported in their role and there were a variety of methods of keeping staff informed and updated of changes in practice. These included monthly staff meetings, regular supervision sessions and an annual appraisal. Staff told us supervision had been taking place regularly and their appraisal gave them the opportunity to reflect on their practice, to identify their training needs and to contribute to the improvement of the service.

Some people did not have the mental capacity to independently make decisions about their care arrangements when staying at the IPU. 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.

Staff were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example when asking people if they wanted any pain relief. One person told us in order for staff to control their severe pain they would probably be in a state of deep sedation and unaware of anything around them. This was unacceptable to them and staff had taken their views into account when a decision was made about their pain management. Staff told us how people's capacity to consent to their

care, could at times fluctuate when they were in pain or taking medicine which made them drowsy. They could describe how they would ensure when people had to make important decisions about their care, that discussions would take place at a time when people were best able to understand the information.

The social workers were responsible for undertaking mental capacity assessments when people were deemed to lack the mental capacity to make decisions about their care and treatment. They had a good understanding of the legal process and the documentation they needed to complete. They gave examples of appropriate DoLS referrals the hospice had made to ensure that restrictions to people's liberty had been legally authorised. Staff told us that they had become more skilled in understanding the requirements of the MCA and the implications of the Act when supporting people. They had encouraged people to make decisions about their care, treatment and preferred place of death whilst they still had the mental capacity to make these decisions independently. For example, one person's swallowing ability was deteriorating. After assessment by the community speech and language therapist and dietician, the nurses discussed the option of inserting a feeding tube directly into the person's stomach. This would provide nutrition if in future they couldn't get enough food or liquids by mouth and is called a percutaneous endoscopic gastrostomy (PEG). Through full discussion and demonstration to the person of what the PEG would involve the person was supported to make an important decisions about their future care while they still had the mental capacity to do so.

People told us that the mealtimes and the quality of food and choice were exceptional, their individual needs were met and staff went out of their way to meet their preferences. Their comments included "The food is wonderful", "This is like a luxury hotel" and "The food is good and one has good choice." The hospice placed a strong emphasis on the importance of eating and drinking well and the IPU staff worked very well with the hospice's dietician. The dietician told us "The nurses are very skilled and the referrals I get are always appropriate. Through training they have developed their skill and can confidently develop nutritional plans for people struggling to eat due to nausea or dry mouth. They now only refer to me if a more complex plan is required". The dietician reviewed the nutrition plan of all people that require tube feeding on admission to ensure they would receive optimal nutrition.

Trained hospitality volunteers supported and encourage people who were reluctant, or have difficulty, to eat and drink and this significantly improved people's wellbeing. One relative told us "The staff here are amazing nothing is set in time my sister has been on a soft food diet the staff will always get her a meal even if she has missed her lunch." The hospitality volunteers spend most of the day with people and supported them to identify menu choices and kept them company during meal times. The dietician was highly complementary of the hospitality volunteers' skills. They told us "They get good training and know how to support people appropriately. People really enjoy having their companionship during lunch and we have seen people eating more since the hospitality volunteers had been introduced".

Staff went out of their way to meet people's food preferences and to encourage people to eat for as long as their health allowed. The chef told us "People often have really poor appetites so if they have a special request and we do not have it in stock I will spend all evening after work looking for it because if we cannot provide it they might not feel like eating for some time. We have Kosher and Halaal food suppliers to ensure we can meet people's religious needs". The chef would also prepare small taster meals for people to try and stimulate their appetite. One volunteer told us "They recently installed an ice cream machine on the ward when we told staff we noticed ice cream was sometimes the only think people might feel like eating, it has been very popular" The hospice had a dedicated food and nutrition group that championed healthy eating and kept people's eating experiences under review.

People were supported to remain independent when eating and drinking. People were supported through

non slip tray mats, plate guards and special cutlery to eat independently. One person had been unable to use a cup and used to lean forward and drink through a straw which had been painful for their neck. Volunteers spoke with the person and then designed and made a cup stand in the 'Man Shed' (a space to bring people together to share practical skills and informal social support) which enabled them to drink without discomfort.

People's health needs were met by a range of health professionals during their stay and in the community, including palliative medicine consultants, palliative medicine doctors, GP trainees, occupational therapists, physiotherapists, dietician, lymphoedema therapist and complementary therapists. People living at home were supported to remain healthy. One person told us "I have a carer that comes in every morning but not on a Monday. I have a sore on my leg that needs dressing so I come to the hospice every Monday, I have a nurse that I come and see and we talk about what is bothering me and she sorts it out, she's fantastic". We saw at the admissions meeting that people's ongoing health needs were discussed and referrals made for example to people's GP's and district nurses as required.

People told us they were supported to manage their pain. One person said "My pain control is a bit tricky, but we're nearly there" and a relative told us " She is always in pain today she has had a bad attack so I told the nurse and they gave her morphine straight away". Where appropriate complementary therapies such as aromatherapy or 'Mindfulness' training were delivered by the complementary therapists to support people to relax and manage their pain.

## Is the service caring?

### Our findings

People and their families valued their relationships with the staff and volunteers and experienced staff as highly motivated and inspired to offer care that is kind and compassionate. Comments we received included "The staff here are fantastic they are so caring and so easy to talk to", "They are here 100%, they are fantastic and always here for me" and "The volunteers that work here always have a smile on their faces and they do so much from working on the reception to changing the flowers in the rooms".

We found many examples during our inspection of staff's determination and creativity in overcoming obstacles to ensure people's wishes were met with compassion and empathy. This made people feel valued and that staff often went 'the extra mile for them' when providing care and support. For example, staff made arrangements to ensure people who found it difficult to be separated from their pets could have their pets with them. One person refused to come to the hospice because their much loved dog was about to have puppies. In order to facilitate the admission the dog was admitted with the person, the puppies were born in the hospice and the person was still able to see them before they died. Another person's pony was brought into the hospice so that they could see them again. Staff supported people to re-home their animals so that they would be assured they would be looked after when they have passed.

We found staff at the hospice had been involved in arranging celebrations for many weddings, birthdays and anniversaries. Housekeeping and catering staff put together a surprise birthday party for a person's grandson, decorated the room with balloons, bought presents and provided party food and a birthday cake. The chaplain conducted a wedding of longstanding partners in the Sanctuary (hospice chapel) and the daughter of a person in the IPU got married in the hospice so that her parents could be present at the wedding. Another person enjoyed a tipple and the nurse contacted a charity fund who provided money for the wake and the person had their wake before they died.

We heard from people how staff went out of their way to try and relieve some of their emotional and physical distress. One relative told us "This is a beautiful place with amazing staff who can make a desperate situation bearable." One person attending the day service was not able to eat and staff arranged for them to have a complementary treatment over lunch time. This was so they did not have to watch others eat and also had a pleasurable experience. Another person was unsettled and anxious that their children were not looking after their home properly in their absence and might not cope after their death. In response, one of the therapists visited their home, took photos of the person's tidy kitchen and healthy plants. Staff told us seeing these photos were a huge relief for the person. One of the nurses was also a qualified hairdresser and often visited people to wash their hair at home. Nurses had also visited a person's home to show their husband how to apply their make-up as they could not do this anymore and was not usually seen without it.

Advance care planning and decision making was well established. Staff could describe people's end of life wishes and the support they had provided to people to ensure their wishes would be fulfilled including after their death. One young person had a wish to have a film night with some girlfriends as this was something they had enjoyed throughout their friendship. The facilities team ensured that this could take place and that

the TV and DVD were in the correct position. The chaplain supported a person who had the wish to be buried. After their death the social worker negotiated a local authority funeral that could accommodate their needs for a Christian burial rather than a cremation. The chaplain conducted the burial and facilitated their London based church to hold a memorial service that could support their family. Another person who self-identified as 'Spiritual, but not religious' was visited on the IPU by the chaplain and they conducted the person's non-religious funeral service in accordance with the person's wishes. The chaplain explained the hospice strived to offer religious support to people with faith needs as well as spiritual care to enable people to review their life when they are struggling with difficult questions. Staff understood that spiritual help can take many forms for people which could be found in the familiar ways of culture, friends and family and the familiarity of your personal interests or shared experiences. Staff told us of a person who had travelled a lot and travelling was a very important part of their life. In order to make them feel comforted familiar staff helped their family to put up photo collages of their travels in their room. This helped them to think and talk to staff about these happy times. People were also supported to record their life stories so that their family members could continue to hear their voices after they had passed.

A comprehensive bereavement support service was available for all relatives consisting of either one to one, group or telephone support depending on the needs and preferences of individual relatives. The hospice had received positive feedback from relatives about the support they had received after their family members had died. Words used to describe the bereavement service included, 'fantastic service that changed everything for me', 'truly amazing' and 'outstanding'. The hospice continued to develop their bereavement service to support the needs of all the people using the hospice. For example, the Man Shed was launched in April 2016. This is a creative project that delivers a supportive space for bereaved men, women and teenagers and those with terminal illnesses to work together on practical projects and to access caring support three days a week. The Man Shed also makes tools to support people to remain independent and they had for example, developed a tool to enable a person who lived alone to open their post. People spoke very positively about the Man Shed. One person told us "It gives me an interest and a feeling of fulfilment since I lost my wife I do a lot more now, it's changed my life, if this was to close it would really upset me". Bereavement volunteers established a 'Walk and Talk' group enabling those who had recently lost a loved one to meet others in the same situation whilst walking. One bereaved person noted in their feedback to the hospice 'The Walk and Talk service has allowed me to meet and share experiences with others who are bereaved and this worked in tandem with my counselling to provide me with complete wrap around care'.

People told us staff treated them with dignity and respect. A relative said "Everything they do here is outstanding they have a huge amount of respect for the patients they always talk to her knowing that she can't talk back". When delivering personal care we saw staff adhering to standards which promoted dignity and respect. For example, doors were closed when people were receiving nursing and medical attention and staff ensured people were not disturbed at this time. Signs were also put on the Viewing Room door to ensure people would have uninterrupted time with their loved ones. We observed staff asking for people's consent before supporting them and waited for people to respond before proceeding. Staff took time to listen and did not leave the person until they were comfortable and settled.

## Is the service responsive?

### Our findings

People told us they had been involved in planning their care and they were satisfied that the service they received met their needs. The comments we received included "I've seen my care plan and we have reviewed it and updated it.", "I've met some really good friends since I've been coming here", "We can get involved in the craft side of things if we want to its great here everybody's so friendly" and "I needed to get out of the hospital into a situation like this; I needed the peace to think."

People's care were planned and delivered to meet their health, social, emotional and spiritual needs. People received holistic care because staff understood the importance of working together as a team to provide seamless care for people. Weekly multi-disciplinary team (MDT) meetings were attended by medical and nursing staff, therapy staff, social workers and the chaplain. Comprehensive discussions took place about the care of each person and of close family members. A future plan of care was agreed which reflected people's views about how they wished to receive their end of life care and support. Multi-disciplinary decisions made about changes in people's care and pain management were appropriately documented in people's care records.

The day hospice was run Monday to Friday and this provided people with an opportunity to participate in activities provided by the hospice for example, music, games and arts and crafts. One person told us "It's a fantastic place to come; wish I could come more often during the week". The day hospice was overseen by the therapies team leader and people could also access complementary therapies including reflexology, aromatherapy, relaxation and head massage at the day hospice. The day hospice also ran sessions to support people to manage their symptoms and enhance their wellbeing. For example, we saw sessions were being offered to support people to manage breathlessness and maintain an appropriate level of exercise. People told us these sessions did not only meet their social needs but also provided emotional support and the opportunity to receive valuable information. One person said "I like the group and in the afternoon we get people come in here to entertain us singers and musicians and there's always something to do here".

The National Council for Palliative Care and the Dying Matters Coalition believes that everyone approaching the end of life has the right to the highest quality care and support, wherever they live, whatever their condition and regardless of race, gender, sexuality or any other aspect of their lives. We found Princess Alice Hospice ensured everyone received good quality, personalised end of life care regardless of diagnosis, age, ethnic background, sexual orientation, gender identity, disability or social circumstances. For example, the hospice provided a service to their local prison population. One staff member told us "A young patient at a local prison was referred for symptom control. This was a complex case to manage due to the restrictions in visiting, communicating and providing medications. Our clinical consultant and nurses supported the patient despite the complexities. We were not able to book up visits ahead of time so supporting them required a great deal more flexibility and responsiveness."

The hospice had also developed their service to ensure they can better meet the needs of people living with dementia. Two rooms in the IPU had been refurbished with dementia friendly colours and sensory stimulation to ensure if people living with dementia were admitted to the IPU the environment would better

suit their needs. Staff had received training in dementia awareness and the Alzheimer's Society's 'This is me' documentation had been introduced to ensure staff would have some understanding of the needs of people who might be confused when they were admitted to the IPU. The provider had identified that the IPU would however not always be suitable for all people at the end of life or those living with dementia. As a result they had developed the collaborative Together 2 Care project, working innovatively with two local nursing homes to develop their bed capacity and staff skills to more appropriately support elderly people at the end of their life. The manager of one of the nursing homes told us "Princess Alice Hospice trained 10 of our staff in Level 3 End of Life Awareness and they worked on the IPU as well to gain some more experience. So far we have been able to offer the support to one person; but it has benefitted all our residents as everyone now has an end of life plan in place and staff have a better understanding of the importance of ensuring people are involved in stating their wishes". The hospice had also been commissioned by a local CCG to support care and nursing homes in their area to implement advance care planning for people living in their homes. The nurse delivering the training told me "I supported a home with syringe driver training when one person's end of life care plan clearly indicated they wanted to die in the home" Through personalised end of life planning inappropriate hospital admissions had been prevented and people had been supported to die at home.

The service ran a monthly informal LGBT support group open to any lesbian, gay, bisexual or transgender (LGBT) person who has been bereaved. The chaplain told us "Through our work with bereaved people we have realised that the experience of LGBT people are, at times, significantly different and this can make them feel very isolated. We have started this group to offer a safe place for people to talk about their experiences with others who will understand what they are going through". The hospice was also liaising with other organisations across the area to raise awareness of this group. The hospice was responsive to people's cultural and religious wishes at the end of their lives. For example, a social worker worked with a Muslim patient who wanted to ensure their death care and burial was in line with their faith. The social worker arranged for members of the local Muslim community to come to the mortuary and help prepare the person's body for burial. The social worker was Muslim and also took part in the ritual. Another person had expressed the wish to return to their country of origin to die. Staff had worked with the embassy and airline to arrange the complex transfer and provided equipment to ensure the person could fly home.

The Department of Health's End of Life Care Strategy (2008) recommends provision of 24/7 care that is easily accessed and responds quickly to all end of life care patients regardless of where they are cared for. It states provision of such care can avoid unnecessary hospital admission and enable more people to die in their place of choice. The provider had developed their Hospice at Home service to ensure where required, there was a rapid response to people's changing care needs and advice on care and support was available round the clock. This included the Rapid Response, Night Nursing, Night Response and Enhanced Support service that supported people who preferred to be cared for at home but who were at risk of inappropriate hospital admission or had made it known that they wanted to remain at home at the end of their life. The provider's evaluation of these services demonstrated that the vast majority of people had been able to achieve their preferred place of care and death. We heard examples of the Rapid Response team working with the MPT to ensure people's needs were met. These included facilitating urgent admission to the IPU for a person who could not find a bed at another hospice over a weekend as well as making arrangements in the middle of the night so people had the necessary pain medication to ensure a pain free death. This night response service is available in areas that do not have a dedicated district nursing service thereby enabling people to stay at home and receive care rather than be admitted to hospital or be attended to by the emergency services. Rapid Response nurses had stayed over at people's homes to support families immediately after people's death as they were too distraught to be left unsupported. The hospice also ran a Night Nursing service which provides family and carers with much needed overnight break, staying at the person's side from 10pm to 7am. This provided family carers with much needed rest to ensure they would be able to

continue their caring responsibilities.

The provider had also created an Enhanced Support Service (ESS). When a person experienced a significant change in symptoms whilst at home, which might necessitate a hospital admission the hospice implemented the Enhanced Support service. This created a virtual hospice bed at a person's home, putting them under the care of a bespoke team of specialists. Community nurses told us how this service had supported people to die at home as they had wished. One person referred to the ESS had deteriorated rapidly and the ESS nurses facilitated bringing their wedding forward. Staff had dressed the person in their wedding dress and stayed with the family throughout the day as they knew the person would unlikely have capacity to legally enter into a marriage the next day. Another person on the IPU made an instant decision to go home despite a package of care not being in place. The MPT worked to reduce potential risks and the discharge co-ordinator in conjunction with the CCG put together a package of care, equipment and medication on the same day. The ESS visited to provide additional support and two days later the person wanted to return to the IPU and this was facilitated immediately. The provider's evaluation of the ESS service showed that 88.6% of people using this service had been supported to die in their preferred place of death. The service was highly flexible and responsive to people's individual needs and used innovative ways to support people to remain living at home and fulfil their end of life wishes.

People and relatives told us they would feel comfortable raising concerns with staff if they had any. The provider's complaints process was available to people and their representatives. One relative told us "No, I have never needed to make a complaint but if I needed to it would be to the doctor". The registered manager told us they had received 21 complaints in the past 15 months. There was a process for ensuring people's complaints and concerns were logged, investigated and responded to. The registered manager told us that they had analysed the themes of the complaints and concerns received and used this information to improve the service. For example, they had realised people at times raised concerns because they were not clear about the role of the hospice. They told us "We have reviewed many of our leaflets to ensure people would have a better understanding of what we do and the admissions meetings also explore people's expectations so that we can be clear with them whether we can meet them". People's complaints had been dealt with in accordance with the provider's policy and action taken as a result was used as an opportunity to improve the service for people.

## Is the service well-led?

### Our findings

People and their families consistently told us they received care and treatment that reflected the hospice's ICARE (Integrity, Compassion, Accountability, Respect and Excellence) values. These values were displayed throughout the hospice in a variety of languages to ensure everyone would understand what they can expect from staff. We found these values to be embedded in the hospice and saw staff displaying these throughout our inspection. The Chief Executive told us "These values drive what we do and it is important that people and staff continue to feel engaged with our vision and purpose".

The provider continually strived to improve and develop the service and had a clear five year strategy, developed with input from people and their families. This set out what they were working towards to meet the needs of their local population. This strategy showed that the provider was outward looking and was aiming to ensure all people with life limiting conditions would benefit from a hospice service. They had reviewed their service model and had introduced a new model of in-patient care that supported a greater mix of people by piloting two distinct wards within the IPU; one caring for people with specialist and intensive needs the other being a teaching unit looking after people with generic palliative care needs. This flexible use of IPU beds will allow the hospice for example, to care for people with dementia who do not always have access to traditional hospice care.

The hospice found innovative ways of working with local services to implement national good practice guidelines to improving the transition of young people with long term conditions from children's to adult health services. For example, one of the consultants in palliative medicine was the hospice's transition lead and had worked with local children's and adult hospices and children's health services to develop a local referral system for young adults with non-cancer conditions into adult hospice services. A joint meeting took place quarterly to review the service needs of specific young adults and their families who would require ongoing respite to enable them to continue to care for these young adults at home. This joint working had already enabled two young adults to access the hospice care at Princess Alice Hospice. The hospice understood the challenges families caring for young people with life-limiting conditions faced sourcing respite opportunities. They were working with a local children's hospice and other local hospices to review their services for young adults including setting up a social club pilot project.

The hospice worked in partnership with a local CCG and three other providers to provide the CoSI (Co-ordinated, Safe and Integrated personalised care within the community) project. This is an innovative collaborative model of community care for people in the last six to eight weeks of their lives. The partnership delivers a Night Nursing service and Rapid Response service as part of this project. Through their partnership in this project the hospice had contributed to the development of shared referral pathways from primary care, the community and secondary care. The manager of one of the provider services told us "This has been a very good piece of work with Princess Alice and showed how separate provider organisations can share processes and work together to ensure people get the services they need at home. Within the first year 95% of people had been supported to die at home, this is a huge achievement for all of us". The CoSI service was the National Council for Palliative Care's 2016 Winner of their End of Life Care Champion of the Year award and the Kent, Surrey, Sussex Academic Health Science Networks' End of Life Care Award. The CoSI

partnership had enabled people to receive a tailor made set of services to meet a variety of needs through a single referral thereby reducing the strain on people and their carers to source different agencies to provide their practical, respite and end of life care.

The service was committed to developing an excellent service and identified ways to further improve through research and reflective practice. For example, the hospice was undertaking a collaborative dementia related research study. Although this research project still needed to be completed it had already improved their practice. The registered manager told us they had found that people living with dementia had often been referred back to their GP due to the poor standard of information received during the referral process. The research study identified that many of these people died soon after the referral back to their GP. As a direct result of this work the hospice had subsequently changed their practice and now all people with a diagnosis of dementia stayed with the service for at least a month. This meant an advance care plan was completed for people with dementia in conjunction with the MPT to ensure plans were put in place to support people's end of life needs.

Monthly research seminars took place for staff to discuss different research papers and reflect on the impact of these on their practice. For example, one of these seminars focused on the outcomes of the National Food and Nutrition Survey which was undertaken in partnership with Princess Alice Hospice. As a result a food and dietary needs assessment tool and hospitality volunteers had been introduced to ensure people in the IPU received adequate nutrition. Staff were encouraged to evaluate the work they did and many had published their findings in a variety of professional journals to influence good practice across the hospice sector. The service also shared their review findings at the annual Hospice UK conference and the National Association for Hospice at Home (NAHH) conference. The hospice shared the work they did in relation to their Carers' Strategy at the NAHH conference. This provided other hospices with an innovative example of how services can support and empower carers looking after loved ones living at home at the end of life, which was one of the key messages of this conference.

Opportunities were available for people and their families to regularly contribute in a meaningful way to the development of the service to help drive continuous improvement. We found examples that showed people and their carers had real influence and involvement in a number of issues within the hospice. Through the Patient Journey project the hospice identified that people would prefer to have information tailored to meet their needs rather than receiving a lot of information all at once. People had been involved in the review and rewriting of the hospice's information leaflets as a result. Hospice at Home referred people for a bathing service which is held every Thursday afternoon following people expressing a desire to have a bath. People completed 'Share your Views' feedback cards after each visit and following feedback new water jugs had been purchased that was easier for people to lift and tea and coffee facilities and fresh food had been made available for families staying overnight. People who did not need a specialist nurse input anymore were disappointed that they could not continue to attend the Day Hospice anymore; as a result a social group was introduced for these people to attend.

The hospice recognised that carers have needs of their own and had developed a Carer Strategy in consultation with carers to develop the services available to them. We saw action had been taken in response to the feedback provided by family carers. For example, 'Carer days' had been increased and a Carers' café had been launched to provide carers with an opportunity to share their experiences and the challenges they face with other carers. The Carer Support Needs Assessment Tool (CSNAT) was also being piloted to support staff to identify and signpost carers to the support they might need. Carer Companions had also been introduced; these are volunteers who provided carers with practical and emotional support to continue to fulfil their carer role to people living at home. One carer told us "I really felt valued when I took part in the carer strategy sessions and it is good to see action has already been taken. The support I

have received from the hospice has enabled me to go back to work after many years of not having the confidence to do so".

All staff described clearly and consistently the culture of positive leadership within the hospice. They were enthusiastic, motivated and welcoming throughout the inspection process. One staff member told us about how their role had flourished due to the positivity of the leadership and management team. They went on to say they had been very supported in their health and safety role with training and supervision. Another staff member commented, "This is the best place to work, everyone is kind, committed and professional". A third staff member said "The managers are very approachable, clear in what they expect from us, I have never worked in a place that was this well run and organised". The safety and wellbeing of staff was considered and monitored. For example, due to the nature of this service staff may work in people's own homes where they may place themselves at risk of unforeseen events. Lone working was well managed, the hospice had a policy and procedure in place that all staff knew and we saw evidence of it being regularly reviewed. Staff also had the necessary emergency contact details at hand. This was good practice to ensure all staff returned safely from any visit within the community.

Staff also told us their views were actively encouraged and valued. They told us they were consulted about changes before they were implemented and had been given the opportunity to feed back on the new service model. One staff member told us "It is a big change of direction of the service but they have kept us informed and we have shared our concern". We saw that staff had influenced the review of the new staff bereavement policy and advocated for the hospice to purchase an ear irrigation machine to support people on the IPU with their ear care. The professional practice lead told us following the staff survey of 2015 and employee engagement group was developed, with sub working groups that championed staff's mental health/resilience, their physical health and nutrition. A staff resilience week was held in February 2016, with a resilience booklet produced together with a number of strategies to share experiences and support staff wellbeing.

We found the registered manager promoted an open culture of transparency where lessons could be learned to drive improvements. Staff were encouraged to raise concerns openly and without fear of recrimination. We saw examples of this in the implementation of the accident, incident, safeguarding and complaints procedures. Where appropriate, staff had been enabled through closer support and offer of additional training to ensure consistent high quality care for people using the hospice.

The registered manager understood the improvements that needed to be made across the hospice. The hospice had an array of systems for auditing and reporting to ensure a high quality service delivery. This included, but not limited to, patient safety and quality, medicines management, reports to the board of trustees and the Clinical Issues Committee. We had sight of the minutes and reports of the last meetings for all of these events which demonstrated how the service was scrutinised and how safety was being monitored and reported effectively. This showed a transparent organisation that had clear links of accountability from the 'floor to the board'. Information on matters such as infection control, falls prevention, medicines incidents, staff recruitment/competencies, complaint management, safeguarding and finances were known about by those responsible and accountable within the organisation. Effective methods of communication were in place as well as systems to address any matters arising. For example, we saw the registered manager took prompt action to improve the recruitment records when they identified areas that required improvement.