

Compton Hospice Limited

Compton Hospice

Inspection report

4 Compton Road West
Wolverhampton
West Midlands
WV3 9DH

Tel: 08452255497

Website: www.compton-hospice.org.uk

Date of inspection visit:
20 April 2016

Date of publication:
20 July 2016

Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place on 20 April 2016 and was unannounced. Further phone contact was made with people using the hospices community services on 27 April 2016.

Compton Hospice provides palliative and end of life care, advice and clinical support for adults with life limiting illness and their families and carers. The hospice delivers physical, emotional and holistic care through teams of nurses, doctors, counsellors, chaplains and other professionals including therapists. The hospice had a 18 bedded in-patient unit that accepted admissions for terminal care, symptom control and respite care, at the time of our inspection 14 people were on the unit. The hospice day service welcomes up to approximately 72 people per week and was being used by 10 people on the day of our inspection. The hospices community services that supported people in their own homes was provided by the homecare team which at the time of our inspection was supporting 14 people and the clinical nurse specialist service who were supporting approximately 275 people.

The manager was registered with us as is required by law. The registered manager held the role of Quality and Governance Manager within the organisation. 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.

Staff were trained in how to protect people from abuse and harm; they knew how to recognise signs of abuse and how to raise an alert if they had any concerns. There were sufficient staff on duty. Staffing levels were reviewed and adjusted according to peoples' changing needs. The recruitment process was robust and the provider was as sure, as possible, that staff employed at were suitable and safe to work with people who were cared for by the service.

Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. Medicines were prescribed, recorded, administered and disposed of in safe and appropriate ways. People received their medicines in a timely manner and in line with their preferences.

The staff team were highly qualified and experienced; people felt confident in the abilities and skills staff displayed and that they were well trained. The provider had its own training team and ensured staff were kept up to date with all their training needs and were supported in keeping their knowledge and skills updated. New staff were provided with a structured induction. Regular supervision and annual appraisal were used to support clinical and non-clinical staff.

Management and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and supported people in line with these principles. Staff established consent from

people before providing care and supported people to access independent advice and support when necessary. Resuscitation issues were discussed with people or their representative and the appropriate documentation was completed to a high standard.

People were provided with meals that were sufficient in quantity and met their needs and preferences. Staff knew about and provided for peoples' dietary preferences, restrictions and reduced appetite. People were supported to access all the support they needed in order to maintain their health and wellbeing, including effective symptom management.

Peoples' right to privacy was fully protected and they were always treated with dignity and respect by all staff and volunteers. People told us they were extremely satisfied with the staff approach and about how their care and treatment was delivered. Staff demonstrated they were kind, compassionate and forward thinking in meeting people's needs. People were fully involved in the planning of their care, from symptom and pain management to end of life care. Communication within the service was effective and people felt fully informed of their options for care and treatment. People were involved in the planning of activities that responded to their individual needs. A broad range of activities were available that included creative ways to keep people occupied, engaged and stimulated.

Regular multi-disciplinary meetings were undertaken to review and respond accordingly to peoples' changing needs. The management and staff worked closely with other professionals and agencies to ensure peoples' holistic needs were fully met. Clear information about the service, the facilities, and how to complain was made available to people and visitors. Complaints received were fully investigated and responded to, with evidence of the provider using them as a learning opportunity in order to make improvements to the service. Peoples' feedback was actively sought, encouraged and acted upon. People were overwhelmingly positive about the service they received.

Staff were clear about the leadership structure within the hospice and were fully involved in its development. Emphasis was placed on continuous improvement of the service. Comprehensive audits were carried out about every aspect of the service to identify how it could improve. When the need for improvement was identified, remedial action was taken to improve the quality of the service. A variety of regular clinical, governance and senior management and trustee meetings took place to share and review updates about the service. The hospice supported its staff to take on and lead on projects that would benefit people, staff and improve the quality of the service they provided whilst also meeting the needs of the local community.

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 overall managed effectively.

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

Robust and safe recruitment procedures were followed by the provider.

Is the service effective?

Good ●

The service was effective.

Staff were trained appropriately and received a comprehensive induction and were supervised frequently to ensure their continuous learning and development needs were met.

People's human and civil rights were upheld and staff took appropriate action if people did not have capacity to make decisions; people's level of capacity was regularly reviewed.

People had access to the health care they needed and were referred to internal and external healthcare professionals promptly.

Is the service caring?

Good ●

The service was caring.

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

People were consulted about and fully involved in their care and treatment.

People were supported to access independent advice and support when necessary.

Is the service responsive?

Good ●

The service was responsive.

Peoples' care and support was planned and reviewed in partnership with them, to reflect their individual wishes and highlight what was important to them.

Staff delivered peoples' care in a person-centred way, treating them as individuals and encouraging them to make choices about their life and death.

The provider was supportive of staff in relation to how they met peoples' personalised and diverse needs in relation to end of life care.

People knew how to make a complaint and felt confident that any issues they raised would be dealt with effectively.

Is the service well-led?

The service was well-led.

The management team gave strong and effective leadership and provided a clear strategy for the long term development of the service to its staff and the wider community.

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

The provider used a number of mechanisms to ensure staff were kept up to date and able to give their comments and opinions about the hospices future.

Good ●

Compton 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 20 April 2016 and was unannounced. Further phone contact was made with people using the hospices community services on 27 April 2016.

The inspection was carried out by one inspector, a member of the CQC medicines team, a specialist advisor and an expert by experience. The specialist advisor had the experience working as a nurse within the field of palliative care. The expert by experience is a person who has personal experience of caring for someone who has used this type of care service.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The registered manager had submitted the information as we requested.

We also reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We contacted commissioners from six local Clinical Commissioning Groups (CCG) who had commissioned the service to provide care to people from their own locality to ask for their views on the service. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We spoke with twelve people who used the services provided by the hospice, six relatives, one volunteer, one consultant, two speciality doctors, a physiotherapist, the housekeeper, a cook, the estates manager, 16 staff members, three service managers, the registered manager, the director of nursing and the chief

executive officer.

We reviewed six people's care records, to see how their support was planned and delivered. We spent time observing staff interacting with people and their relatives. We looked at other records related to people's care and how the service operated, including seven medicine records, three staff recruitment records, a range of meeting minutes, quality assurance documents, clinical and environmental audits and records of complaints.

Is the service safe?

Our findings

People using the service told us they felt the support they received was safe and made them feel secure in the way it was delivered. People said, "When they [staff] transfer me from my wheelchair into bed there's always two staff to help me that keeps me safe from anything happening they tell me what they would like to do and how they are going to do it", "I feel safe and well cared for, the staff ensure that I don't fall or stumble and they walk at my pace" and "I have some personal belongings in my room but I know it's safe and no one would take anything away without asking me". Relatives said, "It's definitely a safe service, the carers know how to get the help [person's name] needs".

People told us they felt sure that any concerns or issues they raised would be dealt with appropriately by staff. People told us, "I can sit and chat with the staff, I share any concerns that I have and feel safe knowing that I'm saying these in a confidential way" and "If I was worried or concerned I would chat to the staff and I know they would be very supportive". Staff had received training in a variety of ways in order to keep people safe and protect them. This included how to identify, deal with and report any concerns they may have in relation to potential or actual abuse. Staff told us, "We have training about what the types of abuse are and what to look out for", "Any concerns, first of all, ensure the person is safe and not in danger, then speak to my line manager, take steps to involve the local authority and complete a referral form" and "You are never alone here, so if I have concerns I can discuss them and if necessary alert the local safeguarding team accordingly. We also have a social work team whom we work closely with us when safeguarding issues are reported". Staff demonstrated that they knew their responsibilities to protect people, share and report their concerns. A volunteer said, "I'm aware of my professional boundaries with people; if I see anything that concerns me I inform the staff straight away".

Feedback and outcomes from any safeguarding issues, incidents or concerns were cascaded to staff in meetings. Staff who had reported concerns told us they received direct feedback in relation to these. One staff member said, "We are very much kept in the loop about safeguarding in meetings and in relation to an issue I raised I did receive feedback about what the outcome was". Staff were able to describe the different forms of abuse people may be at risk of and described how they would discuss their concerns with the appropriate internal managers and the local authority. They also understood how they could utilise the providers whistle blowing policy should they need to discuss any concerns in confidence. A staff member said, "I know how to use the whistleblowing policy to report any concerns I have in confidence".

People were supported by staff who knew their individual risks and how to look after them. We found potential risks to people were effectively assessed in relation to their individual health and support needs. We saw people received support and protection in line with their identified risks. For example one person told us, "When I walk around with my cage (walking frame) staff watch what I'm doing to make sure I don't trip or anything like that" and "When I go to the toilet or have a bath staff walk with me so that I feel safe and they are with me in case anything happens to me". Records we reviewed detailed how people's health risks should be managed to maintain their safety and wellbeing and staff we spoke with were aware of people's individual risks. The records we reviewed were updated as required and reviewed periodically. We observed people being supported to use equipment provided to assist them to mobilise. For example, walking frames;

we observed staff knew how to support people safely to use their equipment. We saw pain management care plans were in place and individualised in order to minimise the risks of people experiencing any unnecessary discomfort, also medical treatment plans were clearly documented following ward rounds.

Staff understood how they should respond to a range of different emergencies. Staff were provided with training in relation to medical emergencies that may arise including anaphylaxis (an extreme and severe allergic reaction), where clinical skills were practiced using role play and scenarios to aid learning. Staff took part in regular fire drills and we saw there was appropriate signage about exits and fire equipment throughout the hospice. Training in relation to health and safety was delivered on a monthly basis for staff to attend by the estates manager. Fire safety equipment had been serviced and was regularly checked. Audits were undertaken to make sure all equipment and the building were checked and equipment serviced as required. Checks were regularly completed to ensure equipment was appropriately maintained such as hoists, specialist beds and equipment. We saw a fire risk assessment had been completed by an external agency and that actions required by the provider had been or were in the process of being completed. Reports on progress of any actions in relation to the safety of the environment and equipment were shared at regular governance committees, to monitor that the appropriate levels of safety were in place.

The provider operated clear processes and a policy which staff were able to discuss with us in relation to the reporting and learning from incidents. Commissioners of the service told us that when there were incidents within the service they found the provider was keen to understand what learning opportunities existed so that they were able to make changes to improve care standards. Staff members said, "The managers keep us informed of any incident outcomes and what we can learn" and "They (management) expect us to report everything and make sure we follow policy". Reporting of any incidents, including updates about any investigations and subsequent changes to practice and learning were made available to the clinical quality and governance committee each month. Staff told us they were kept informed of outcomes in relation to incidents they were involved in and those that occurred within the wider hospice in various meetings. The service identified that the highest number of incidents reported were in relation to falls; as a result the decision was made by management to provide falls prevention training to staff on the inpatient unit. This demonstrated that the management team were keen to learn from incidents and maximise the safety of people using the service.

We reviewed the processes for recruitment within the hospice and found these to be effective. Staff confirmed that they had to provide satisfactory evidence in relation to their character, skills, qualifications, work and personal history before commencing in their role. The provider completed the appropriate checks and obtained the information they needed to ensure that staff were suitable to work with people who used the service.

People told us there were enough staff on duty to ensure their needs were met in a timely manner. People told us, "The staff are brilliant when I press my call button they are here within minutes to make sure that I'm okay. There's plenty of staff and volunteers around to look after me it's the same in the evenings and weekends too", "There's always staff around to help and support me; they answer the nurse call straight away no messing about there, they are here in a flash" and "There's lots of staff around including the volunteers. If I need anything they do it straight away but if they are busy they say I will come back in a few minutes and they do". During our inspection we observed that there were plenty of staff on duty. The director of nursing services discussed how the skill mix and level of staffing was established with the use of a dependency tool. However they had trialled several tools but found that reviewing staffing and levels of support that people required on a daily basis was the most effective tool. The hospice had its own bank of staff it could call upon to cover any shifts as required; this was mostly made up of current and ex-employees of the hospice.

People we spoke with who were receiving care in their own homes via the hospice at home team told us the staff supporting them were mostly the same group of staff. One person told us, "The visits are flexible and [staff member] is always here within five minutes of when she is due or on time". A relative said, "There's consistency with the staff who come; [relative] feels comfortable with them and so do we as a family".

People spoke positively about how the staff managed and provided them with their medicines. They described how staff supported them with their medicines saying, "The staff guide me on my medication and explain what they are for", "They give me my medication at the prescribed times as agreed and they have never forgotten to give it to me", "I feel safe about my medication, as staff tell me what it's for, the side effects it may have and what to expect from taking the tablets" and "They [staff] gave me some new medication, they explained what it was for and to be aware of any side effects but there hasn't been any". A relative said, "My relative receives the medication as prescribed by the medical team, so I don't have any concerns there".

The provider used a community pharmacy for the supply of all medicines including out of hours. The hospice employed a palliative care pharmacist to provide clinical advice and support to the nurses, doctors and patients. Doctors prescribed medicines for people and used medicines that people brought in to the hospice. A doctor checked medicines for accuracy when a person came in to use the service. The staff did not routinely support people to look after and self-administer their own medicines. This meant this choice of independence was not always offered to people. People were discharged with a full list of their medicines including additional information such as a chart of when to take the medicine and what it was for.

The service had a clear system in place for managing the ordering and supply of medicines. Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored securely and monitored appropriately. All medicines were stored securely for the protection of people who used the service. Staff had quick access to emergency medicines in the event of a severe allergic reaction. Daily temperature records were available which recorded the temperatures for the medicine refrigerator. However, we found twenty-two records between March and April 2016, which documented that the refrigerator temperatures were not within the recommended safe storage range for medicines. Staff said there were no records available to show any action taken to ensure refrigerated medicines were stored safely.

Staff locked away prescription pads securely with a copy kept of each used prescription for audit trail purposes. Staff knew how to report medicine incidents and we saw evidence they were investigated and an action plan was completed. Incidents were discussed at regular meetings with clinical staff to share learning.

Is the service effective?

Our findings

People were positive about the level of skills and knowledge that staff demonstrated when supporting them. People said, "Great well trained staff", "The wards are well managed by trained and competent staff", "The staff are all well trained", "The staff must be well trained as the level of care and competency is very good" and "It's so refreshing just being able to talk to different members of staff who have different skills and a variety of ways to help with my illness". Relatives told us, "The staff have fantastic levels of knowledge, all of them, everybody is superb; there are no weak links" and "The staff know what's what".

There was an education team who provided a variety of training for all staff including any updates and refreshers staff needed in relation to their basic training and any additional training staff required was sourced from external experts according to identified need. The provider had its own training venue nearby the main hospice site. In addition there was a nurse employed three days per week as a manual handling co-ordinator and another employed two days per week as the infection, prevention and control lead, and their roles included the provision of training. Staff told us, "They (managers) actively encourage training here, there are lots of opportunities for continuing professional development (CPD)" and "I am completing a degree in advanced communication; my manager has been very supportive. I have my next lot of training lined up to complete when I am finished". A volunteer told us, "I have regular and ongoing training which keeps me up to date with my role". Staff received an annual appraisal where they told us any future training needs were discussed and reviewed. One staff member said, "We have an annual appraisal to set goals and objectives for the coming year". A commissioner we contacted prior to our inspection told us how they had seen evidence of how the provider invested in developing the skills and confidence of their staff in specialist areas.

A robust induction package was offered to all newly recruited staff which included training in the 'essentials of palliative care' and placements in all clinical areas. The provider had begun to map current training with the care certificate and had commissioned skills for health e-learning which is care certificate compliant. The care certificate sets fundamental standards for the induction of adult social care workers. Staff told us they were supervised closely within their induction period and that competency checks were undertaken during this period. Staff described their induction as 'useful' and 'informative'. Staff said, "I shadowed various members of the hospice team, undertook training, and I had two mentors to support me", "My induction was comprehensive, it included training, shadowing and spending time in all service areas and if I had any issues I knew I could seek support from anyone", "I act as a mentor for new staff; we work in pairs and very closely with new staff. They only go out alone when they are ready, it's all done at their pace", "During my induction all my learning was outlined and I got to see and experience all aspects and areas of the hospice and met with my manager frequently" and "Induction includes an overview of the whole organisation; the induction process has improved massively over the years". We saw and staff told us they were set learning objectives on each induction placement, which included answering questions about clinical signs to look out for and evidence of what they had learned from what they had witnessed. Healthcare assistants working in the hospice at home team were expected to work two shifts per year within the inpatient unit so their practice could be effectively observed.

Staff received regular support and supervision from a variety of sources. This included peer supervision and debriefs which staff were encouraged to attend if they were involved in a complex or particularly challenging incident. Staff described the ways in which they received support, telling us, "We have regular supervision, both individually and group", "I am able to access a range of supervision but prefer to have mine individually, which has been facilitated" and "I am supported, very much so, supervision is readily available".

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. We found that consent was sought, obtained and recorded before any aspect of people's care and treatment was carried out. One person told us, "Everything that happens to me is discussed with me and they (staff) make sure I am involved in making any choices". A relative told us, "The staff communicate very well and if my relative is unsure of what they mean they say it in a different way so they can understand because they get confused at times". Another relative said, "They (staff) came and talked [relative] through his options, they talked about a variety of things early in the process, where he wants to be, what care he wants; it was good that they (staff) spoke to him about these things when he was well enough to understand".

During our inspection we observed people being supported and encouraged to make decisions and choices for themselves. Staff were able to outline how they continually assessed people's ability to make informed decisions, as often due to medicines prescribed and progression of their condition, their mental capacity could fluctuate. Records showed for example, a doctor had comprehensively documented specifics about a patient's advanced dementia thus evidencing their level of mental capacity to make decisions.

Staff gave us examples of when a DoLS referral might be considered. At the time of our inspection no one was subject to a DoLS authorisation. Records we reviewed provided further evidence of the ongoing assessment of people's level of capacity during their stay. Staff had received training in relation to the principles of MCA and DoLS and they were able to demonstrate to us their understanding of how this should be applied in practice. There was a designated MCA and DoLS champion who attended a local steering group to share learning and updates that could be adopted by staff in relation to best practice.

A relative said, "The DNAR is in his file; the staff supported us to do this". Documentation in relation to people's decisions about resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were in place. These were completed to a high standard and had been completed with the person's knowledge, participation and agreement where possible, or alternatively their designated representative. A staff member said, "We work closely with people to ascertain their wishes, for example resuscitation issues".

People gave us positive comments about the quality, choice of food and drinks available to them. Comments from people included, "There are snacks and drinks around all day so that's good for me; the meals are excellent as well with choices from the menu", "The food is good with plenty of choice and drinks are available during the day and in my room at night", "The food is good and hot and tasty too" and "We have lovely food and even though I'm Asian they can cater for my needs, which I feel is very good of them".

Relatives told us, "My relative eats so very little and often refuses any food but the staff encourage them to eat a little and they give my relative fortified drinks and things like that to help", "I have seen the meals and they are well presented and look nourishing and appetising" and "Its a super menu, but if there isn't anything [relative] likes, they ask what he fancies and they prepare that".

Staff told us there were choices available outside of the menus. We observed that a person changed their mind about their lunch and had been presented with alternative options. Staff confirmed that additional food from the menu was readily available throughout the day and night to meet peoples' nutritional needs. People who remained in bed had a jug of water or juice of their choice that was within reach and replenished throughout the day and night. A relative said, "The staff are always coming in to check we are okay and offering us food and drinks". The hotel services manager sent out meal satisfaction surveys; the most recent they had received back were in the process of being analysed at the time of our inspection. The kitchen manager told us they met with members of staff every three months to 'iron out any problems and act on their feedback to improve the food service'. Recommendations from the speech and language therapists were followed. The chef was knowledgeable about people's individual dietary requirements, preparing soft diet food or pureed meals when people had difficulties with swallowing. Staff demonstrated they knew those people who needed additional support and monitoring to ensure their nutritional needs were met. We observed staff had time to help people to eat and drink effectively and people were supported when they needed encouragement. Nutritional assessments were completed and appropriate care plans outlining how these needs should be met were in place.

The provider employed a range of healthcare professionals including a team of doctors who worked across all services provided by the hospice; including people in the in-patient unit, the hospice day service, at home and in out-patient clinics. The variety of health care professionals employed enabled peoples' health and wellbeing to be responded to effectively when people's needs changed. For example by a physiotherapist or a psychotherapist. We saw people were also referred to external healthcare professionals when necessary.

We observed a multi-disciplinary meeting where peoples' individual health needs were discussed by the team and the need for both internal and external referrals were actioned. The provider had sourced training for members of the medical team so that ultrasounds could be carried out on the ward for certain conditions thus reducing the need for transfer to the local hospital. An ultrasound scanner had been purchased by the hospice for this purpose. This meant the provider was keen to minimise any delay for people using its service in receiving the interventions they required.

Is the service caring?

Our findings

People were very positive about the support they received and told us they found all aspects of the service to be caring. Comments we received included, "It's a place you can't describe; rating it would be excellent in care and looking after me", "It's very good here, very caring staff", "Very friendly and genuinely concerned about how things are with me" and "I'm going home today and it's been a very positive and enjoyable experience if you can say that, the staff are so caring and will do anything for you". Relatives told us, "They (staff) are fabulous at caring for my relative and nothing is too much trouble for the staff or volunteers. The care that they provide should be a template for all patient care services to follow", "The care and compassion shown here is just so genuine", "The staff are golden, they are so lovely" and "I think they (staff) are wonderful, they have been brilliant with me as well as (relative)".

Staff told us how proud they were of the work they did and the support they were able to provide to people. Staff members told us, "I show people I care by being very reliable and not letting people down. I always making sure they have what they need and that they understand their treatment and their medication. I always show interest in people's family and look at their individual care needs also", "I love working here it is a honour and privilege to care for people" and "The last days of care a person's relative receives is what they remember so that makes it even more important for us to do our utmost to get it right".

The hospice had a homely feel and we saw that it was a social atmosphere where people were encouraged to chat if they wished, and were listened to. However peoples' need for privacy and quiet was also seen to be supported. A relative told us, "They move (relative) from the bed and put them in an armchair looking out into the garden which is lovely and thoughtful of the staff because it makes my relative very happy". Staff were smiling and engaging; they stopped to listen to people and responded to them with apparent interest. We saw all the staff approached people in a friendly and caring manner, demonstrating calmness in their approach. They followed peoples' pace when they helped them and when they conversed with them. We observed friendly and appropriately humorous interactions between people and staff.

People told us their friends and relatives visited regularly and were welcomed to the hospice. A person told us, "What is marvellous is that any of my children can stay overnight if they want to, which I think is a good thing for families and the visiting times are flexible which gives my family plenty of time to see me". Facilities were provided for the families of people using the service to stay overnight either within the person's room or nearby in a designated room. Such measures ensured people could retain and find comfort in routines with those who were important to them.

Spiritual and cultural needs were considered and bereavement support and counselling to was available to people and their families. Bereavement support was offered by the service's bereavement service and was provided for as long as the person or family required it. This could be provided at the hospice or at the home of the bereaved person. One person told us, "This place is a god send to me, it keeps me sane and happy, I chat with the staff and they try and meet my cultural needs when I come for support. I often go to the spiritual room for prayers and quietness". There was a quiet sanctuary room where people could go to be alone for reflection or prayer or to be with others in order to meet their spiritual needs. The chaplain and

their team of volunteers were available for people at all times. Spiritual support was available to everyone, whether or not they had a particular faith. A staff member said, "Spirituality is about what's important to the person". People and relatives told us staff understood their emotional needs and focused on their wellbeing. Staff were seen to be acutely aware of peoples' need for comfort and support, providing appropriate touch when needed such as gently stroking a person's arm. Care plans and medical notes described how patients' emotional needs had been addressed.

People told us they felt fully involved in planning all aspects of their current and future care needs. They told us they were involved in all discussions about their care and treatment and were able to express their views, preferences and wishes in this regard and also in developing advance care plans. One person told us, "They (staff) communicate any concerns in an appropriate way and include my relative in the conversation. If they [staff] have any concerns they talk to us both to find out what our views are". A relative described how their loved one had been supported to make an advance care plan, they said, "They (staff) were so sensitive and marvellous how they did it, supporting him to make choices and decisions and giving him time to think; they made sure he knew he could change his mind at any point". Another relative said, "I have been fully involved, they (staff) have helped me to help (relative)". A person shared their experience of making end of life care choices saying, "I am able to face the future without fear now with all the support I have received to make decisions. (Staff members name) helps me to function, she understands me". Records we reviewed demonstrated peoples' end of life choices were documented and adhered to.

People told us they felt informed about their treatment and care and staff gave them the information and explanations that they needed. Comments received included, "They (staff) communicate very well, from the doctors to the care assistants to the volunteers", "I ask a question and they don't know the answer they find out for me", "When (staff member's name) visits we talk just like a normal conversation, not focussed on illness and death all the time, but then she will pop a specific question in but it's done cleverly, so you don't really notice" and "At no stage was I unclear about what would happen, if you think of anything you can call them, it's very reassuring". Relatives said, "They (staff) communicated so well with us, you could ask anything but rarely needed to as they (staff) were so forthcoming with information; I knew everything that was going on with (relative)" and "They (staff) communicate well and explain what needs to be done, it's told to us in 'easy' ways of understanding and if we are unsure they explain it in another way".

Staff we spoke with described the ways they communicated and consulted with people and their families to have all the information they needed, both verbally and supported with written care records and information leaflets. One person described how staff effectively communicated saying, "We went back to the hospice to get the death certificate. One of the nurses, whom we had not ever met, asked how one of my family was who had been hit very hard by (relative) death. So even then they (staff) had communicated well enough with each other to be asking about an individual family member's welfare". A staff member said, "It's important to listen to people, talk and get to know them, take your time, give them the explanations they need and help them to make choices". Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors.

Personal care was offered discreetly. Staff showed a good understanding of the balance between maintaining people's privacy whilst also acknowledging the need to monitor their complex health needs. People told us, "I rate the dignity and privacy I am given and there's nothing I would want to change", "I have been here four times and it's always the same, excellent care, dignified, compassionate and they respond to me with gentleness and respect", "When they give me my personal care they make sure the curtains and the doors are closed to protect my privacy. They tell me what they are going to do and that it's okay by me, which of course it is" and "When they provide my personal care they maintain my independence by only doing the tasks that I can't do or reach; I feel treated like a person and not a patient". Relatives said, "When

staff delivered personal care they were so discreet, absolutely marvellous", "Immediately every aspect of care was dignified from the day (relative) was brought to the hospice; it was amazing, they were completely focussed on making him comfortable" and "Staff here treat [relative] with such dignity, they make sure there is no embarrassment for him, they talk him through everything".

Staff gave us examples of how they considered peoples' privacy and dignity when providing support, saying, "I wait to be invited in and always consider if the person has visitors, if there are other people there, check with the person if they are happy to proceed with the visit", "It is important to get to know people slowly, as some people are very private; slowly build up a relationship to gain peoples' trust and confidence, always being respectful of their wishes", "Things to consider around privacy and dignity are introducing yourself to people, find out what name they like to be known by, gain their trust, explain everything, ask what their usual routine is and get to know peoples' likes and dislikes" and "I am mindful of people's choices and respect that you are in their home". A volunteer stated, "I'm aware of the importance of confidentiality and always treat people with dignity and respect". People confirmed they had their independence maintained in the way their care was provided. They told us that where necessary, staff supported them to regain their personal strengths and had helped them to cope and come to terms with their condition. A person told us, "Without the support I have had I don't think I would be as well as I am; they (staff) have helped me to take some control back".

For those people who did not have a family member or carer who was appropriate to support them to make decisions, staff knew how to access advocacy support through their internal and other external services. Staff said, "There is a Macmillan Advocate that we can go to and report if there is anything people need help with and also we do advocate on people's behalf" and "Recently one person we supported had concerns about their pet and it's care after their passing, so we involved the advocacy service to support them to make some decisions". At the time of the inspection there were no people who required an advocate; however staff were able to explain how they would respond should a person require one.

Is the service responsive?

Our findings

People told us they felt the service was very responsive to their needs and wishes. They told us, "The staff are very good and supportive and help me when I need it", "Yes, staff know a lot about me and what my needs are", "Doctors and nursing staff have been to see me every day to make sure that my treatment and care is going well", "If I press my nurse call button they are here in seconds to see what I want", "The staff visit or are in touch by phone and they always encourage us to ring if we have any concerns or questions; if you have a 'wobble' there is someone there to talk to" and "The nurse who visits me is so helpful and if I need anything this is sorted very quickly". Relatives we spoke with confirmed the responsiveness of the service saying, "I have a number to call anytime I need to know anything about medicines and everything else", "Staff understand and take account of (relatives) changing needs really well" and "I have been totally amazed by it all, I can get a good night's sleep as they will come out and support us at night, I keep telling them (hospice at home staff) how impressed I am".

People's care and support was planned in partnership with them. We observed the staff provided personalised care, spending time with people to discuss a management plan for their symptoms; including their emotional and spiritual needs and identifying their preferences and choices. People told us, "I come here every week (day hospice) and coming here has given me my life back", "It's in a sense all centred around my needs and they help me stay positive too" and "I wasn't convinced this was the place for me (day hospice) but the staff were very welcoming and identified my needs and abilities, I am now doing things here that I can carry on doing at home instead of getting depressed". A number of weddings, christenings and blessings of marriage has taken place on the unit at people's request. Also people had been supported to have their pets to stay with them overnight in their room, which they had identified as being their wish.

People told us their care and support was planned in partnership with them and they felt in control of their own treatment. Upon first contact with the service, often through the clinical nurse specialist (CNS) service, staff spent time with people and encouraged them to ask questions, and discuss their options. This included where they wished to spend their last few days of life. A person said, "The CNS has gone through everything with me and has given me all the information I need". The hospice at home team enabled people to be at home if they had chosen this as their preferred place of death. A relative who had been able to fulfil the wishes of her husband to be cared for at home said, "I made a promise to my husband, we promised each other; I was able to keep my promise with Compton Hospices help". People were supported to make advanced decisions. A staff member described how, where possible, they built therapeutic relationships with people before raising such issues, saying, "I get to know the person a little first and build on things from there". People we spoke with told us they had discussed their future care decisions. A person said, "I have discussed my future wishes for care and it was done very professionally and respectfully".

People told us how they had been supported by staff to reduce any social isolation they may experience due to their condition through accessing community based support services. A person told us, "I have been pointed to other community activities or support groups I can get involved in for when I'm not here (at the day hospice)" and another person said, "They (staff) have helped me to access other services that can support me in the community".

People who came each week to the day hospice for support told us of the positive benefits they gained from attending. They said, "There's activities that I can do but I'd rather sit and chat with other patients and share our thoughts together, it helps me", "We all sit and chat and know it's kept inside the group so it's a safe environment to support and encourage each other too" and "I'm always working in the art and craft group and that's every time I come because it stimulates me and I feel good about myself and my family have seen a change in me for the good too". Day hospice staff told us they were able to monitor people and the progression of their condition, through their attendance; reviews were conducted and access to medical review was organised as necessary for people.

The staff provided support to both people and their families with both the practical and emotional needs. One person told us, "The social worker supported me with some family issues I had, as I was suffering due to trying to juggle too many responsibilities. The whole family were considered and it was amazing". Another person told us, "The nurse suggested things that could be done for me at home and I have been supported to get the equipment I need, like a disability badge and carers allowance". A relative said, "Even when we needed a prescription, they [staff] found a pharmacy that I could get these specific drugs from, which was very helpful". The social work team were trained to provide counselling and psychological support to families and pre bereavement support for children. Observation and documentary evidence showed us how well staff interacted with people, listening and responding to their needs. Staff also cared for people in a way that respected their individual choices and beliefs.

Admission meetings took place each morning and were attended by medical staff, the ward manager, discharge liaison nurse and the hospice at home co-ordinator. These were held to discuss, arrange and prioritise the needs of people accessing or using the service. People were reviewed at least daily by a doctor so there were opportunities for people and their families to ask questions. The daily review also helped to ensure that people thought likely to be entering the last days or hours of life were identified. This meant people nearing the end of life had timely access to the support, equipment and the administration of medicines they needed. One person told us, "They [staff] manage my symptoms very well and if I'm in pain they give me something to help and monitor the pain to make sure I'm okay". A relative said, "The staff visited pretty regularly before but are now increasing how often they visit as things are worsening".

We found a high standard of care planning in the records we reviewed, for example the 'individualised' sections of the care plans we reviewed were all fully completed and detailed peoples' wishes, decisions and preferences. Discussions with staff demonstrated that they were fully aware of peoples' preferences and choices. There was definite feel from staff that they were enabled by the provider to be creative in the way they provided the service and acquire the necessary skills to develop themselves professionally. The provider had implemented several clinical initiatives including the development of a joint clinic with a respiratory consultant at the local hospital (which helped to introduce patients with chronic obstructive pulmonary disease to the hospice at an early stage). An outreach service provided by the physiotherapy team who were specifically supporting people with breathlessness symptoms. In addition, many of the CNS team were trained as non-medical prescribers [a healthcare professional who is trained to prescribe medicines who is not a doctor]. Although the impact of this has not been formally evaluated, it was clear that people in community had speedier access to the medicines they required.

Staff told us how they were able to keep up to date with any changes to peoples' health and care needs. A volunteer said, "We have a talk [with staff] when we come on duty, keeping us aware of any relevant information that needs to be given to us as a volunteer". A staff member said, "I always take into account what is written in the records when visiting people at home as people's needs can change dramatically". The provider operated a 24 hour advice line for those people known to the hospice and for medical professionals seeking advice for people who weren't known to the service. People we spoke to who were

receiving care from the hospice in the community were aware of this service and that they could call if they needed any support at any time. One person said, "I know what's available, who to phone and who to speak to".

Compton Hospice had set up a palliative and end of life care in prisons project to improve the end of life care for prisoners and the adoption of Macmillan Adopted Prison Standards (MAPS), as the care being provided in local prisons failed to meet these standards. The programme was amended over time to incorporate the most helpful elements (recognising when someone is unwell, what is palliative and end of life care, supporting others/self-care). They were able to then deliver this training in one day as part of the prison staff's ongoing training and support; all healthcare and prison staff were invited to attend these sessions. The project and its evaluation had been shared at a number of conferences, including the bid paperwork, job description, and person specification. This has led to other project lead roles being developed around the country including a post within a local prison. The lead of the project had received an externally recognised award in the category of clinical audit for their work. This meant that the service had tailored specific training to meet the needs of people in diverse circumstances at the end of their life, giving them choice and control to get the right care and treatment when they need it.

Staff gave other examples of how they had been supported to develop in-house and local initiatives with management support. One staff member told us, "We identified a gap in education and training in nursing homes, and we were asked to start a project to improve this. I was able to go to my manager and had her full support to develop this". Other examples of staff initiatives included the development of internal guidelines in relation to oral care and the creation of a comprehensive induction program for student nurses.

All the people we spoke with said they had seen information about how to make a complaint, comment or suggestion when they started using the service. People told us, "I have no worries or concerns but I would talk to the doctors if I needed to complain but I have never had a reason to", "If I'm concerned or worried I'd chat with the staff who I know would help me" and "Complain, yes I know how to do that, but I have no worries or concerns as it's such a great place to receive care and treatment". Relatives told us, "All the information we need is here, including how to make a complaint" and "If I had any concerns I would speak to the nurse or doctor and they would reassure me or deal with my concerns". There was an open, inclusive and a listening culture among all staff who worked at the hospice. Staff we spoke with were aware of the ways in which people could make comments, raise concerns and complaints and described to us how they would support people to do so. Staff said every comment was taken seriously and dealt with as quickly as possible. A staff member said, "I would provide the person with the complaints procedure, give them contact details for my manager and assist them to record their concerns formally; I know it would be investigated".

All formal complaints were recorded and investigated by the appropriate departmental head and records were well maintained. Departmental heads explained when complaints were investigated, the outcomes were discussed at governance meetings, shared with the trustees and senior managers duly informed staff of the outcomes and any lessons learnt. Compliance with the complaints process was monitored through checks and regular audit. Complaints we reviewed had been addressed in line with the providers own complaints policy. Learning and changes to practice that were identified were actioned as necessary following the investigation of a complaint. For example following a recent complaint we saw that an information leaflet had been developed to provide people with knowledge about a specific type of medicine for people and their relatives.

Is the service well-led?

Our findings

People told us their experience of the service had been 'excellent' and 'faultless'. Other comments we received from people included, "It's a really wonderful place to be in for my care and support", "A lovely place to be if you need help and treatment", "I'm so very happy that I decided to come here", "There's absolutely nothing I would want to change, how can you change a superb service" and "It a very good service, everyone would benefit from it". Relatives said, "I wish there were more places like this. It makes me want to volunteer", "The service we have received has been excellent", "There's always a calm atmosphere, there is really nothing I would want or need to change, you can't improve on this perfect care and treatment service", "Compton Hospice is absolutely superb and I was delighted with the service we received", "I am very happy with the service we have, you couldn't ask for better" and "The are very special people, the service they provide is marvellous".

There was an effective leadership team that oversaw the running of the service, which included a newly recruited Chief Executive Officer (CEO), the registered manager and a director of nursing. All the staff we spoke with told us they had confidence in the way the service was managed. Staff praised the leadership team for their approach and consistent, effective support. Staff told us, "The whole organisation is great, there is always someone to talk to and you never feel alone, they are very supportive", "I can go to my manager at any time about anything", "It's a lovely place to work, it's the best place I have ever worked", "The new CEO has sent us emails and plans to meet and wants to spend a few hours with each individual team" and "Personally I think it's a good service, I feel very well supported, they are fair". We saw that volunteers were a vital part of the hospices day to day effectiveness. Those we spoke with told us they felt very much part of the organisation and were complimentary about the service. They said, "Compton Hospice nursed my mother and husband through their end of life, it was beautifully done so that's why I'm here and I love it" and "It's a really good place to work, I have been a volunteer here for many years, I feel so valued and feel part of the team".

Staff told us they felt informed and were consulted about plans for development of the service. The provider used a number of mechanisms to ensure staff were kept up to date and able to give their comments and opinions about the hospices future. These included updates through emails, attendance at regular department meetings, newsletters and surveys. Staff reported that they had been actively engaged in the development of the clinical aspects of the hospice strategy. For example, one member of staff spoke positively about a working group they were part of which was looking at a specific clinical area that needed further development. Staff said, "We are kept up to date, any changes are done in consultation and we are asked to attend meetings", "We have weekly meeting, emails to keep up to date with what is happening in the wider organisation, we are well supported" and "There have been a lot of changes in our team, it has expanded considerably; we were all included in the discussions regarding this at team meetings, we were informed and included in the developments made and how we would operate in the future".

The registered manager was aware of their responsibilities for reporting any significant events that affected or the service to the Care Quality Commission. Prior to our inspection we requested information in the form of the Provider Information Return (PIR); this was fully completed and returned to us in a timely manner. The

registered manager had joined the organisation last year and staff were positive about their impact upon how the hospice was run and managed. A staff member said, "[Registered managers name] has been really good, she has made quality issues more professional, she has done incredible things and made a real difference".

There was an effective system in place to regularly check and monitor the quality of the service. There was a comprehensive program of in-house regular audits such as medicines, infection control, environment, incidents and complaints that fed into committees and board meetings for consideration and scrutiny by senior managers and trustees. For example, the recording system for incidents demonstrated that all the relevant information had been considered and analysed without delay. The registered manager was informed of incidents as they happened and we saw action was taken to minimise the risks of reoccurrence. A pharmacy committee met each month including community pharmacy staff, department leads and lead nurses to update and discuss emerging best practice and provide incident updates. We also saw completed audits for general medicines and for controlled drugs. We saw action plans had been developed and evidence of changes implemented in practice because of the audit findings.

People and families were asked about their experience of the service through satisfaction surveys. These could be completed on paper or online. We saw the provider was responsive to feedback that was provided and had changed practices where a need had been identified. For example, the hospice at home team had created a checklist for newly referred people which staff completed with the person by phone, prior to their initial visit. This was to ensure consistency in setting the limitations and expectations of the service, as a result of comments made. People were asked to complete these on day three of admission to the in-patient unit however the registered manager told us that the return overall was poor across all departments. They told us the organisation had identified this was an issue and aimed to improve the level of responses as one of their priorities. We saw that comments books and suggestion boxes were available for people and visitors to make less formal contributions about their care.

The provider promoted a culture of openness and willingness to learn. The provider had analysed and shared the results of the most recent staff survey with staff. Four areas had been highlighted where some less positive comments had been received. At the time of our inspection a series of four staff focus groups had been arranged, to be facilitated by the registered manager, human resources advisor and lecturer practitioner. Staff we spoke with were aware of the sessions and told us they appreciated this opportunity. They told us, "At present sessions are being put on for us to attend, as a response to the findings from the staff survey, which is really great" and "It's great that the staff survey is being followed up". This meant the provider valued its workforce and was keen to address areas identified as lacking in need of review or improvement for their staff.