Phyllis Tuckwell Memorial Hospice Limited

Phyllis Tuckwell Hospice

Inspection report

Menin Way
Waverley Lane
Farnham
Surrey
GU9 8BL

Tel: 01252729400
Website: www.phyllistuckwellhospice.org.uk

Date of inspection visit:
19 July 2016
20 July 2016

Date of publication:
19 October 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 19 and 20 July 2016 and was unannounced. The last comprehensive inspection of Phyllis Tuckwell Hospice had taken place in November 2013 and was followed by a focused desk-based inspection in July 2014. During the inspection in 2013 we had found out that not all of staff caring for people had been supported to deliver care and treatment safely and to an appropriate standard. At the inspection in 2014 we found out that the provider had addressed our concerns and met all the required standards.

Phyllis Tuckwell Hospice provides palliative and end-of-life care, advice and clinical support for adults with life-limiting illnesses, their families and carers. The hospice delivers physical, emotional and holistic care with the aid of teams of nurses, doctors, counsellors, chaplains and other professionals including therapists. The hospice runs an 18 beds in-patient unit and accepts admissions for end-of-life care, symptom control and respite care. At the time of our inspection 17 people were in the unit. The hospice also provides community services designed to support people in their own homes. The hospice's day service welcomes up to approximately 42 people per week and was being used by 10 people during our inspection.

There was a registered manager in post. 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. 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 to make sure people were protected from harm.

People and their relatives told us they were very satisfied with the care. We saw that people were treated with dignity, respect and compassion. People were involved in the planning of their care which meant their care preferences and choices were identified so that they could be met by staff.

Accidents and incidents were recorded and monitored to identify how the risks of their recurrence could be prevented.

Medicines were safely stored and those requiring refrigeration were stored within their recommended temperature range. Nurses recorded the administration of medicines on prescription charts including prescribed creams applied by care workers. Staff had the skills to effectively manage people's medicines so these were available and administered safely to people.

Staff and volunteers had been suitably recruited and there were sufficient staff with a variety of skills to meet people's individual needs and to respond flexibly to changes.

People were supported by sufficient numbers of staff to provide care and support in accordance with the individual needs of people. There was a flexible approach to adjusting the levels of staff required. People who were receiving care in the in-patient unit told us the staffing numbers were appropriate and assistance was provided promptly when requested.

Staff received the training and support they needed and were highly motivated to undertake their roles and deliver sustained high quality care. People were extremely confident and positive about the abilities of staff to meet their individual needs.

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). The service manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The service had made applications under DoLS to ensure that people were not deprived of their liberty unlawfully.

Staff provided meals that were in sufficient quantities and met people's needs and choices. People and their relatives praised the food they received and they enjoyed their meal times.

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 staff's approach and about the way their care and treatment was delivered. We observed staff were kind, compassionate and forward thinking in meeting people's needs. Staff knew how to meet the changing needs of people with progressive, life limiting conditions.

Staff were highly motivated and committed to providing people with the best possible palliative and end-of-life care. The service had received a large number of compliments concerning the kind, compassionate and caring manner of the staff team. People told us staff dedicated their time to listen to people and did not rush them. As people stated, staff did all they could to meet people's individual wishes and requests.

The service had a holistic approach to caring for people at the end stages of life. Supporting the person and their family members was seen as key to their well-being. Family members received support after the death of their loved one through individual or group bereavement counselling. People's spiritual needs were met and there was a range of different complimentary therapies.

People's needs were thoroughly assessed before and at the time of being admitted to the service. The staff team ensured that care and support were offered in a timely way, and services were offered as flexibly as possible depending on people's needs. People's care plans were personalised and contained detailed information about their preferences and advanced decisions in relation to end-of-life care.

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' various 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.

There was an open culture where people and their relatives were encouraged to share their experience of the service. Staff understood the ethos and values of the service and how to put these into practice. They felt valued, listened to and well supported. This resulted in the staff team being motivated to give a high standard of care to people.

Staff were clear about the leadership structure within the hospice and were fully involved in the hospice's development. Emphasis was placed on continuous improvement of the service. The managers regularly assessed and monitored the quality of care by completing audits and seeking feedback from people who use the service and their relatives.

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.

People were protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage people's medicines safely.

Potential risks to people were assessed and measures were put in place to reduce these risks. Where accidents or incidents had occurred, these had been analysed and learning was shared amongst staff to prevent reoccurrence.

Robust recruitment processes for new staff ensured they were suitable to work with vulnerable people. These checks were also carried out for volunteers.

Is the service effective?

Good ●

The service was effective.

People received support and care from the staff team who were well-trained and used their knowledge and skills to meet people`s needs effectively.

Staff followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. People's capacity to make decisions and give consent was assessed and recorded.

Staff encouraged and supported people to have a balanced diet that met their individual needs and professional advice was sought if people's eating and drinking abilities deteriorated. The hospice environment met the specialist needs of people who used the service.

Is the service caring?

Good ●

The service was caring.

People were treated with care and compassion. Staff respected people and their choices and they promoted people's privacy and dignity.

People were consulted about and fully involved in their care and treatment. The service was very flexible and responded quickly to people's changing needs or wishes.

Staff supported the emotional well-being of people and their relatives with end-of-life care being provided with sensitivity and compassion. The care people received enabled them to experience a comfortable, dignified and pain-free death.

Is the service responsive?

Good ●

The service was responsive.

People and their families were fully involved in assessing and reviewing their needs and planning how their care should be provided. This included their wishes and priorities regarding their end-of-life care.

The service sought feedback from the people who use the service, their families and the community to monitor and improve the quality of care.

Information about how to make a complaint was available and people were able to raise concerns easily. When complaints had been received, they were used to learn lessons and drive improvements in the service.

Is the service well-led?

Good ●

The service was well-led.

The registered manager 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 making decisions about how the service was run.

We saw a number of quality assurance systems and audits to monitor performance and to drive continuous improvement.

We found that the hospice worked in partnership with other organisations at regional and national level which helped the service make continuous improvements to the quality of care.

Care Quality Commission

Phyllis Tuckwell 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.

We inspected Phyllis Tuckwell Hospice on 19 and 20 July 2016. The inspection was unannounced which meant that staff and the provider had not been informed about our visit.

The inspection team consisted of three members: an adult social care inspector, a pharmacist inspector and a specialist advisor. A specialist advisor is someone who has up-to-date knowledge and experience of working in a specific field. The specialist advisor who participated in this inspection had extensive knowledge and experience in palliative care. Palliative care is a holistic, multi-disciplinary approach to providing patients with relief from the symptoms of a life-limiting illness such as pain and stress. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.

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

During the inspection we observed how staff interacted with people using the service. We spoke with five people who were provided with care and support by the service, and one relative. We spoke with in-patient and out-patient staff, including the registered manager, two human resources officers, five nurses, five health care assistants, one housekeeping manager, one domiciliary staff member and two volunteers.

We looked at six care files for people who use the service. We also looked at documentation concerning medicine handling, such as medicine charts and administration records. We observed a handover meeting at which medical and nursing staff exchanged information and planned treatment for people using the service.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, the training matrix, staff rotas, minutes of meetings with staff, surveys, quality assurance audits and record relating to maintenance of equipment. We were present at a Multidisciplinary Team Meeting (MDT). An MDT is a meeting of a group of health and social care professionals from different clinical disciplines who together make decisions regarding the recommended treatment of people.

We completed a tour of the building to look at how hygiene and cleanliness were maintained.

Good ●

Is the service safe?

Our findings

All the people we spoke with told us they felt safe accessing care and support from the service. One person stated, "I feel absolutely safe here." Another person said, "I feel safe. I have my medicines always on time." One of the volunteers commented on the carers' skills, "People here are in very safe hands."

Staff and volunteers were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. They were able to give us hypothetical examples of a risk of someone being abused and the steps they would take to protect that person. Staff told us they were able to recognise signs of abuse. A member of staff explained what these signs may be, "Sometimes a patient may be upset, withdrawn or have bruises and fingermarks on their body." They described how they would refer people to appropriate organisations to ensure they were protected from potential abuse. This included the local authority safeguarding team and the Care Quality Commission [CQC]. Staff said, and records showed, they had received training in how to keep people safe from abuse and there were up-to-date policies and procedures in place to guide staff in their practice within this area.

We saw a wide range of possible risks to each person's well-being had been considered and assessed, for example people's mobility and skin care needs. People's care records detailed the action to be taken to prevent any identified risks and staff knew how to manage these risks. For example, a person was at risk of pressure ulcers. We saw this risk was reduced as the person had appropriate equipment in place, such as a special mattress to help relieve the pressure on their skin.

We saw that when safety incidents had occurred, they had been reported and investigated appropriately. Staff told us they were made aware of actions to be taken to reduce further incidents through staff handover meetings and changes to people's care records. The service used a communication book where all the incidents were logged. Each incident was discussed at handover meetings. There were also regular ward meetings and the minutes were emailed to all staff members. As a result, each staff member was informed about the incidents and any changes that were implemented to prevent reoccurrence. For example, a thorough analysis of medicines related incidents had revealed that most of the medication errors had been committed at the lunch time. The service had changed the medicines administration time where possible which resulted in a lower number of incidents.

Appropriate staff and volunteers recruitment processes helped to protect people from those who may not be suitable to care for them. All the recruitment files inspected showed that appropriate checks had been carried out before staff or volunteers were recruited. Clearance from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they were suitable to work with vulnerable adults and children. References had been sought from previous employers and employment histories had been requested. Reasons for any gaps in the employment histories of prospective employees and volunteers had been explained at job interviews and appropriately recorded. Relevant checks were carried out to confirm the professional registration status of doctors and nurses.

We looked at the in-patient unit staffing arrangements for the service and saw there were sufficient numbers of staff to meet people's needs. The staffing rota was consistent and reflected the actual number of staff on duty on the days of the inspection. The day hospice was managed by an in-patient manager who performed the role of the leader coordinating the work of staff and dedicated volunteers. Community services were provided by experienced and suitably trained staff. The registered manager informed us that staffing levels were closely monitored. If needed, staffing numbers were increased to support people with more complex needs or additional staff were scheduled for 'one to one' nursing. Staff told us that any shortages in staffing were always covered by the regular or bank staff. A member of staff commented on the service's management, "They are very good with staffing levels." A volunteer stated, "There are enough nurses. If one is on holiday, another nurse is brought immediately. They are never short of nurses. Sometimes there are too many volunteers if some patient cancels their visit at the day hospice." One person told us, "With all the helpers there seem to be more than enough nurses."

There was an effective system in place for obtaining medicines including those required in an emergency in the inpatient unit and the day hospice. Dedicated prescription and administration charts were used for prescribing and the administration of medicines via a syringe driver. The syringe driver is a portable pump used to provide a continuous dose of medicine through a syringe. There were processes in place to allow doctors to pre-approve a range of discretionary medicines for the nurses to administer without delay. This enabled the nurses to treat people's minor ailments immediately. Records of medicines administration were clearly documented on the chart by nurses. The recorded medicines also included prescribed creams applied by care workers. Appropriate processes were in place for the safe disposal of medicines.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room. Medicines that required additional control because of their potential for abuse (controlled drugs) were stored securely. Temperature records for the medicines refrigerator showed that medicines requiring refrigeration were kept within their recommended temperature range. Similar records were not currently available for the room temperature due to a broken thermometer. This means that unrecorded unsuitable temperature could potentially compromise the stability and shelf life of people's medicines. However, the service was planning to collect this information once they had the required equipment which they had already ordered. A range of emergency medicines, including oxygen, were readily available. Records indicated regular stock checks of medicines had been undertaken as per the service procedure.

Medicines were administered safely. All the people we spoke with told us they received their medicines regularly and staff observed people whilst taking them to ensure safe administration of medicines. There were specialised guidelines in place regarding the administration of medicines. Staff competencies were assessed on an annual basis. We found that medicines were given on time and the medicine administration records (MAR) charts were completed to show what medicines people had received.

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

People were cared for in a safe environment. Regular environmental and health and safety checks were carried out to ensure that the environment was safe and that equipment was fit for use. For example, the records showed and staff confirmed that the fire alarm tests were carried out on a weekly basis. Checks were also conducted to ensure that equipment such as hoists, the nurse call system and fire equipment was in good working order.

People were protected from the risk of infection. The premises and equipment were clean and the staff told us about the procedures they followed to prevent and manage potential outbreaks of infection. We saw that protective equipment such as aprons and gloves were readily available and utilised by staff and volunteers. Bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices. There was hand gel at various points in the building for staff and visitors to use to help protect people from infection.

The kitchen staff ensured the kitchen remained clean and free from potential cross infection. They adhered to food safety standards and ensured the food was prepared safely. They wore appropriate protective clothing and food was kept at appropriate temperatures. Other staff had limited access to the kitchen.

Housekeeping staff adhered to the colour coding system in place for their cleaning equipment. Care staff and nurses wore protective disposable gloves and aprons when delivering personal care so as to reduce the risks of cross contamination. One of the domestic staff told us, "We use a colour coded system and things like aprons and gloves are never taken outside of a room. They are disposed of then and there." As a result, the spread of a potential infection was reduced. We observed that staff washed their hands and used hand cleansing products before performing various tasks. The maintenance staff took action to reduce potential risks relating to Legionella. They regularly flushed all the taps and showers including those that were not in regular use to ensure that clean water was flowing through the system. They also ensured correct water temperatures were maintained to avoid systemic contamination of the system. There were appropriate waste management arrangements in place. Sharps were stored in sharp containers which were used and emptied as per provider's policy. Sharps are any needles, scalpels or other articles that could cause wounds, cuts or punctures to a person handling them. Care equipment, such as stethoscopes, syringe drivers, and thermometers was stored clean and dry following the use. Each individual involved in providing care contributed to preventing infections with an outstanding general outcome.

There were robust contingency plans in place in case of an untoward event. These plans assessed the risk of such events as staff sickness or bad weather conditions affecting the continuation of the service. The contingency plans also provided guidance on what action should be taken to continue the service.

Good ●

Is the service effective?

Our findings

People and their relatives told us they received excellent care from highly skilled staff. One person said, "They have knowledge we do not have. They are also skilled in interpersonal communication." Another person commented on staff's skills, "They are certainly qualified and knowledgeable."

New staff underwent a comprehensive staff induction programme according to their specific role. Each staff member was assigned a mentor whom they shadowed until they could demonstrate they had attained the level of competency required for their role. The 'Care Certificate' had been introduced for all new health care assistants. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes and hospices are expected to uphold. The provider had reviewed the Care Certificate in line with other providers of this course and had amended its format to adjust it specifically to the hospice setting. The new amended course was scheduled to start in February 2017. Staff valued the support and guidance offered by the mentoring programme and told us that their induction had prepared them well for their role.

People were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and to the specific care needs of individuals. Staff told us they received all the training they needed to work effectively and provide the best quality of care. We saw that the same level of development opportunities were offered to staff at all levels who worked at the hospice. For example, care assistants were offered and supported to achieve nationally recognised vocational training. Staff told us that the registered manager considered any training that may potentially benefit people who use the service and improve their experience. When asked about training opportunities, a member of staff told us, "I love it. I had a chance to do an assistant practitioner course."

There was an on-going programme of training for staff, provided by e-learning and face- to-face training. This was monitored to ensure that staff kept up to date with the skills and knowledge they required. This included health and safety, fire awareness, moving and handling, infection control and safeguarding adults. Medical staff had received specialist training in pain management. Staff told us that the training in communication skills had been particularly useful in helping them to liaise with families in very stressful circumstances. Nurses undertook specialist training in tissue viability, continence, nutrition and hydration which are specific to the care of people with life limiting illness. A member of staff told us, "Training is very good. This is linked to our appraisals and the manager encourages me to attend to conferences." The service supported staff through Nursing and Midwifery Council (NMC) revalidation process. Revalidation is the process that allows nurses to maintain their registration with the NMC and demonstrates their continued ability to practise safely and effectively. All nursing staff were required to complete the revalidation process every three years in order to renew their registration.

Volunteers helped to deliver care to people at the service. They acted as companions, sitters and transport escorts. All volunteers were provided with relevant training, for example with food hygiene. One of the volunteers told us, "I've been trained to do hand and foot massage."

Staff told us that they received excellent support from their colleagues and the registered manager. Support was achieved through regular individual supervision sessions and an annual appraisal. A member of staff described why they felt supported by the service, "We receive annual appraisal and regular supervision. Our monthly one-to-one meetings are very supportive and our ideas are acted upon or considered. We also have reflective meetings once a month." Another member of staff told us, "Supervisions are useful. Without them, you would be at a loose end."

Staff told us there were times when staff needed a particular kind of support due to the emotional nature of the-end-of life care they provided to people. The service tried to address that need in various ways. For example, staff could use the counselling service and the chaplain was also available to them if required. Staff were also offered the opportunity to participate in support groups where health care professionals provided them with practical and psychological support.

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 hospices are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA.

At the time of our inspection people using the service had capacity and did not require any DoLS. However, staff understood the role of the MCA and the need to act in a person's best interests if the person they cared for had difficulty making a decision. Staff explained that such decisions may regard, for example, people's treatment or their wishes as they approached the end of their life. Staff also described how medical staff assessed the person's mental capacity and they discussed together whether the service needed to make decisions in the person's best interest. Best interest decisions were taken following a process which involved a meeting with nursing staff, a consultant and the person themselves or their rightful representative. A member of staff told us, "If people were assessed as unable to make a decision, we must act in their best interest." The registered manager had submitted an application to the relevant authorities when a person had to be deprived of their liberty.

People were supported to eat, drink and maintain a balanced diet. People told us and we saw they had a comprehensive nutritional assessment prepared when they had moved into the hospice and a copy was shared with the kitchen staff. This assessment identified people's dietary needs and gave staff guidance if people required assistance to eat or drink. We saw there was an input in the care plans from dieticians and a speech and language therapist to help prevent the risk of malnutrition. Care plans also specified whether people needed their food soft, pureed, blended or if they could follow a normal diet. High protein drinks were kept which could be given to patients before a prescription for a regular supply was made. All staff could describe people's needs in terms of nutrition and hydration in their end-of-life care.

All the people we spoke with told us they enjoyed the food at the hospice and they appreciated the varied and flexible menu. A person praised the quality of the food served at the hospice, "They do wonderful lunches here. They are very tasty." A volunteer confirmed that opinion saying, "The quality of food is very good. They are very accommodating in terms of food. If they would like anything different, then the kitchen staff will make them an omelette, a jacket potato or salad. I make a point of asking patients if they are happy with the food. It is important to give feedback to the kitchen staff."

Health care for people was provided by a multi-disciplinary team comprising consultants, doctors, clinical nurse specialists, nurses, health care assistants, occupational therapists and physiotherapists. Each person in the in-patient unit had a named nurse assigned to them. Their responsibilities included making sure the person's individual needs were met and the continuity of their care was maintained. People's care records showed in detail how they were supported with their medical and health care. Staff recognised that people's healthcare needs could change and demonstrated awareness of how these changes could be reported and effectively acted upon. There were effective handover meetings involving the teams of nurses. These meetings were used to plan care and to pass on medical and health information within the staff team. They gave clear and precise information about each person's individual medical and health needs and the short term plans for their care. Therefore, people could be assured that all professionals understood their individual health needs.

There were environmentally adapted controlled rooms to support those with limited mobility or cognitive impairment. The room for people with cognitive impairment had improved lighting and a contrasting but relaxing colour scheme. A door sensor alarm was fitted so this would alert staff if a person left the room. The room was adapted for a person to use a wrist sensor fall alarm and was equipped with a range of telecare monitors. Telecare is a system for support and assistance which is provided at a distance using information and communication technology. It ensures continuous, automatic and remote monitoring of users by means of sensors, and therefore minimises various risks, such as the risk of fall.

The hospice was spacious and accommodated the equipment required to provide effective care. Overnight facilities were available to people's relatives if required. This enabled relatives to stay with people and be fully involved in their end-of-life care. People could access the areas of the hospice freely, which included the hospice grounds. There was a garden which was well tended by a volunteer gardener. In the day service unit there was a main lounge where people could sit and chat. There was also a separate art and craft room, a quiet room for private conversations, and a therapy room. The art and craft room was equipped with a sink that could be lowered and raised so it could be used for people with limited mobility. The service also had an on-site gym to promote people's health and well–being, enabling people to remain mobile and active. The gym was staffed by physiotherapists and each person had an individual physiotherapeutic programme. The equipment and facilities were suited to meet the needs of people who were receiving end-of-life care and care of the body after death. The service had its own mortuary and chapel/private area, so family members could spend time with their loved ones after they had died.

The multi-faith room within the hospice provided a warm welcome and place of sanctuary for people and their relatives of all faith backgrounds and for those who didn't hold any religious beliefs. Quiet rooms and the multi-faith room created space to think, rest, contemplate, connect, reflect or pray. These rooms contributed to promoting well-being as well as equality and diversity within the hospice. The hospice provided a private space for families to find quiet time and reflection, helping them to manage the stress and grief brought about by the challenges of life limiting illness.

Good ●

Is the service caring?

Our findings

People who use the service and family members told us they were very happy with the care and treatment provided. One person said, "If you are made to feel welcome, you will appreciate it." Another person using the day services told us, "I think that the hospice is fantastic. I got diagnosed with my condition 10 years ago and I've been coming here ever since."

All staff we spoke with appreciated the fact that they had enough time to listen to people and respond to their wishes without being rushed. A member of staff told us, "There is time to spend with patients and relatives." A person's relative said, "It's really nice. Nothing seems to be too much to ask." Another relative praised staff, "They are extremely helpful. Without their support, I would find life more difficult." A volunteer commented, "Staff in the hospice: the doctors and the nurses give people time to listen to them and to talk to them."

People told us they were supported with care and compassion. One person said, "The nurses are very caring and they talk to you. I'm tremendously happy to be here." Another person told us about the volunteers, "The helpers are really friendly. They are always willing to do something for me." One of the people from in-patient unit told us, "The treatment that I had and the attention I had also from the admin staff was admirable. Far beyond what I would expect from them."

Positive relationships had been built between staff and those they cared for. People were well cared for and staff showed kindness and consideration towards people they looked after. As a result, people felt very comfortable and relaxed in the presence of staff. We noticed that when needed staff knelt on the floor when speaking to people to ensure they were at the same eye level and to aid good communication. We observed a carer knelt down to ask one of people, "Do you have everything you need? Is there anything you would like me to help with?" People told us that being listened to by staff gave them control over their environment and treatment.

People were given choices and supported to make decisions concerning various aspects of their daily routines. These included choosing meals, clothing and places where they wanted to spend their time. 'Do not attempt resuscitation' orders and advanced care plans (records of people's end-of-life care preferences and choices) also showed that people and their families had been involved in making crucial care decisions. Before staff undertook any actions, they explained to people what they were going to do and why they asked for their permission.

Staff were knowledgeable of people's needs, preferences and personal histories. One person told us, "They know how to take care about me, they know things I like. They are very caring". Staff told us they had access to people's care plans and were given time to read them. They felt this was an important part of learning what mattered to people.

People and their families told us that staff showed respect to people and promoted their dignity. A person remarked, "Most definitely, they treat you with respect and dignity. They never talk about your illness. They are trying to get you away from it. They are very discrete." A volunteer told us, "We treat them with utmost respect." We spoke with staff to check their understanding of how to treat people with dignity and respect. Staff told us that people were assisted with their personal care in a way that ensured they maintained their dignity. The means staff used included closing doors and asking people about their personal needs discreetly. A member of staff told us, "They have got curtains in the bay that are pulled down and we use towels while helping people so they are not too exposed. We use screens to protect people's privacy but we also give people their private space if they need it."

Family members could access bereavement support services after the death of their loved ones. The hospice ensured these services were available to people within or away from the hospice site, dependent upon the needs and preferences of the families. People and their relatives had access to services which provided support and counselling with regard to their emotional, spiritual and religious needs. These services included bereavement support before, during and after the death of a person. The service had appointed a child and family support worker. Children were offered pre-bereavement and post-bereavement counselling to help them cope with the loss of their loved ones. One relative commented, "It was so difficult for me to get through that period of time. It was the hospice that helped me to cope with it, made that time less difficult for me and my family." The hospice offered counselling and bereavement services and they remained in contact with relatives following a person's death for as long as the relatives felt they needed it.

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

People could easily access information about the services provided by Phyllis Tuckwell Hospice, which was readily available throughout the service. The information leaflets covered a wide range of topics, from practical support with finances, through information about support groups and organisations to advice on funeral arrangements. Information booklets about specific health related conditions were used by staff in the hospice. They were also given to people as part of their consultation with health care professionals to help them understand their health needs and how to manage them.

Visitors were encouraged to meet people without restriction if people wished to have guests. Family members who wanted to spend more time with their dying relative were accommodated in the hospice. Staff at the reception were polite and made sure if people wanted to be visited before the visitors were taken through to the ward or room.

We saw that staff were kind and courteous and showed respect to people and family members. There was a warm, friendly atmosphere. The service had a relaxed and homely feel: people were encouraged to chat if they wished, and they were always listened to. Staff were positive and cheerful in their engagement with people. They communicated with people in an individualised and responsive manner. They laughed and joked with some people and talked quietly at other times. Staff willingly sat with people, engaging them in conversation and listening to them with genuine interest.

Good ●

Is the service responsive?

Our findings

People told us they felt the service was very responsive to their needs and wishes. A person using day services told us, "It is fantastic. I look forward to that every week." Another person remarked, "It is brilliant. I refused to come here at first as I did not know what it was. I went through their booklets and I called them. My god, I'm so glad I did." The relatives we spoke with confirmed the responsiveness of the service. One relative told us, "I cannot speak too highly of the support and care given to them when needed by Phyllis Tuckwell Hospice and know that I can rely on their excellent support in the future." Another relative pointed out, "They not only supported the late [name] but the whole family with the kind of support you can only dream about." Another person's relative said, "My husband looks forward to going there and always returns home in a very happy mood."

People were admitted to the in-patient unit at the hospice from their own homes, hospitals or clinics. People attended the day service for physiotherapy, occupational therapy, creative and complimentary therapies, social worker input, medical assessment and intervention and out-patient appointments. The hospice's at home service provided additional support for people who were seriously ill or approaching the end of their life and wished to remain in their own homes. The hospice staff worked closely with the district nurse teams, GPs and other community based professionals to provide this support. Staff told us that before they worked in the community, they had covered shifts at the hospice to get to know people in advance.

Following the initial referral to the hospice, people had an assessment carried out by one of the team members. The aim of these assessments was to discuss priorities and matters which were important to individuals and to identify people's goals, expectations as well as any concerns. People's individual care and treatment needs were assessed to help make sure these could be met. People were often accompanied by their family members who could discuss any concerns they may have. People's care plans were personalised and gave clear details about each person's specific needs, expectations and wishes.

People's care and support was planned in partnership with them and their relatives. Both people and relatives were asked about their needs and preferences and these were recorded in people's plans of care. The assessments were prepared with regard to various aspects of care, such as personal care, mobility, medical conditions, nutrition, wound care, medicines, pain management, social needs and support for family members. The care plans were used to guide staff about how to care for people according to their individual needs. Individual preferences and differences were respected. Nursing staff communicated people's information with appropriate members of the multi-disciplinary team. Staff talked knowledgeably about providing people with care. Staff knew how to provide support for people's physical, mental, emotional and spiritual needs.

Staff were able to demonstrate their understanding of how to provide people with personalised care. The care given to people followed the guidance recorded in their care plans. People's changing needs were monitored and observed by staff on a daily based and a record was made in their medical notes. As a result, any changes were immediately responded to. A person told us, "They looked at my house to check my bathroom as I recently had difficulties using this at home. I did not know how to use the hospice's one and today they are helping me by teaching me how to use it independently. They even helped me to get a disable badge."

Changes in people's needs were assessed on a daily basis or, if needed, more frequently in order to address them appropriately. Staff attended thorough handover meetings at the beginning of their shift. Each person was discussed in depth including care needs, changes to treatment and care plans and medication requirements. Relevant information was shared with care staff at handover and MDT meetings after they returned from leave or days off. Time was given to allow staff to discuss events which had occurred whilst they had been off duty. As a result, each staff member always had the most up-to-date knowledge of the current situation which ensured the continuity and consistency of care delivered to people.

The day service was well-organised and responsive. For example, the in-patient unit was able to provide care to a person with an underwater chest drain because staff had been appropriately trained in this area. As a result, the patient did not have to be bothered to travel to the Acute Trust three times a week. In another example, the use of the hospice's therapy room (mock home setting) helped to plan the discharge of a patient, avoiding a time consuming and tiring home visit prior to the discharge. Other recent examples of responsiveness to people's needs included arranging weddings, confirmations, and a trip abroad for a person who had wanted to be at home for Christmas time.

People using day services told us that they were surprised by the range of activities provided by the hospice. A person admitted, "I was really surprised when I arrived here." Another said, "We do quizzes, we have a lady playing the piano and we have singalongs. We also have a big selection of music. Most of it is our music from the fifties, the music we understand." The service tried to find out about people's hobbies and interests and to help people spend time according to their wishes. A person told us, "The first week I came here I asked if anyone played scrabble. No one did. The next week they had the scrabble board and I played scrabble with their volunteer. Then it became a regular occurrence."

People said the day service offered them a regular opportunity for companionship. It also reduced the risk of people's isolation and loneliness. One person said, "It is a nice change from sitting at home to be able to come here and to talk to everybody." Another person told us that there were many activities offered, but they liked to sit and interact with other people and this choice was respected. They said there was always someone around to talk to and we observed staff and volunteers talking to this person during our visit.

Staff were able to tell us about the needs of all people who were using the service at the time of our inspection. Staff also described how they responded to people's emotional needs and wishes concerning their care. One person pointed out, "They can recognise your mood. They know if you would like to be left alone and they know how to approach you."

The service went above their contractual duty in meeting the needs of people. A person said, "We went to Wales and they arranged palliative care there." The person told us how much it meant to them and their family to enjoy their holiday together.

The hospice was responsive to the needs of people with cognitive impairment or suffering from dementia. People who could not use verbal communication were provided with a visual pain assessment chart with body maps so they could indicate the source and level of pain. A selection of bright and easy to use cutlery and crockery was available for people to use. There were methods ready for people to help manage their stress. Examples included aromatherapy, relaxing music or videos.

Care and support was inclusive and responsive to the diverse needs of the people who use the service.

Spiritual support was available to all people and their relatives and there was a spiritual space at the hospice that people of all beliefs could access. The environment could be adapted to display only literature and religious objects of people's individual faith. This meant that if people could not access their own place of worship, a suitable environment was available for them to practise their faith.

A range of information was provided to people, their family members and friends. It helped them to understand how the hospice operated and made them aware of relevant external support services and agencies they could contact. Accessible information was provided for people about how to make suggestions or complaints about their care. People stated they knew how to complain. A person told us, "I would tell the nurses. They have sorted out everything for me." Another person said, "I would speak to the person allocated to my care package. If she did not take it seriously, I would go to the manager."

Clear records had been maintained of people's concerns and these records showed the service had responded in line with their procedures. There had been 17 complaints since the last inspection. People's concerns and complaints were monitored and appropriately investigated. We also saw letters of appreciation. Relatives wrote in their comments that they were grateful and thankful as people were in good hands and were well looked after. One of the relatives wrote, "We felt privileged to be able to stay at the Phyllis Tuckwell Hospice and your care was beyond reproach." Another relative wrote, "You all made a difficult time easier to bare and allowed us to spend quality time with our father. He was able to pass with dignity with his family at his side."

Good ●

Is the service well-led?

Our findings

People and their families were all very positive about the care provided and the management of the hospice services. One person told us, "I believe that the place is running really well. I feel they are like the family to me. I know all their staff names." People told us that all staff, regardless of their role, were friendly, kind and supportive which created an atmosphere of calmness at the service. We noted that staff working in all the areas of the service were motivated, enthusiastic and committed to providing a high quality service to people and their families.

There was a clear management structure at the service. The staff were aware of the roles of the management team and they told us that the managers were approachable and were regularly present at the service. All the managers we spoke with demonstrated an excellent understanding of all aspects of providing care to people. This indicated they had regular contact with staff and people who use the service. Senior staff acted as a role model to ensure all staff knew what excellence in care was. Senior staff promoted the service's values in all aspects of work with staff and within the community groups.

The registered manager had been in post since June 1988 and they were dedicated to constantly improving the service. The registered manager was aware of their responsibilities for reporting any significant events that affected 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.

All the staff we spoke with told us they felt supported and enjoyed their work. One staff member said, "Everyone pulls themselves together. It is a good team and the manager is very supportive She helped me when I had personal problems."

Volunteers formed an important part of the service and provided support in a variety of ways. Those volunteers who were trained provided support to people using the Hospice Home Support and to their families. Others helped with daily tasks in the in-patient service arranging flowers around the hospice, serving tea and coffee to people and visitors and greeting visitors at reception. One of the volunteers told us, "I've been coming here for 20 years as a volunteer. I absolutely love this place. The standard and quality of care are extremely good."

People and families were asked about their experience of the service through regular satisfaction surveys. We found that the surveys gave overwhelmingly positive feedback to the service. A person wrote, "The nurses and doctors were very attentive and nothing was too much trouble for them. Very kind, special people." A person's relative wrote, "I was so grateful that after receiving excellent care in the hospice she was enabled to go home for three weeks before her passing away, with an excellent support package from community nursing arranged by the hospice."

The hospice's staff were encouraged to participate in shaping the service. Their ideas and suggestions were sought and taken seriously by the registered manager. A member of staff told us, "My manager would listen to me. We have a handover meeting each morning and they ask about our suggestions if there is anything we would like to bring forward." Another member of staff said, "I have mentioned the call bell system and they are bringing it in. We are to be issued with pagers and there will be no more noise so patients can sleep in peace undisturbed."

The provider promoted a culture of openness and willingness to learn. The provider had analysed and shared the results of the Patient-Led Assessment of the Care Environment (PLACE). PLACE reviews the care environment and rates it for example, on cleanliness, condition, appearance, food and hydration. It also looks at whether privacy, dignity and wellbeing are maintained. As a result of the PLACE assessment, the service had improved on being a dementia friendly environment. For example, a PLACE review had revealed that toilets had not been marked with a picture or text that would have made it recognisable to a person suffering from dementia. This issue had been addressed by the registered manager who had ordered and put in place appropriate signage.

There was an effective auditing programme for all the services the hospice provided. These covered health and safety, medicines, incidents and accidents, training, care records, nutrition and hydration, and staff competency checks. The results of the audits were used to enhance the functioning of the service. For example, the findings of a prescribing audit had indicated that the hospice had not adhered to Prescription Writing Standards 2015.In order to address this issue, the service had organised a meeting for the hospice's doctors to remind them about the required standards. This resulted in improvement in the writing of prescriptions which became more detailed and contained all the required information. In another example, a nutritional screening documentation audit highlighted that completion of the tool had not always been thorough. The registered manager had attached details of the audit to the communication book so that all staff had access to it. The nutritional screen assessment and a guide of how to complete it had been incorporated in all care plans. Examples of properly completed assessments for guidance and reference had been provided to staff. As a result, the quality of nutritional screen assessments had significantly improved.

A clinical governance group met every three months to drive continuous improvement for the benefit of people who use the service and staff. For example, the clinical reference group monitored key performance indicators such as medicine incidents, falls, safeguarding reports and DoLS applications. The clinical governance group was also responsible for the review of relevant NICE documents, review and introducing new policies and review of audits and satisfaction surveys. We saw the management team benchmarked the service against other hospices and used this as a measure of how they were doing. They also aimed to identify the areas where improvements needed to be made, and these were introduced immediately. For example, incident benchmarking statistics had shown that there had been fewer falls and pressure ulcers but more medicines related incidents than the national average. The findings had been analysed and discussed at team meetings. The service had responded to this by introducing a new policy and procedure for the reporting and management of clinical incidents.

We saw evidence of regular staff meetings. The topics of the recent meetings included such subjects as a new call bell system, study days, changes in procedures and duty of candour. A member of staff told us, "I like team meetings. We are all together and it is a good atmosphere. You can communicate and share ideas more when we are together."

The hospice maintained links with the local community by organising open days. Members of public who had no knowledge of the hospice were encouraged to visit the hospice and participate in a workshop. The aim of the workshop was to introduce the hospice to wider community but also to provide guidance and advice to people who were considering using the hospice's services. Leaders of the local communities were invited to the hospice and then informed their local communities about the hospice, its purpose and services. This resulted in two-way learning and facilitated access to hospice services for people coming from the local minority communities.