Hospice in the Weald

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Inspection report

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Ratings

Overall rating for this service	Good	●
Is the service safe?	**Requires improvement**	●
Is the service effective?	**Good**	●
Is the service caring?	**Outstanding**	☆
Is the service responsive?	**Outstanding**	☆
Is the service well-led?	**Good**	●

Overall summary

Hospice in The Weald is a local charity covering a catchment area in West Kent and East Sussex that provide palliative and end of life care, advice and clinical support for adults with life limiting illness and their families and carers. They deliver physical, emotional and holistic care through teams of nurses, doctors, counsellors, chaplains and other professionals including therapists. The service cares for people in three types of settings: at the hospice in a 15 beds 'In-Patient Unit' plus up to two people in the day procedures room, or in their 'Hospice Day Service' that welcomes approximately 120 persons per week, and in people's own homes through their 'Hospice in the Home' service that supports approximately 700 people. The service provides specialist advice and input, symptom control and liaison with healthcare professionals. This includes a training centre and offering advice and support to staff in nursing and residential care settings in the community, receiving up to 130 palliative care referrals per month. Services are free to people and the Hospice in the Weald is largely dependent on donations and fund-raising by volunteers in the community.

Summary of findings

The services provided include counselling and bereavement support; a Lymphoedema service (for people who experience swellings and inflammations); an outpatient clinic; occupational and creative therapy, physiotherapy, chaplaincy and volunteer services that include approximately a thousand volunteers.

This inspection was carried out on 12 and 13 October 2015 by two inspectors, a pharmacist inspector and an expert by experience. It was an unannounced inspection.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the Nursing Director for the service. They oversaw the running of the service and were supported by a leadership team that included a chief executive officer (the provider) and five directors.

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 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. There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place which included the checking of references.

Some practices regarding the administration of medicines were not in line with current controlled drug legislation. We have made recommendations about this.

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

People were at the heart of the service and were fully involved in the planning and review of their care, treatment and support. Plans in regard to all aspects of their medical, emotional and spiritual needs were personalised and written in partnership with people. Staff delivered support to people according to their individual plans.

The environment was well designed, welcoming, well maintained and suited people's needs.

Staff had received essential training including end of life care and were scheduled for refresher courses. Staff had received further training specific to the needs of the people they supported. All members of care and support service staff received regular one to one or group supervision. Staff received regular one to one supervision sessions and an annual appraisal. This ensured they were supported to work to the expected standards.

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

The staff provided meals that were in sufficient quantity and met people's needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences, restrictions and reduced appetite. Staff communicated effectively with people, responded to their needs promptly, and treated them with genuine kindness and respect.

People's feedback was actively sought, encouraged and acted on. People and relatives were overwhelmingly positive about the service they received. They told us they were extremely satisfied about the staff approach and about how their care and treatment was delivered. Staff approach was kind, compassionate and pro-active. Relatives told us, "All the staff here are extraordinary, nothing is too much trouble, they have great empathy and genuinely care for people" and, "I trust them with my life and I trust them with my death; they understand how I feel, they know what I need, they truly care about what they do."

Clear information about the service, the facilities, and how to complain was provided to people and visitors.

Summary of findings

People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent or refusal before they supported them.

Staff pre-empted and responded to people's individual needs and requirements. People and their relatives told us that the way staff responded to their needs was "Outstanding" and "So personalised". They said, "The nurses, doctors, and indeed all the staff are marked by kindness, compassion, and a deep sensitivity to your needs; nothing is too much trouble".

People were involved in the planning of activities that responded to their individual needs. A broad range of activities was available that included creative ways to keep people occupied, engaged and stimulated. Varied outings were available and attention was paid to people's individual social and psychological needs.

The registered manager was open and transparent in their approach. They held a vision for the service that included "Providing the best care possible 'with and not to' patients, families and carers." Staff told us they felt valued and inspired by the registered manager to provide a high quality service. They described him as "Passionate about care". The management team had launched a pioneering project to provide 'cottage hospice care' to people in the community.

Relatives' comments about the management of the service were extremely complimentary. A comment included, "The Hospice in the Weald has an unsurpassed reputation for excellence; it is extremely well managed by managers who care."

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 needs for improvement were identified, remedial action was taken to improve the quality of the service and care. The service worked in partnership with other organisations to drive improvements at national level.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement ●

The service was not consistently safe because we identified some shortfalls in respect of medicines, although some remedial action was taken on the day of our inspection. We did not see that people had experienced any negative outcomes as a result of these shortfalls. However we found that some aspects of monitoring processes in regard to medicines needed to be consistently embedded to ensure that improvements were sustained over time.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

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

Robust and safe recruitment procedures were followed in practice.

The environment was secure and well maintained.

Is the service effective?

Good ●

The service was effective.

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

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

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Outstanding ☆

The service was very caring. People's feedback about the caring approach of the service and staff was overwhelmingly positive and described it as, "Outstanding", "Exceptional" and "Truly remarkable".

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. People valued their relationship with the staff team who often performed beyond the scope of their duties and pre-empted people's emotional needs.

The service was very flexible and responded quickly to people's changing needs or wishes. Staff communicated effectively with people and treated them with utmost kindness, compassion and respect.

Summary of findings

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

Is the service responsive?

Outstanding ☆

The service was very responsive. People's feedback described the service as, "Outstanding" and "So personalised".

People told us staff had outstanding skills and knowledge; they told us that staff understood and anticipated their needs which enhanced the quality of their support.

The service provided person-centred care based on best practice and focussed on continuous improvement. People's care and support was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them.

The service had creative ways to involve people and their families and stimulate their engagement through personal projects and individual activities. People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life.

The service took a vital and key role in the local community. People, their families and friends were actively encouraged, enabled and supported to engage with events outside of the service.

Is the service well-led?

Good ●

The service was consistently well-led by the leadership and management team. People described the leadership of the service as, "Truly exceptional" and, "Second to none." The service was described as a role model for other services.

The management team promoted an open and positive culture that placed people and staff at the heart of the service. Person-centred principles were put into practice by staff. The provider and registered manager promoted strong values based on person-centred care and inspired staff to work in partnership with people.

Staff felt supported, valued and inspired under the registered manager's leadership.

Strong emphasis was placed on continuous improvement of the service and best practice. Inventive ideas from staff had been encouraged and implemented to drive service improvements and ensure best practice.

The service worked in partnership with other organisations to ensure they followed best practice and provided a high quality service.

Hospice in the Weald

Detailed findings

Background to this inspection

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

This inspection was carried out on 12 and 13 October 2015 and was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people who approached the end of their lives.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. The registered manager had not been asked by the CQC to provide a Provider Information Return (PIR) subsequent to one submitted in December 2014 at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However the registered manager had anticipated our request for information and had collected relevant information which we looked at during our inspection.

We looked at the premises. We looked at 12 sets of records that related to people’s care and examined four people’s medicines charts. We looked at people’s assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and the activities programme. We observed a ‘ward round’ and the administration of medicines. We sampled the services’ policies and procedures.

We spoke with three people who stayed in the Inpatients Unit and four of their relatives; seven people who used the Hospice Day Service, eleven of their relatives and six volunteers. We also spoke with four people who received support from Hospice in the Home in the community.

We spoke with the registered manager, the medical director, the personnel manager, the fundraising director, six members of nursing staff, three care workers, a creative artist and an activities co-ordinator in the Hospice Day service, and two care coordinators in the Hospice in the Home team. We also spoke with four managers of care homes where the Hospice in the Home team was providing training, support and advice, a G.P. who provided regular care and treatment in the service and three district nurses who oversaw people’s care in the community. We obtained their feedback about their experience of the service.

At our last inspection in December 2013 no concerns were found.

Requires improvement ●

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "I feel I am in the best hands possible", "I feel very safe here." Relatives told us, "There would not be a safer place for our Mum to be; we have every confidence in the staff" and, "We have peace of mind knowing she receives the best care possible by staff who really care and go the extra mile to make her feel not only safe but comfortable." A district nurse told us, "Soon after the Hospice in the Home team has visited a person we see the difference, they start to feel safer because it is a specialised service."

There was an effective system in place for obtaining medicines including those required in an emergency. Prescribing was done on dedicated treatment charts and records of administration were clearly documented on the chart. There was a separate chart for the administration of medicines via a syringe driver (portable pumps that are used to provide a continuous dose of medicine through a syringe). The prescription did not indicate how long the syringe driver was to be given over and neither did the policy, however we were told that all the drivers were pre-programmed to only deliver the medicines over 24 hours. There was a system in place with the use of stickers to identify if people had more than one chart. There was a clear way of identifying whether a medicine needed a reduced dose because of renal impairment and there was also a mechanism to allow nurses to give a range of discretionary medicines which had been pre-approved by the doctor. This allowed nurses to respond in a timely way to treat people's minor ailments.

There was comprehensive information available to people about medicines being used outside the terms of their UK licence, or medicines that may not be licensed in the UK. The use of such medicines is widespread in pain medicine and palliative care because the mixing of two or more licensed medicines is considered to produce an unlicensed preparation. A patient information leaflet was available and if necessary a discussion with the doctor allowed people to make an informed choice about their treatment.

Up to date references were observed to be in use which provided information about the safe and correct use of medicines and comprehensive policies and guidelines were in place. Regular medicines management meetings were taking place and medicines incidents were reviewed. Actions had taken place following previous dosing errors with syringe drivers to ensure that recurrence of such errors could be minimised. There were regular and effective competency checks for staff administering medicines. When these recorded checks had identified a need for a refresher course this was provided.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room or in secure lockers at people's bedside. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely.

No one was self-administering their medicines but systems were in place should people request to do so. There were some omissions in the administration records where a code or reason had not been recorded. Therefore checks could not be carried out effectively to establish whether these medicines had been given. Medicines requiring cold storage were kept within a refrigerator in the treatment room which had high and low temperature alarms set; however staff had failed to log the fridge temperature on one instance and were not logging minimum and maximum temperatures. We recommend that the minimum and maximum temperatures are recorded in line with good practice.

Prescriptions forms were available to be used if required so that people could get medicines from community pharmacies. A system was in place to track and monitor prescriptions, however the way prescriptions reference numbers were tracked was not fully effective. We were assured a more effective system would be implemented without delay.

There were medicines available in a kit for use in a particular emergency; these were not being checked regularly as per the service's policy. However none of the medicine in these kits was out of date. A particular medicine that may be required in an emergency to reverse the effects of sedatives was not available. However once this was brought to the staff's attention this was ordered on the day. We found two out of date medicines. We discussed this with the registered manager who ensured the outdated medicines were safely disposed of without delay.

During visits to hospital for appointments, oral liquid medicines were supplied for people in intravenous syringes rather than syringes dedicated for oral / enteral use. This was not in line with the relevant patient safety alert NPSA/2007/19 from the National Patient Safety Agency.

Requires improvement ●

Is the service safe?

Controlled drugs were dispensed from stock rather than obtaining them on an individual prescription. The service's requisition book did not fully satisfy the criteria with regards to the information supplied when ordering controlled drugs. This was not in line with the Misuse of Drugs Regulations 2001. We recommend that practices are reviewed in line with current controlled drug legislation and patients safety alerts.

We identified these shortfalls in respect of medicines, and some remedial action was taken on the day of our inspection. We did not see that people had experienced any negative outcomes as a result of these shortfalls. However we found that some aspects of monitoring processes in regard to medicines needed to be consistently embedded to ensure that improvements were sustained over time.

Staff knew how to identify abuse and how to respond and report internally and externally. Staff knew how to access the safeguarding of adults and whistle blowing policies. These policies were up to date and reflected the guidance provided by the local authority. Staff training records confirmed that training in the safeguarding of adults was part of the induction for all members of staff. This was complemented by annual training and refresher courses which were up to date. Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. A member of staff told us, "If we spot anything that gives us concerns we report it straight away" and, "Our patients' safety is paramount and any of us [members of staff] would act and report any suspicion of abuse."

There were sufficient care staff on duty, to support and care for people in the In-Patient Unit, Hospice in the Home and in the Hospice Day Service. Although there were vacancies for additional registered nurses and health care assistants, existing staff covered these posts with help from bank staff. Five clinical nurse specialists had just been recruited to join the service. The registered manager who was also the director of nursing covered up to three shifts per month in the In-Patient Unit. They worked in close collaboration with the medical director who was a consultant in palliative care medicine. The medical director was supported by a second consultant in palliative care medicine, an associate specialist, three specialist doctors, a specialist registrar (who was training to become a consultant) and a senior house officer (who was training to become a GP). The team of doctors worked across all services and visited people in the In-Patient Unit, the Hospice Day Service, at home, in out-patient clinics or in hospitals. One of the doctors was always on call at weekend and overnight for advice with a consultant in palliative medicine consistently available for further advice if needed.

Rotas indicated sufficient staff were in attendance in the In-Patient Unit on day, 'twilight' and night shifts. Staff told us there were enough staff to care in the way people needed and at times they preferred. We observed staff were available to help people at various times depending on their wishes. The Hospice in the Home team and the In-Patients Unit met twice daily to discuss admissions to the service and these were prioritised according to people's needs. The registered manager told us, "We never close beds, although we monitor our threshold for admission if needed; our staff are very dedicated and before vacancies are filled we alter shift patterns, call on our bank staff and ensure staffing levels remain consistent to meet patients' needs." Additional staff had been provided to respond to an increase in people's needs.

Safe recruitment procedures were followed. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable to work with people. Staff members had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and were obtained from their most recent employer.

Disciplinary procedures were in place to ensure staff respected their code of conduct. There was a 'Disciplinary and Capability' policy that provided suitable guidance for managers concerning how to proceed when there was a concern. Senior members of nursing staff were knowledgeable of the procedures to follow and told us how this had been used to keep people safe. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual. These were reviewed daily by nurses and were updated appropriately. Staff were aware of the risks that related to each person. There was a risk assessment carried out for one person who was at risk of falls due to their health condition. This assessment included guidance for staff about how to promote their safety and this was followed in practice. This included the lowering of their bed; an auditory alarm; and a relocation of the person to a room closer to the nurses' station for frequent monitoring. These measures had been discussed and agreed with the person. All beds in the service could be lowered to the ground level and crash mats were used where indicated. When a patient who had cognitive impairment had been assessed as being at a particular risk, an additional healthcare assistant had been deployed to sit with them to ensure they remained safe. Staff ensured that people had their call bells within easy reach so that staff could respond when they needed help. Therefore measures were in place to keep people as safe as possible.

The premises were cleaned to a high standard and records were kept to evidence frequent cleaning throughout the day. Cleaning standards were monitored to ensure people remained as safe as possible from risk of contamination. Systems were in place to make sure the staff were aware when a person had an infection. People's rooms were deep-cleaned using steam cleaning equipment before any admission. Systems in place for the segregation of laundry and the management of waste were implemented appropriately.

There was an infection control lead and infection controls audits were carried out regularly. An issue with the sluice had been identified in an audit dated July 2015 and records showed this had been resolved. Detailed infection control policies were in place and had been reviewed to reflect current national guidance. These included hand washing policy and standard precautions, such as instructions concerning how to deal with spills of bodily fluids. Hand washing audits had been introduced and staff were observed washing their hands after they had been in a person's room. Staff reported they would challenge others if they found that hand hygiene was not observed. Staff wore appropriate personal protective equipment which was in ample supply. These measures protected people from the risks of acquiring an infection while in the service as much as possible to keep them safe.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks that included clear guidance for staff to follow. There was an 'evacuation box' in place that contained plans and equipment in case of an emergency. Staff understood how they should respond to a range of different emergencies including fire, and fire training was part of their induction. Staff took part in regular fire drills which helped them to remember the procedures and there was appropriate signage about exits and fire equipment throughout the home. Fire safety equipment had been serviced and was regularly checked.

Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. An electronic system was used to log and monitor maintenance requests. Maintenance issues were dealt with in a timely manner. The premises were secure for people because there was a robust security system in place. This system identified visitors and monitored access to the In-Patient Unit. Alarmed exits were linked to staff 'bleepers' so that staff were able to help people access the gardens. Staff monitored peoples' whereabouts while maintaining their privacy, to ensure they were safe and able to call for help if needed.

Good ●

Is the service effective?

Our findings

People said the staff gave them the care they needed. Two people who stayed in the In-Patient Unit said, “They [staff] are ever so marvellous and efficient” and, “I could not be in better hands, this is a superb place where I know I will be well looked after.” Relatives told us, “The staff know what they are doing, they are very professional” and, “The staff communicate so well with everyone, they respect the pace when you are poorly and they are ever so gentle.” People commented positively on the quality of food that was provided, they described it as “Marvellous”, “Fantastic” and, “Wonderful”. A district nurse told us, “When the hospice team is involved in the community, they provide so much advice and support for people, they are truly efficient.” A doctor who provided care and treatment for people in the service told us, “Coordination and communication in the Hospice is an example for other primary care teams.”

Staff knew how to communicate with each person. A person was not able to communicate verbally and was not fluent in English. Their relative had been used to interpret and the person used a system of written communication and body language to express themselves. This was clearly indicated in their care plans and staff told us, “We manage to understand each other very well that way.” Staff talked with people ensuring they were positioned at eye level to facilitate effective communication. The medical director gently acknowledged when a person experienced shortness of breath and gave them time to recover before engaging further in conversation. When people were feeling ill, staff used a gentle tone when they spoke and appropriate touch to communicate their empathy. A member of staff told us, “We get to ‘read’ people well and know when they wish to talk or when they prefer to be left alone.” A relative told us, “What makes this place special is how the staff communicate with everyone, they are compassionate and transparent.”

Staff shared information about people’s care following a ‘ward round’. The medical director talked with each person on the In-Patient Unit and discussed their options with them. They then reported their findings with a team of doctors and ascertained the best way forward to manage people’s symptoms. Handovers took place between staff shifts and updated information about new admissions, people’s health condition, their mood, their appetite and medicines reviews was communicated appropriately. This system ensured effective continuity of care and that staff were knowledgeable about people’s individual care and treatment.

New care and nursing staff had a thorough induction before they started working at the service. This included the shadowing of more experienced staff until they could demonstrate they had attained the level of competency required for their role. Competency checks were carried out regarding personal care and the administration of medicines. Staff were provided with a booklet that contained comprehensive information about the code of conduct and standards the provider expected them to uphold.

Staff had appropriate training and experience to support people with their individual needs. Staff were provided with essential training that was up to date, and were scheduled for refresher courses. A training needs analysis had been completed and this had linked specific skills to particular roles. This had effectively identified each member of staff’s training needs and had informed the service’s training programme. For example, training about sharp instruments safety, spiritual assessment tools and resuscitation documentation had been scheduled in November and December 2015 for all care staff in the In-Patient Unit. The staff we spoke with were positive about the range of training courses available to them. One staff member told us, “The training is amazing, I have learned so much here.”

Specialist clinical staff delivered training to a wide range of healthcare and social care professionals across several different health and care settings. These professionals included consultants, GPs, nurses, physiotherapists, paramedics, care workers, social care workers and counsellors. The registered manager told us, “Providing palliative care and clinical skills training has always been part of what we do.” Two managers from local residential care homes told us, “The Hospice team came to teach our staff about palliative care and this was invaluable to us” and, “They offered face to face training for our staff and have always been available and responsive with advice and support, they are amazing and this has enabled us to respond to our residents’ needs much more effectively when they reach the end of their lives.” There was an out of hours telephone helpline that was accessible by local care homes so they could obtain support at all times. Therefore training, advice and support was provided to the community effectively.

Staff had the opportunity to receive further training specific to the needs of the people they supported. Staff followed an individual personal development programme that included their training and development needs. Both matrons had attended advanced specialist safeguarding training and had plans to roll out further training for staff. Training that was specific to end of life care was provided, such as symptoms management, coping with bereavement, specialised quality palliative care, care in the last few days and communication skills. Nursing staff received additional refresher training for the verification of people's death, venepuncture and cannulation (for staff that are required to take blood as part of their role) and the management of syringe drivers.This ensured staff had the knowledge and skills they needed to care for people effectively.

Staff told us they were encouraged to enrol and study to progress within the service and that they were supported to gain qualifications. A matron told us how they had been supported to complete a high qualification in palliative care and had gained a teaching award. One to one supervision sessions for staff were regularly carried out in accordance with the supervision policy. Staff training and support needs were discussed at supervision. Members of staff told us, "We are given clinical supervision and plenty of opportunities for learning, there is always someone to ask" and, "Supervision sessions are so useful, we can bring any issues knowing they will be discussed properly." An annual appraisal of staff performance was scheduled for all staff to ensure expected standards of practice were maintained. This ensured that staff were appropriately supported and clear about how to care effectively for people.

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 discussed the requirements of the MCA and DoLS with the registered manager and they demonstrated a good understanding of the processes to follow. Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. When people had been unable to leave unaccompanied and needed continuous supervision to ensure they remained safe, their mental capacity had been assessed appropriately. This ensured people's rights to make their own decisions were respected and promoted when applicable. When people had been assessed as being unable to make relevant and specific decisions, applications for the authorisation to restrict their freedom in their best interest had been submitted to the DoLS office. The registered manager had considered the least restrictive options for each individual. Comprehensive records were made of how appropriate meetings had been held to discuss people's best interest and make a decision on their behalf as per the requirements of the MCA.

Staff sought and obtained people's consent before they supported them. One person told us, "They are very respectful and always ask me, 'is this OK, would you like us to come back later'?" When people declined, for example when they preferred their own company, their wishes were respected. Staff told us, "We are aware that people may feel unwell and at times want to be left alone, however we keep checking on them discreetly to assess whether they still feel that way a while later but in any case we always respect their wishes."

People praised the food that was served; their comments included, "I don't like meat but they have encouraged me to eat a little chicken for my health – I usually have the fish or omelettes they are marvellous" and, "My favourite is the quiche and the soup is fantastic." The chef regularly received cards from relatives thanking them and requesting recipes for their fresh soups which were made with local ingredients.

People were consulted when menus were planned and specific requests were taken into account. Menus were rotated every four weeks, stated whether particular dishes included possible allergens and offered a variety of alternative dishes. Menus sheets and choice slips were presented daily to people and their visitors by a ward clerk for them record their preference. People's choices were collected early in the morning and catered for as per individual requirement. A person told us, "I can ask for any food, anytime of day or night and they'll do it for me." A person had requested 'green jelly' and this had been enthusiastically provided by a kitchen assistant. The registered manager told us, "Food is so important, it is a pleasure we can provide, it is so integral to what we do."

The catering staff were aware of each person's individual dietary needs and allergies. People had pureed meals or soft diet when appropriate. The chef understood when people who may feel unwell may lose their appetite. They told us, "We do not overload the plate and offer small, attractive and colourful portions; we are flexible with eating times and ensure the food is hot." A meal had been returned uneaten and the catering staff told us, "This person has sore gums and is not feeling well today; it might be just today but it will be monitored." A relative told us how staff offered 'ice pops' when a person's mouth was dry to make them more comfortable. People were supported by staff with eating and drinking when they needed encouragement. A person told us, "I have a problem with hand control but they cut up my food and ensure I have the appropriate cutlery, they are very attentive."

Relatives were welcome to share a meal with their family members. A relative told us, "They say I can stay all night and they can give me any food I require; my wife is on liquid food – they are very good to both of us." Hot and cold drinks were offered to people and each person in the In-Patient Unit and the Hospice Day Service. 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. All feedback that had been collected in food satisfaction surveys was very positive and included, "The catering staff were noticeably considerate going to so much trouble to make sure the meals were appetizing, always with a cheery word."

People were referred to healthcare professionals when necessary. For example, before a person had returned home, the service's occupational therapist had visited their home to assess what equipment and adaptations may be required and ensure this was provided. Staff worked in close partnership with people's GP when they supported people in the community. The service's clinical nurses specialists were 'attached' to GP practices and attended regular 'Gold Standards Framework meetings' where they took referrals from GPs, practice nurses and district nurses. All organisations providing end of life care are expected to adopt a coordinated process such as the Gold Standards Framework, which is a systematic, evidence based approach, developed to improve quality of care for patients with a life-limiting illness. People were referred appropriately and without delay to consultants such as neurologists and oncologists, to hospital specialist teams such as chronic pain team and specialist nurses such as tissue viability nurses. This ensured that staff responded effectively when people's health needs changed.

The premises had been designed and decorated taking people's physical and psychological needs in consideration. They were spacious, well-lit, and decorated in calming tones. Corridors were wide, with handrails to help people move around when necessary. All doors had been designed for easy access by people in wheelchairs. The reception was welcoming with ample seating area and facilities for refreshments. There was a sitting room with games to keep visiting children entertained and a well maintained fish tank to attract visual interest and promote relaxation. The Hospice Labyrinth had been created in the garden, specifically designed as a spiritual tool for patients and families to walk around, while contemplating difficult issues and trying to find inner calm and peace.The attractive gardens that surrounded the premises were maintained to high standards by volunteers and had been designed to promote an atmosphere of peace and comfort. It included ample seating areas for people to relax in.

All bedrooms in the In-Patients unit were spacious, had attractive views, were well equipped and specifically designed to provide a calming environment. They included a ceiling hoist to enable people to move from their beds if needed, an en-suite with shower equipped with aids, a fridge, a 'drug pod' for people's own medicines, padded adjustable armchairs chair for people and their visitors. A bathroom was equipped with a fully adjustable bath which provided hydro-massage, hydro-sound systems, pillow and foot support. The Matron described to us how this room was decorated and furnished "to look and feel as homely and inviting as possible".

Good ●

Is the service effective?

Two twin bedrooms were available to accommodate carers and/or families when they wished to stay and z-beds and reclining chairs were available for those wishing to stay in the same room as their loved ones. A room overlooking the gardens and the main garden water feature was available whenever people or their visitors needed time to themselves, and was used for any religious service that people wished to have. There was a 'clinical room' where staff and relatives could talk in privacy about practical aspects of their relatives' care. There were sluice rooms, a room to keep oxygen supply, a procedure room for blood transfusions, and a small gymnasium where people received physiotherapy treatment. The kitchen was spacious with modern appliances and ample storage. A kitchenette was situated close to the In-Patient Unit to enable staff prepare and provide drinks and snacks without delay. The nurses' office was situated in the In-Patients Unit so staff were able to have immediate access to people when they needed help. Three rooms were available for people to have counselling sessions. The Hospice Day Service was accommodated in a vast well-lit area that included comfortable sofas, armchairs, tables, and storage for art and crafts materials. All office space provided a pleasant environment for staff to work in and two main roomsaccommodated classroom teaching, workshops, seminars and meetings.

There were plans to modernise the premises further and upgrade the bedrooms. One room had been fully refurbished according to this new model and had been used to accommodate a person and their relatives. The provider's premises improvement plan aimed to upgrade all bedrooms to a similar standard, and provide double bed facilities to accommodate people and their spouse when they wished to remain together. In this new room, there was additional storage space for people's belongings and motorised wheelchairs, an overhead ceiling hoist that connected the bedroom with the en-suite wet room, new curtains and a bed settee that enable relatives to stay close to their loved one.

Is the service caring?

Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided and the manner in which it was delivered. All their comments were overwhelmingly positive. People told us, "This is the best place to be at this time, the staff here are angels on Earth", "The care is so excellent here they could not give better care, there are no words to adequately explain how lovely they are", "The staff are absolutely amazing, exceptional" and, "I trust them with my life and I trust them with my death; they understand how I feel, they know what I need, they truly care about what they do." People's testimonies included, "The nurses, doctors, and indeed all the staff are marked by kindness, compassion, and a deep sensitivity to your needs; nothing is too much trouble". Relatives told us, "The staff are simply outstanding, truly remarkable; they have compassion, great understanding and strength which they communicate to us when we need it the most" and, "All the staff here are extraordinary, nothing is too much trouble, they have great empathy and genuinely care for people."

There was a homely feel to the service in the In-Patient Unit and the Hospice Day Service. A volunteer told us, "It really feels like family here." There was a social atmosphere where people were encouraged to chat if they wished and were listened to. Staff were smiling and engaging; they stopped to listen to people and responded to them with apparent genuine interest. Their approach was kind, patient and respectful. They followed people's pace when they helped them and when they conversed with them. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names. While the medical director and doctors were talking with a person in a bedroom about pain management, they noticed that two of the chairs they were sitting on were squeaking. This distracted the person as they lost the thread of the conversation. The chairs were removed and disposed of straight away to ensure such details did not hinder vital communication with people.

Staff were attentive to people's needs including their emotional state. Testimonies from relatives who had received support from the staff included, "There aren't really words to do justice to the exceptional job the wonderful staff did for our Mum– they went far beyond the care of duty; nothing was ever too much; we could not have even contemplated coping without the endless compassion they showed." Counselling therapy was offered and provided to people. This extended to their relatives including children to help them come to terms with loss and bereavement. Counselling for children often involved the use of creative activities such as drawing, painting, using puppets or sand trays. This approach can enable children to find ways to express their thoughts and feelings about what is happening to them when their relative has a life limiting illness. Reading material was recommended to parents to use with children, to promote their involvement in the therapy process. The relatives we spoke with told us they received "Excellent support" from all the staff who showed a great understanding about how they may feel. One relative told us, "Sometimes it is just a look, a smile, a squeeze of the hand, a hand on the shoulder or a nice hot cup of tea that makes the difference; The staff are so understanding, there is always the opportunity to sit down with them and chat and have a cry or a laugh that makes them so special."

Staff showed kindness and knew how to convey their empathy when people faced challenging situations. They often performed beyond the scope of their duties and pre-empted people's emotional needs. For example, people said, "When my mum took a turn for the worse, a nurse just kept her hand on my shoulder, she could sense that was the physical comfort that I needed" and, "When I was being transferred to hospital, I remember the kindness of the nurses as they stayed near me and made sure I was as comfortable as possible. One nurse - even though she had finished her shift - waited until I was safely on board the ambulance before going off duty" and, "A nurse that we had come to trust and like very much, sat by me one of the evenings when I was outside mum's room; she stayed with me and looked back at me with sympathetic, tear filled eyes."

Staff used appropriate touch when needed such as gently stroking a person's hand while they experienced some discomfort. They always checked to assess whether such gestures of empathy were welcomed by people. They offered companionship to people who stayed in their bedrooms when they considered that people may not wish to be on their own. One member of staff told us, "Sometimes, they only want us to be close by; we check what feels right for them." The staff responded quickly to

Is the service caring?

people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected and updated in their care plans.

Staff were in turn supported by the management team if they experienced emotional difficulties due to the nature of their work and were also able to receive counselling. One member of staff told us how, when staff had needed to congregate in 'the quiet room' to mourn the loss of a person, directors had stepped in to ensure staff cover so that staff could have some 'time out' to reflect.

Visitors were welcome at any time. The registered manager told us, "Families are welcome day and night; we could never impose visiting times restrictions, we feel people belong to their family and not to us and they should be able to see them whenever they want." Relatives were able to bring people's pets to visit their owners in the service, to bring them comfort and lift their spirit. A relative told us how "Wonderful" it was to being able to visit late evenings after work, they told us they could relax and watch TV with their loved one and share a supper "Just like we do at home." Such measures ensured that people could retain and find comfort in routines that were familiar to them.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. Photographs of the staff were on display and each member of staff wore a badge that indicated what position they had. The registered manager had re-named several job titles to make their significance clearer to people. There was a comprehensive information booklet that included the service's mission statement, the range and nature of services available, the structure of the medical team, Out-patient clinics, how to complain, and a list of information leaflets that were available to download from the service's website or in a printed format. It also included names and contact details of the provider, of the six directors involved in the running and management of the service, and useful telephone numbers including how to contact the service out of hours. All information was available in larger format to help people who may have visual impairment. A section titled 'Frequently asked questions' pre-empted possible enquiries and provided clear answers. The service had an updated website that contained clear, comprehensive information and that was user-friendly.

The leaflets that were provided for people addressed practical situations and acknowledged how people and their relatives may feel when coping with a terminal or life limiting illness and end of life care. For example they included information about coping with bereavement and what support was available, about supporting a child when someone in the family had a terminal illness and 'what to do' when someone died. A leaflet on 'Strong painkillers and driving' informed people on risks they may take. Face to face information was provided to people tactfully in a way that ensured they were able to make fully informed decisions. The medical director interacted with transparency and sensitivity when a person enquired whether they may be well enough to attend a forthcoming family event. They had presented information and options to the person such as bringing forward the family event and suggested that it could be held in the service. They had ensured the person's anxiety was alleviated and had promoted a climate of trust in which the person could be confident their concerns were listened to and responded to.

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. They took part in discussions with staff to express their views, preferences and wishes in regard to their care, support and treatment, and were invited to take part in 'advance care plans'. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. This included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they wished to be their legal representative. These advance decisions were recorded, effectively communicated to staff and respected. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. A matron told us, "This service is all about nurturing people and we help people getting what they want right through to the end." A relative told us, "My mother was supported to die the way she wanted and in great dignity, she was listened to and most importantly she was understood." Testimonies

Is the service caring?

described how staff had met individual needs with "Deep sensitivity." For example, staff had remained with a person in their home all night and stayed awake to offer comfort and relieve their anxiety. A person had been helped and supported while tracing a relative they had not seen for several decades. They said, "The staff have really helped us to see the positives and rebuild our relationship." As staff demonstrated great understanding and empathy, people could be confident that their individual needs were met and responded to in a way that may exceed their expectations.

Each person in the In-Patient Unit had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered. A person's health condition had changed and a doctor had explained to the person what side effects they may experience should they wish to proceed with a new medicine. The person was fully involved in the decision and their wish was respected.

All staff knocked gently on people's bedroom doors, and waited before entering. Bedroom doors were left closed or open at people's request and staff checked regularly on people's wellbeing. Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal needs. People were assisted with their personal care needs in a way that respected their dignity. A person told us, "They are very respectful and they realise it is not easy for the person who is in bed but they make you feel at ease". A relative told us, "Dignity is respected at all times." When people had physical examinations, the medical staff maintained eye contact with the person to assess whether they were in discomfort and responded to them accordingly. When the medical team were with people, a sign on their door indicated a 'ward round' was taking place, to ensure people were not disturbed and that their privacy and dignity was respected.

When staff handed over people's valuable items such as their jewellery to their relatives, this was carried out with sensitivity. A matron told us, "We do not use brown envelopes because we find them too impersonal, we use lovely canvas pouches with a heart on it instead and hand them over with care because we know these objects mattered to people and their family."

We observed instances where staff demonstrated particularly considerate attitude. For example, when a person needed to drink using a straw, staff helped the person do this discreetly when their children were visiting to minimise their curiosity and protect the person's dignity. Another person who did not wish to be photographed by their family while they were unwell was presented with an option of a hand print to give to their family instead. During handovers and after 'ward rounds', staff spoke about people respectfully and maintained people's confidentiality by not speaking about people in front of others. The notice board that listed people in the In-Patient Unit identified people by their forenames only and people's records were kept securely to maintain confidentiality.

An education programme 'Learn to Care' was available for carers and families. It educated carers about how to care for people at home between visits from domiciliary care workers or the service's nurses and/or care workers. The registered manager told us, "We aim to enable families to care and not take care away from them." The staff promoted independence and encouraged people to do as much as possible for themselves when they wished to do so. People followed their preferred routine, for example some people chose to have a late breakfast, spend time in the gardens, stay up late, sleep in a comfortable armchair rather than a bed, or have a bath at any particular time of the day or night. A member of staff told us, "We follow their lead; whatever they want to do is what is done." The registered manager told us, "If a person wishes to die at home, we do everything possible to make sure this happens, as the person is the decision maker."

Attention was paid to people's spiritual needs and chaplaincy support was available to people 'of all faith and no faith', which means that it was accessible to all. A person had commented, "The gathering run by the chaplain at the Hospice is non-denominational and so even people like myself can attend and just take the time for reflection." Relatives were invited to light up a candle in the memory of their loved ones during a 'Light up a life' service and during remembrance services. A relative's testimony included, "I have attended other Hospice in the Weald remembrance services over the last year and always take great comfort in being surrounded by others who understand my loss and like me want to take time to remember a loved one, especially at difficult times of the year". This helped support relatives who wished to remember their loved ones and find comfort in the company of others.

Staff knew how to respond to each person's diverse cultural and spiritual needs in a caring and compassionate way. A

Is the service caring?

member of the travelling community had been supported to access available services and had remained in the service for several days. Their family members had been encouraged to stay and reside with them while care had been provided. An interpreting service had been used by the Hospice in the Home team when they provided support for a person who did not speak English. The registered manager had access to an advocacy service, should there be a need to communicate with people if they had cognitive impairment.

Is the service responsive?

Our findings

People and their relatives told us that the way staff responded to their needs was “Outstanding” and “So personalised”. They said that they were given individual consideration by staff who were “Diligent and devoted.” They also described the staff as, “Receptive”, “Exceptional people”, “Giving outstanding care”, “So approachable” and “Open.” Relatives told us, “Every need my mother has is met without delay”, “We are kept informed every step of the way and are told what to expect next, they are so good at keeping us involved”, “The doctors and nurses are exceptional, they introduce themselves and discuss issues with us both [my wife and I]” and, “The plan of care may change from one hour to the next but we still get informed.”

There was an extensive collection of testimonies and feedback from people, friends and relatives who expressed how responsive the staff had been to people’s needs. All were extremely positive and thanked the staff for their “Love”, “Kind-heartedness”, and “Outstanding care and compassion” towards meeting people’s needs. A manager of a nursing home who received support from the Hospice at home team told us, “They respond to each person’s needs and treat them as individuals.” A district nurse said, “The staff in the Hospice in the Home team are reactive and quick to respond.” A GP who came to the service to provide regular treatment for people in the hospice told us, “Compared to other primary care teams they are very responsive and take real ownership.”

People were able to self-refer and their needs were assessed within 72 hours. Newly referred people were invited to attend the Hospice Day Service for an introductory day. They met with a member of the clinical team so that their individual needs could be understood. Personalised goals, frequency and length of their attendance were discussed and agreed on. The day service also offered ‘drop in’ sessions for people and their carers to attend without prior booking. This ensured that staff could respond to people’s needs when they arose. Admissions to the In-Patient Unit ensured that people received a management plan of their symptoms, emotional and spiritual support, pain relief and specialist care.

People were provided with a ‘symptom and concerns checklist’ to complete that helped staff appraise people’s individual perspectives. There were honest discussions with people about what they could expect and how the services available may support them. A matron told us, “We are committed to ensuring that people get what they need when they need it and that we can take care of their additional needs within the service and avoid having people going to acute services.” For example staff were able to respond to a person who had experienced a blockage in their catheter while they visited the hospice day service so they had not needed to go to hospital.

People’s care and support was planned in partnership with them. Staff anticipated how people felt when planning their care and support. Upon admission in the In-Patient Unit, and when people received support from the Hospice in the Home service, staff sat with people, enabling them to spend as much time as they needed and encouraged them to ask questions, discuss their options and reflect upon them. As people and staff worked as a team to ensure each support plan was unique and responded to specific needs, people felt valued and understood. People were encouraged and helped to complete advance care plans to record their wishes regarding how and where they wanted their end of life care to be managed. People told us staff had exceptional skills in this particular regard and an excellent understanding of people’s decisions and preferences. A relative told us, “This was not an easy subject but they did it magnificently, with total honesty and gentleness and no judgment whatsoever.” People’s care plans included strategies in regard to their pain and symptom management that were updated on a continual basis. For example during ward rounds, doctors updated the care plans on a laptop computer to ensure nothing was missed. The updates included changes in people’s health and about how to respond when people experienced changes in their symptoms or pain levels. Discussions with people about their wishes and their consent about any changes in their treatment were recorded. This meant that when people’s pain increased they could be confident that responsive action of their choice was taken.

People’s wishes were at the centre of their care planning. Staff were aware of people’s care plans and were mindful of people’s likes, dislikes and preferences. For example, they knew when a person preferred a late breakfast, a shower in the morning, or that they preferred to sleep on top of their chair at certain times. One staff member told us, “What matters to them is what matters.” People were offered the options to have a bath or a shower every day and were able to request these at any times including at night time. A fully adjustable bath provided hydro-massage and hydro-sound

Is the service responsive?

systems that enabled people to input music of their choice. People could be confident that staff understood what was important to them and accommodated their wishes whenever possible.

There were additional care plans that were updated hourly when people approached the end of their life, to monitor closely their comfort and respond to their changing needs. These plans were based on priorities of care that were identified by the Leadership Alliance for the Care of Dying People (LACDP), a coalition of 21 national organisations that was set up to lead and provide a focus for improving the care of people who are dying and their families. The care plans were centred on the individual, included food and drink, symptom control and psychological, social and spiritual support. Sensitive communication took place between staff and the person, and those identified as important to them. Therefore people's needs in the last hours of their life were met by well-informed staff who were knowledgeable about people's individual requirements.

When a person was anxious because they were too unwell to participate in a family celebration event, they were presented by staff with an option they might not have considered, such as bringing forward the event and holding it on the hospice premises. As staff demonstrated an inventive approach that was practical and sensitive to people's needs, people could gain an enhanced sense of psychological wellbeing.

When people remained in the In-Patient Unit for a short period to have their symptoms managed, there was effective transition management to ensure they received continuity of support at home. Care plans that were written by staff of the Hospice in the Home informed the care plans that were developed in the In-Patient Unit. This ensured that staff were fully informed of any changes in people's health, medicines or treatment when people went from one service to another.

The arrangements for social activities were innovative and met people's individual needs. A broad range of daily activities was available in the Hospice Day Service. There was a creative artist who was assisted by an activities co-ordinator and volunteers. The programme of activities included creative expression projects, and memory projects that included the making of recordings and collages, book writing, quilt making, and photography. There were individualised advance care planning work, art and crafts, quizzes, games, clay modelling, photography workshop, spiritual gatherings and outings. A team of nine 'Hospice Therapy Dogs' visited the hospice regularly, to provide an opportunity for pet-lovers to cuddle and play. People were consulted about what they enjoyed doing and were involved in the planning of the activities programme.

The creative artist told us, "Each activity responds to each person's wishes. For example, a person told us how they had always wanted to see a particular painting in a French museum, and we ensured they had a virtual tour of the museum via the internet to see that painting for themselves." A testimony from a relative included, "My mother's trips to the Hospice Day Service were filled – in just a few hours she would do so much. The creative artist fully encouraged her not to give up her art. Her right hand was becoming more stiff and unresponsive, but they helped her see this as an opportunity and she tried painting with her left hand instead." As activities were adapted to each person, people could be confident that their individual abilities were taken into account when they wished to communicate in a creative way.

One-to-one activities were provided for people who remained in their bed in the In-Patients Unit, such as watercolour painting, jewellery making, screen printing and memory projects. A volunteer had brought plants and compost to a person's bedroom to help them pursue their interest in gardening. When people did not wish to join activities and they preferred to read, watch television or listen to music, this was respected.

The registered manager told us how people's families and friends were invited to visit them at any time. They told us, "We provide care for the whole person and adapt entirely to them and their needs, this include respecting their need to see whoever they want whenever they want." A relative said, "Hospice in the Weald allow people to visit their loved ones whenever they want, day or night, so friends were able to create a rota, meaning that she was never on her own." As visitors were welcome at any time of day or night, and as they were enabled to remain overnight with their family members if they wished, social isolation was reduced.

The Hospice Day Service involved people's children and grandchildren when they wished and individual projects were created. Additional activities sessions had been provided at weekend to enable people's families and friends to come in and take part every day if they wished. Organised outings to local places of interest were planned

Is the service responsive?

taking in consideration individual requirements. For example, visits to artists' studios and sculpture gardens had been organised for people who liked art. The registered manager told us, "Often people discover their creative side when they become unwell and it is important that we give them every opportunity to enjoy and explore this." One person told us, "One talented artist teaches me to draw; I never knew I had the talent." They showed us the drawing they were working on and said, "The artist taught me to look for light and shade, I was advised about grips I could use for holding a pencil steady." A relative told us, "The staff engages people in a remarkable way and get them motivated to be creative, our father has come out of his shell and is actually taking great pleasure in doing things here." A boat trip had taken place over three days to include all who wished to take part. Staff had ensured people with wheelchairs had access to the trip and people had been encouraged to take photographs and create positive memories. A staff member told us this had been a "Huge memory building" and people told us they had enjoyed this "Tremendously".

People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life. A room were people's families could enjoy quiet times to remember their loved ones included a 'memory tree' onto which relatives placed remembrance messages and artefacts. They were encouraged to attend support groups and socialise in the Hospice Day Service in a comforting setting to ease their grief. A relative described the service as a "Life giving place." Therefore the service provided emotional support for families that was continual, beyond the provision of care for people.

A wide range of therapies that were additional to medical and nursing care were available to respond to people's needs in regard to relaxation and general wellbeing. Complementary therapies included aromatherapy, massage, reflexology, music therapy, occupational therapy and physiotherapy. People were able to try and choose the therapies they preferred and when they wished to have them. A person in a wheelchair was encouraged to go to the gymnasium for a short period and move their legs. The exercise machine assisted their movements and reversed the process when their leg became tired. The person told us, "I have played 'Scrabble' standing up; it is a wonderful feeling."

Flower displays were provided to brighten up the environment. There was a room dedicated to flower arranging where volunteers prepared bouquets and arrangements that were displayed throughout the hospice. A specialist volunteer told us, "I have been doing this for 14 years and everyone really appreciates the work; beautiful flowers lift people's mood." Visitors told us how they appreciated the displays and how this contributed to positive feelings when they entered the premises. One relative told us, "It gives us a sense of beauty and serenity."

The service took a key role in the local community and was actively involved in building further links. The Hospice maintained a high profile in the community and was regularly prominent in the local press. Recent articles featured the provider and the registered manager explaining the aims and ethos of the hospice and how a new launched project would create a new model to reform end of life care. This new model would provide support to both the individual as well as their family, educate carers when necessary and respond to people's needs to remain in a homely environment durin the end of their life. Links with the community were actively sought and encouraged by the leadership team; these occasions were arranged by the events management team who organised events such as races, golf days, concerts, film screening, magic shows, clothes sales, 'make-over fun' days, open gardens day and Christmas markets. The fundraising director told us how volunteers and staff contributed to the planning of events. A website 'Hospice Web' had been created for staff and volunteers to access and contribute with ideas. The fund raising director told us, "Our events bring the community together and maintains vital links." These events improved people's experiences as they were actively included and connected with their local community.

Innovative ways were adopted to ensure as many people as possible could be involved in giving their feedback. People were invited to give testimonials that were filmed and posted on the service's website with their consent. These films were called 'Hospice voices' and contained accounts of people's experiences of the service. The service website included a link where people could input their profile, photos, and update their personal diary. Any visitors to the service's website were invited to input their comments. Additional feedback was actively sought about every aspect of the service and people, their visitors and staff were invited to make suggestions using a comments box displayed in the entrance. This was emptied every

Is the service responsive?

week by the registered manager, although it was seldom used. The staff told us, “We prefer to talk to the manager and directors directly whenever we need to.” People had been consulted about the design of the premises and as a result a dividing partition had been removed in the day services area to provide an open-plan effect. A person told us, “This way we can get a better overview of each activity and who is there to socialise with.”

Annual satisfaction surveys were carried out and responsive action was taken to address shortfalls that were identified as a result. For example, when a person had commented in a survey that a noisy door inconvenienced them at night, a door silencing system had been implemented without delay. All comments in the surveys were extremely positive about the quality of the service. They included, “A safe haven amidst the storm we were fighting”, “I know that Hospice in the Weald will continue to support me and my family for as long as we need; they are doing everything possible to help me and my family every step of the way and in so doing, are helping me to feel a person of value once again.”.

The registered manager showed us how the next survey included interviews of people and relatives conducted by people not directly connected with the service, to capture more effectively the experiences of people and their families. Two minor complaints had been received by the service since our last inspection. These had been addressed promptly according to the service’s policy and to a satisfactory outcome.

Good ●

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. People's feedback about the way the service was led described it as "Truly exceptional" and, "Second to none." A person who remained in the In-Patients Unit told us, "This is a place where there is an excellent team; the managers are part of the team and we get to know them and they get to know us just like we get to know all the staff." Relatives told us, "The Hospice in the Weald has an unsurpassed reputation for excellence; it is extremely well managed by managers who care" and, "This is a very well managed and efficient hospice where everything is well organised and where they thought of everything." A district nurse said, "We work in excellent partnership with the Hospice in the Home; they are superbly organised." A GP who provided regular treatment in the service told us, "The hospice is a fantastic organization to work for; it has a clear vision and is well-led by a team who is clearly passionate about care; I cannot praise the leadership high enough."

There was an effective leadership team that oversaw the running of the service, that included a chief executive (the provider), the registered manager who was the director of nursing, and five other directors. All the staff we spoke with told us they had confidence in the way the service was managed. Staff praised the provider and the leadership team for their approach and consistent, effective support. They said they could come to the provider or any of the directors for advice or help and they "Never failed them." All of the staff we spoke with told us that they felt valued working in the service, and felt motivated to maintain high standards of care.

The registered manager had joined the service in January 2015 and had taken remedial action to ensure the service's registration with the CQC was accurate and up to date. They had particular experience and expertise in leadership, nursing and palliative care.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They told us of their vision and values, described the aim of the service as "Providing the best care possible 'with and not to' patients, families and carers" and told us, "The initials of the Hospice in The Weald spell the word 'with'; this word symbolises how the hospice works in partnership with people." The provider spoke to us about the core values that underpinned the service. They included, "To put patients first; to deliver the most effective palliative care we can; to be open, honest and transparent in all that we do." The service's mission statement and strategy was based on care that was "Compassionate", "Individualised", "Holistic" and "Supportive." From what people told us and our observations, these principles were implemented by all staff throughout the service. A person who had been hospitalised previously told us how they appreciated the improved personalised care that they received in the Hospice. They told us, "Here the staff got to know me, the whole of me, and we value and respect each other." Therefore people received care and support by staff who upheld strong values about person-centred care, and positive connections were promoted that enhanced their experience of the service.

The provider and registered manager were visible in the service and knew each person who used the service by name. The registered manager worked shifts in the In-Patient Unit and stepped in to deliver nursing care to people when there were unexpected shortages of staff. Members of the leadership team ensured continuity of management when this occurred. The registered manager took an active part in monitoring standards of practice. A member of staff told us, "He rolls up his sleeves and leads by example." The staff told us they were inspired by the registered manager's examples and values and described them as "Truly inspiring", "An effective leader", and "A beacon." Two members of staff told us, "He is passionate about care" and, "He always tells us 'Another day, another opportunity to care', and he means this."

There was a recording system concerning accidents and incidents that ensured relevant information was considered and analysed without delay. Action was taken to minimise risks of recurrence. The registered manager reviewed the reports of accidents and incidents, forwarded the information to the Chief Executive, and carried out investigations that were recorded. These were audited to identify trends and patterns and were discussed at monthly clinical management team meetings. Quarterly reports of accidents and incidents with audits were provided to a local governance committee for further examination. The registered manager showed us how, in case of a person having experienced a fall, an email was sent to nurses and the information was also shared in staff handover sheets. This system ensured that all staff were informed and remained vigilant about risks of recurrence so as to keep people as safe as possible. We found that some aspects of monitoring processes in regard to medicines needed to be improved and consistently embedded to ensure that improvements were sustained over time.

The registered manager, provider, directors and staff participated in many fundraising events in the community and made people aware of the services available. They had hosted a 'Hospice in the Weald Choir of the Year Competition' in a local theatre and people told us of how they felt inspired to support the service by their "Enthusiasm, passion and commitment" towards the service and its purpose.

The Hospice Leadership Team involved the staff with the running of the service. Regular staff forum meetings were held where staff were invited to bring suggestions about the running of the service. A member of staff had suggested a 'swap day' where 12 members of staff exchanged their positions for a day with each other to appraise other departments' perspectives and this inventive idea had been implemented. Members of the leadership team had taken part in the exercise. The registered manager told us, "This is a brilliant idea and is now a scheduled occurrence." Such initiative made the staff team more understanding of each other's roles and as a result the team that cared for people was cohesive. Another member of staff had suggested a monthly 'Dementia Café', where people, their families and carers could access informal support and information regarding the role of palliative care and dementia. The provider was exploring how to implement this suggestion and develop the idea to create a monthly dementia clinic. The aim of the venture was to reduce isolation that people with dementia and their families may be experiencing. Therefore, people were supported by a service where management and staff embraced new ideas about how to improve quality of care.

The service worked in partnership with other organisations to ensure they provided a high quality service. They worked in collaboration with Continuing Health Care (CHC), local authority services, a chronic pain team and a neuro-rehabilitation team to get people home when they wished to and were well enough to do so. They had established close links with the local authority and the local Clinical Commissioning Group (CCG) to create a new federated scheme which included an accredited National Vocational Qualification (NVQ) centre. This centre provided opportunities for staff in local residential homes and domiciliary care agencies to study and gain qualifications in dementia and end of life care. A team of specialist nurses visited every care home in the area to establish connections with the hospice services, to check that standards of end of life care were upheld, and to provide training and support when shortfalls were identified. A manager of a care home told us, "We work together with the common goal to improve standards of care for people at the end of their life." As a consequence of this project, people who received care and support in residential settings and in their home could be confident that the quality of staff practice was monitored and upheld.

People were placed at the heart of the service and the registered manager placed emphasis on continuous improvement in all aspects of their care. They had a plan to drive improvements in the service and worked in partnership with other organisations to that effect. For example, improved satisfaction surveys were scheduled to take place involving the participation of the University of the Third Age, the England Centre for Development, and Canterbury Christ Church University. The registered manager explained how these surveys will include anonymised interviews of people and relatives, conducted by people not directly connected with the service to capture more effectively the experiences of people and their families. A new computerised system was in the process of being implemented, to improve monitoring systems. For example, the new system allowed managers to monitor staff training in their respective departments, to promote closer monitoring. The registered manager had updated the service's clinical governance framework to re-define it and reflect changes in the monitoring system.

There was a robust system to monitor the quality of the service. The clinical management team held monthly meetings and the hospice leadership team held fortnightly meetings. Every aspect of the service, including staff training and policy and guidelines reviews were discussed. The policies were comprehensive, reflected every aspect of the delivery of care in the service and were updated on a continuous basis. A computerised system scheduled policies for regular reviews and these schedules were adhered to. Staff were made aware of the updates and knew where to locate the policies for guidance.

There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. Outcomes of clinical audits were overseen by the medical director and discussed at an 'Audit and Research Group' meeting that took place every eight weeks. Where appropriate, audits were discussed with the clinical management team, a clinical governance committee and the board of trustees. Audits of incidents were discussed at Clinical Governance Committee Meetings to explore how risks could be further managed. Satisfaction surveys and complaints were scrutinised to identify whether people's experience of the service could be improved. They had identified that people were fully satisfied and two minor complaints had been addressed satisfactorily.

Some audits were carried out regularly to ensure compliance with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care that defines clinical best practice. NICE provides specific quality statements and measures to provide service providers with definitions of high-quality care. Such audits to measure how the service performed were completed either monthly or quarterly, documented and used effectively to monitor the quality of the care provided. They included advance care plans, staff response time when urgent care had been provided, health records, infection control and medicines management. An audit on infection control had identified improvements to be made and remedial action had been implemented.

The service used more extensive audits to inform their partnership working with other organisations. These were 'stand-alone' audits that included in-depth research and looked into a particular aspect of practice. An audit on people's documentation about their resuscitation status had identified that documentation was kept in a variety of places in people's homes. It had identified a need for a robust national electronic system to prevent inappropriate resuscitation. As a result, the service worked with the Clinical Commissioning Group (CCG) to develop a system to ensure national access to end of life information across organisations, such as people's decisions about resuscitation. An audit had been carried out on 'drug dose alterations in renal impairment', and as a result a review of the service's renal dosing guidelines had been carried out. Another audit on the involvement of families in key decision-making had identified that standards had been met in 100% of the researched cases.

The registered manager said, "Audits help us demonstrate not only clinical effectiveness; we use the outcomes of audit to inform policies and improvements in practice." A clinical audit had been carried out to identify the level of risk of a particular medical condition in regard to people's veins. Following this audit, new guidelines had been provided to staff for them to follow when they assessed people who came into the service. A follow-up audit had been carried out to check the effectiveness of these assessments and included recommendations and action plans with time scale for completion.

The provider had introduced a new model of service titled 'Meeting more unmet need'. This was an internal working document that made clear the service intentions and approach in regard to developing the service. It explored the 'how' and 'when' to deliver a model of service through lessons learned during the past years. This project was in line with the hospice's business plan and set clear objectives to attain within a time frame. As a result of this project the number of hospital admissions was being reduced and people had more opportunities for remaining at home if they wished during the end of their life.

The provider and registered manager told us about a pioneering project that they had launched to create a local 'cottage hospice'. This innovative project aimed to allow families and friends to be intimately involved in looking after their loved ones, with nurses on hand to help. Carers would be guided and trained when necessary to look after people in ways they preferred. Accommodation would include double beds so couples will be able to remain together if they chose to, and rooms will feel "More like a room at home and less like a clinical environment." The registered manager said, "Families need to be involved; it is about what we can do about keeping families and carers together with the patient at the end of life; it is about creating an environment where you are in charge; this is about getting down to that individualised care and supporting people who provide it, and creating a more positive experience; it is about giving people quality time and that is the gift of hospice." Such a project presented a new model of end of life care and meant that people would be provided with more flexibility in the way they wished to manage the end of their life. This project was in progress and had not yet been implemented in the community.

Good ●

Is the service well-led?

All records relevant to the running of the service that we saw were well organised and reviewed regularly. All records were kept securely and confidentially. Archived records were kept for the appropriate period of time as per legal requirements and disposed of safely.