Ellenor Lions Hospices

Ellenor Gravesend

Inspection report

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Date of inspection visit:
11 May 2016
12 May 2016

Date of publication:
27 July 2016

Ratings

Overall rating for this service	Requires Improvement ●

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?	**Requires Improvement** ●

Summary of findings

Overall summary

The inspection took place on 11 and 12 May and was unannounced. Ellenor Gravesend is a hospice that offers specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver personal, emotional and holistic care through a multi-disciplinary team of nurses, doctors, counsellors, physiotherapists, spiritual leaders and a range of volunteers. The service cares for people in three types of settings: at the hospice in a 15 bedded 'In-Patient Unit'; in the 'Hospice day service' which provides support for up to twenty people; and in people's homes. The service was providing services for 503 people in the hospice and the community at the time of the inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were safe systems in place for the ordering of medicines, but there were some shortfalls in the administration and disposal of medicines.
Most records were held on a computer system and available to all health professionals involved in the person's care to ensure continuity of care. However, some records, such as aspects of people's health care on the in-patient unit, were inconsistent and contradictory so although people received the care they required, this was not reflected in their records.

People said that they felt well looked after and safe when receiving care from the service. Staff received training in safeguarding adults and children and understood the importance of protecting people, visitors and themselves.

People said that there were enough staff available to promptly attend to their needs. They were were cared for by a staff team who felt well-supported so they had the skills and knowledge to meet people's needs.

Assessments of risk were individual to people's specific needs and identified how risks could be minimised. Accidents and incidents were responded to and monitored to see if there were any patterns or trends that required improvements to be made to ensure people's safety.

Checks were carried out on all staff at the service, to ensure that they were fit and suitable for their role. New staff received a comprehensive induction and training to ensure staff had the skills and knowledge to support people with long-term illnesses or who needed end of life care. The service encouraged staff to further their learning and had an educational centre which delivered accredited training in palliative care.

People were supported by a multi-disciplinary team and referrals were made to other professionals to seek their advice and input when it was required. Their health, medical and nutritional and hydration needs were assessed and closely monitored.

The service recognised that some young people saw themselves as adults and had established a transitional pathway which enabled them to receive age-appropriate respite care on the in-patient ward. Young people received support from nurses whom were known to them and undertook activities that they enjoyed during their stay, making it a positive and valuable experience.

Staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. 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 service had made an application under DoLS to ensure that people were not unlawfully deprived of their liberty.

The service provided outstanding end of life care and people were enabled to experience a comfortable, dignified and pain-free death in the place of their choice when possible. It had received a large number of compliments concerning the kind, compassionate and outstanding caring manner of the staff team.

Peoples' psychosocial, spiritual and therapeutic needs were catered for and supporting the person and their family members was seen as a key to people's well-being. This included bereavement counselling, therapies and support from the chaplain based at the service.

People and family members were involved in planning their care and treatment. People's individual wishes with regards to their care were recorded and staff went the 'extra mile' to ensure they were realised.

People benefitted from the service building links with other hospices, the ambulance service and with the local community. They were able to make their views known and knew how to make a complaint or raise a concern. When complaints had been received, these had been investigated and used as lessons learned to improve the service.

The service was led by a strong management team, who led by example. There was an open culture, staff and people were listened to and valued. The service had a clear direction of the areas in which it intended to develop further to meet the needs of the local community. Education and research was seen as key to making improvements in the lives of people with palliative care needs.

We found two breaches of the Health and Social Care Act 2008 (Regulated activities 2014). You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

People's medicines were stored safely, but improvements were needed in the administration of some medicines.

There were sufficient numbers of trained and experienced staff to meet people's needs. Checks were carried out on all staff who were employed by the service to ensure they were suitable.

Staff were trained in safeguarding adults and children and knew how to report any concerns.

Assessments were made of potential risks to people and control measures were in place to minimise their impact.

The service was clean and procedures were in place to promote good infection control.

Is the service effective?

Good ●

The service was effective.

People received care from a staff team who felt well supported and understood how to give effective care.

Staff were trained to ensure that they had the skills and additional specialist knowledge to care and support adults and young people with long-term illness or at the end of their lives.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and how to act in people's best interests.

People's dietary needs and preferences were taken into account and meal times were significant social events, which could be shared with other people, staff and/or family members.

Is the service caring?

Outstanding ☆

The service was exceedingly caring.

Staff showed kindness, compassion and empathy to people in difficult situations. People valued their relationship with the staff that went the 'extra mile' to meet people's needs.

The service was highly complimented for the manner in which it treated people and their family members as individuals and with dignity and respect.

Providing support to people, and their family members, was key to the service. The range of support available to people's families included counselling and bereavement services and support groups, which continued after the death of their loved one.

Adults and young people's different needs were fully met by the adaptable and flexible nature of the service.

Is the service responsive?

Outstanding ☆

The service was exceedingly responsive.

People's care and support was planned proactively with them and reflected their choices and preferences. Advanced care plans detailed where and how people wanted to receive their care.

At the end of life, people were enabled to experience a comfortable, dignified and pain-free death.

People had opportunities for companionship, and to engage in activities and therapies.

People were actively encouraged to give their views and raise concerns. When complaints had been received, they were used to drive improvements in the service.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Records were held securely, but some people's records on the in-patient unit were not accurate.

There was a system in place to maintain and monitor the quality of the service. The service was working towards making improvements in areas where shortfalls had been identified.

There was an open culture where people and their relatives were asked for their experiences about all aspects of the service.

The management team led by example and disseminated the vision and values of the service to the staff team. Education and research were undertaken to help make improvements to the lives of people with palliative care needs.

Ellenor Gravesend

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 checked 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. At our last inspection in December 2013, we found the service was fully compliant with legal requirements.
This inspection took place on 11 and 12 May and was unannounced. The inspection team consisted of an inspector and a pharmacist on the first day and an inspector and a specialist nurse on second day.

Prior to the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This helped us plan and inform our inspection. We also obtained feedback from a commissioner of the service.
We spoke with nine people who used the service and one relative. We also spoke with thirty three staff, including the registered manager, director of patient care, housekeeper, kitchen assistant, thirteen nurses, five health care assistants, doctor, volunteer, chaplain, administrator, the head of well-being, health and safety officer, maintenance person, and the Chief executive officer, the director of human resources and two assistants.

We spent time on the in-patient unit, attended two multi-disciplinary meetings and spent time talking to people using the day hospice. We looked at six people's care plans and checked how their care was planned and delivered. We also received feedback from a commissioner of the service.
During the inspection we viewed a number of records including seven staff recruitment records; the staff training programme; staff rotas, five people's medicine records; medicines and safeguarding policy; health and safety records; risk assessments and audits; compliments and complaints logs and quality assurance questionnaires.

Requires Improvement ●

Is the service safe?

Our findings

People said they were well looked after, that staff were always around and available to keep them safe. One person told us," It is a first class service. I cannot fault it. It is not like hospital. To be honest, when I first heard about the hospice I did not want to come here. I was worried. But everyone was so welcoming so I had nothing to worry about". Feedback from relatives to the service concurred that the hospice was a safe place to be cared for. One relative stated, "We felt so fortunate to have him in the hospice, in a place where he felt safe and secure and where we knew he would be so well cared for"; and another relative feedback, "She was made to feel not only safe but extremely special by all the staff that came into contact with her".

Prescribing was undertaken by two consultants. A pharmacist also visited at least twice weekly to advise on prescribing. Processes were in place to ensure that medicines for the management of pain were administered in a safe and timely manner. Peoples' prescription and administration charts were fully completed, inclusive of reasons for missed doses and peoples' allergies. Staff recorded when patches (either for pain relief or nicotine replacement) were applied to patients, regularly checked that they had not fallen off and were aware of the need to rotate the site of skin to which they are applied. However, there were no records of where the site patches were applied to; this should be recorded so staff can refer to previous applications to ensure patches are rotated correctly. Application of medicated creams were recorded on MARs. Electronic records for non-medicated creams such as barrier and moisturising creams did not always contain details on where these creams were to be applied to people. This should be recorded, as effective application of these creams is important in order for people to maintain healthy skin.

The service had effective processes in place to allow patients to take out medicines when on day leave. However, people were provided with non-oral syringes for use with liquid medicines when on leave. This is contrary to national guidance. The hospice had rectified this by the second day of the inspection. However, this is not a long enough period of time to ensure that the improvement had been embedded and sustained at the service. Peoples' notes showed that staff regularly monitored and responded to their symptoms, including pain. The service provided people with a take-home medicines reminder card when they were discharged. These were completed by nurses alongside people and their families prior to discharge to ensure they understood what their medicines were for and how to take them.

Controlled drugs (CDs - medicines which are at higher risk of misuse and therefore need closer monitoring) were stored securely. Destruction of controlled drugs was undertaken and recorded appropriately. Staff conducted balance checks of controlled drugs. High strength preparations of CDs were kept separately from other strengths to help prevent incorrect selection. Blank prescription forms (FP10s) were stored securely and there were processes in place to track their use in the hospice. This is important in preventing misuse of prescriptions. Waste medicines were stored securely. However, there was a considerable quantity of waste medicines still awaiting collection. The hospice rectified this by amending their waste collection arrangements by the second day of the inspection. However, this is not a long enough period of time to ensure that the improvement had been embedded and sustained at the service.

These shortfalls in the recording and disposal of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual and stock medicines were kept securely. Appropriate arrangements were in place for ensuring medicines were not used past their expiry date. Emergency medicines and oxygen cylinders were available, in date and stored appropriately. Records showed that medicines requiring refrigeration were kept between the recommended 2oC and 8oC. Therefore, people's medicines were stored so they were safe to use.

Nurses appropriately prepared syringe drivers for people (a system which allows medicine to be administered by slow release over a period of 24 hours) during a medicines round. Staff had good access to up to date resources which they may need for medicines administration, including guidance on the use of syringe drivers. Staff clearly explained information people were given about unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms).

Staff had completed training in medicines management and their competency had been assessed to ensure they knew how to administer medicines safely, including via a syringe driver. The service had undertaken audits on medicines use, inclusive of reviewing incidents and near misses in 2015. This work had been continued into 2016 as part of a drive for quality improvement there was evidence of changes as a result. For example, a new prescription chart had been designed with the aim of reducing errors and omissions in administration of medicines. Staff had good knowledge of how to report errors and were able to demonstrate learning from previous events by providing specific examples of changes to processes.

A lead nurse was responsible for overseeing all safeguarding concerns. There was a "whistle-blowing" policy for staff to report any poor practice at the service and a safeguarding policy for adults and children. This set out the different types of abuse, staff's responsibility to act respond to and report any concerns, and the responsibility of the service to contact the local authority. All staff received training in safeguarding children and adults at induction and via yearly updates. This training included discussing scenarios to ensure staff knew how to relate safeguarding policy to day to day practice, to keep people safe. Staff understood their responsibility in reporting abuse and the important of the procedures to protect people, their relatives and themselves.

People said there were sufficient numbers of staff available to meet their needs. During the inspection there was ample staff available on the in-patient unit and in the day hospice to respond quickly to people's care and treatment needs. A ward manager was responsible for the day to day running of the ward and they were supported by registered nurses and health care assistants. The staffing rota was consistent and reflected the staff on duty on the days of the inspection. The day hospice was managed by a team of nurses and health care assistants. Community services were provided by teams of experienced trained staff. The "Hospice at Home" team and "Care Home Support" team had a joint lead with separate staffing rotas that reflected the staffing needs of each team. Both people who used the hospice and those in the community received specialist input from the multi-disciplinary team of health and social care professionals that included bereavement counsellors and a physiotherapist. Volunteers worked throughout the hospice, making drinks, spending time talking to people and their family members, transporting people to the day hospice, providing activities and manning the reception area. Therefore, there was a range of skilled and experienced staff available for people to meet their needs.

The service employed some nurses on a flexible basis to ensure there were staff available to cover absences and vacancies. These nurses could support people in the hospice or the community. The deployment of staff was flexible. During the inspection a nurse was transferred from the ward to the day hospice as this was where there were was a greater need. This was an efficient system to ensure people's safety.

There were robust recruitment procedures in place for staff and volunteers, which included a clear monitoring system to ensure that all checks were completed before staff started employment. These checks involved applicants completing an application form, including a history of their previous employment, attending an interview and gaining suitable character and/or work references as appropriate and a Disclosure and Barring Service (DBS) criminal check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Disciplinary procedures were set out in the service's policy and in the staff handbook. They included the expected standards of staff performance and behaviours and what performance and behaviour may lead to disciplinary action. The service had followed these detailed procedures to ensure that staff working at the service were of good character and had the necessary skills and knowledge to carry out their duties.

Risk assessments were centred on the needs of the individual and included skin integrity, levels of mobility, risks of falling and mental well-being. These assessments were undertaken at the time the person was first known to the service and were reviewed on a regular basis. Control measures were in place to minimise these identified risks. This included the provision of specialist equipment such as airflow mattresses and hoists and specific guidance, such as how to assist people safely when attending to their personal care needs.

The lead in health and safety had developed a programme of audit, improvement and review to ensure the safety of the environment for people, staff and visitors. They worked in conjunction with the other heads of department to ensure that assessments of risk were suitable and up to date and reported on progress to the risk governance group. Regular checks were undertaken of equipment and services such as gas, electricity, fire equipment, hoists and medical devises. Fire drills were held to ensure all staff were confident and knew their individual responsibilities in evacuating the building and keeping people safe. Policies and procedures in relation to health and safety had been summarised so that each member of staff knew their aim and which procedures applied to them. Environmental risk assessments were in place to minimise the risks of people living and working at the hospice from potential hazards such as slips, trips and falls. The service had a business continuity plan for emergency situations such as if there was a flooding or gas or electricity failure.

There was a clear procedure to record and respond to any accidents, incidents or near misses such as if a person fell or developed a pressure sore. A record was made of each event, together with the details of what had happened, who was affected and the immediate action taken. These events were investigated and reported to the risk governance group to see if there were any patterns or root causes. Any recommendations to promote a safer environment were acted on and reported to the board of trustees. The service was clean throughout on the two days of the inspection. Housekeeping staff took pride in the quality of their work, understood their roles and responsibilities, followed schedules of cleaning and undertook regular checks to ensure all areas of the service were cleaned to the same standard. Staff understood how to effectively manage any outbreaks of infection or spillages. The service had worked with the local Clinical Commissioning Group to make improvements in the area of infection control. A lead nurse for infection control had been appointed whose responsibilities were to identify and monitor the effectiveness of infection control procedures in the service. Infection control audits were regularly carried out to ensure all areas of the hospice were sufficiently clean and to reduce the risk of infection. Bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices and there was hand gel for staff and visitors to use at various points in the building.

Good ●

Is the service effective?

Our findings

People and relatives indicated that the service was effective as staff had the skills and knowledge to give them the care, treatment and support they needed. One person told us, "The nurses have a specialist knowledge in my condition and help me mange it". People said they had access to the health care professionals they needed. One person told us, "Nurses monitor my health needs. They ask me about my symptoms and talk to me about them and any changes and they look at my medicines". Many people who lived in the community gave examples of how nurses had helped them to access the medical treatment and equipment they needed. Comments included, "I get my bloods done by the nurse, which means I do not have to queue up for hours at the hospital"; "I could not get a doctor's appointment, but the nurse rang up and got me one straight away"; and another person "It was taking a long time to get a wheelchair, and the nurse sorted it out for me".

Health care for people was provided by a multi-disciplinary team made up of consultants, doctors, clinical nurse specialists, nurses, health care assistants, and a physiotherapist. Nursing notes were recorded as a computer record to show how people's health care needs were monitored and met. They could be accessed by any health care professional involved in the person's care, to ensure consistency of care. For people in the in-patient unit there was also a paper record by their bedside to record and monitor daily interventions such as pressure areas on their skin and mouth care.

Staff told us that they received excellent support from their colleagues and senior staff and that there was good communication between nurses and health care assistants to ensure the effective care of people. The service had recognised that there was inconsistency in supervision being provided for staff across the service and had surveyed staff to establish what type of support they required. A supervision plan was now in place to ensure that all staff had access to regular supervision. Therefore, people received care and treatment from a staff team who were well supported.

Staff said there were opportunities to reflect on their practice. They said these were not regular events, but if they asked for them, they were always provided. Reflective practice is where staff personally and critically reflect on their work, on what they are doing well and what they need to do better, to ensure continuous learning. Debriefing sessions took place, after a death or a significant event that staff could reflect and learn from. The chaplain was available to offer periods of reflection and spiritual support and staff valued their presence and contribution. The chaplain and family support worker knew staff well and so observed when they required that 'extra' bit of support. Staff had access to counselling services which were widely advertised and taken up by staff.

'Schwartz rounds' were regular events. This is where staff come together to talk about the emotional and social challenges of caring for people in a safe environment. These were open to care and non-care staff and the majority of staff responded that they were positive learning experiences. One staff member described them as "Emotional and thought provoking, making me value my colleagues even more" and another as, "The panel were very clear and passionate about their experiences, and it was great that they were all so different". Each session looked at a different issue such as 'I didn't know what to say' and 'The patient who made a difference to me'. This gave staff the opportunity to share their stories and offer support to one another.

There were effective handovers between each team of nurses. These meetings were used to pass on medical and health information from one team of staff to another. The information given was comprehensive about each individual's needs was clear and concise about the short term plans for their care. The physiotherapy department ran breathing exercise which helped people with managing symptoms of their conditions. They also ran low impact exercise programmes for people known and not already known to the service. A review of the programmes in February 2016 found that people had shown significant improvement in muscle strength to help them stand, walk at a faster pace and in their confidence so they were less hesitant when walking.

The hospice managed two teams of community nurses whose role was to visit people in the community and people living in care homes, who had palliative care needs. This was to offer people nursing support; specialist palliative care advice, symptom control and end of life planning to ensure people could die where they wished to and avoid being admitted to hospital. The Care Home Support team worked alongside the Hospice at Home staff to offer this guidance, training and support. People remained under the care of their named GP and the service worked closely with them, district nurses and other community services to support the person to remain in their own home or care home.

As a result of feedback from people who used the service, a triage nurse had been appointed as the main point of entry for people needing the service. This enabled the service to centrally prioritise and manage referrals more quickly, to ensure that contact was made by the appropriate team of nurses. A review of the role demonstrated that there had been a 75% reduction in the number of referrals declined, indicating that the service was supporting a growing diverse range of people. There was a 24 hour, seven days per week telephone advice service managed by the in-patient unit nursing team. There was a clear protocol in place whereby issues could be escalated to the clinical nurse specialist, doctor or consultant. This gave people the assurance that they or their family members could seek medical support or advice at any time and enabled people to remain at home, according to their wishes.

People had a nutritional assessment when they were first known to the service and care plans included nutritional and hydration needs. People in the in-patient unit were offered hourly comfort checks, which involved offering drinks and mouth care. People in the community with more complex nutritional needs were referred to a nutritionalist or speech and language therapist who advised on the consistency of a person's diet and fluids, to aid swallowing. Therefore, people had access to the specialist support they required to ensure they had adequate nutrition.

People's needs and choices were taken into consideration when providing them with meals. A patient on the ward said, "I only ate breakfast and a meal at lunchtime when I was at home. Here they give me what I had at home". Another person told us, "They came and asked me what I would like and gave me a choice. I am going home with a piece of cake today!" All food was planned and prepared by the in-house catering team. They offered people two choices each day, but were flexible and could offer alternatives. One person told us, "I did not like anything on the menu the other day. I asked for a salad and tuna and they gave it to me". A catering assistant explained that one person on the ward did not know what they wanted to eat that day. They were going back later to see if they could tempt them to eat something such as pineapple or something refreshing. Catering staff understood the importance of presenting food that was appetising and appropriate, such as small portions or pureed food that looked appealing.

People in the day hospice were provided with a lunchtime meal which they ate in the dining room. This meal was a focal point for people to come together and socialise and was made a special occasion. "They bring around the drinks trolley before lunch and I have a glass of wine", one person told us". People were complimentary about the food. One person told us, "I can no longer cook a lot of home so it is great to have a meal here. The food is great here". A Sunday roast was always provided at the weekend and was available to people and their family members so people could eat and spend time together as they would as if they were at home. There was a microwave for families to use, should they wish to bring in food for people which they had prepared.

New staff received a comprehensive staff induction programme which had been developed by the service according to staff's individual role. One staff member told us, "This was the best induction I had ever had. There was a clear plan for me in place and I was made to feel very welcomed by a brilliant team of staff". All roles included shadowing an experienced member of staff and undertaking training that was essential for their role such as safeguarding, infection control, health and safety. There was a specific programme for volunteers which included the impact of illness and loss, customer care and confidentiality. Health care assistants completed a work book which covered all key areas such as communication and symptom management and to ensure they understood the principles and how to put them into practice. Nurses were trained and their competence assessed in basic life support and venepuncture (obtaining blood).

The service had invested in 'train the trainer' to enable their own staff to be qualified to train staff in a number of areas. There was an on-going, classroom based programme of training for staff which helped embed their knowledge through the use of scenarios. This was monitored to ensure that staff kept up to date with the skills and knowledge they required. All staff had received training in palliative/end of life care and the majority in bereavement, pain management and positive behavioural support (PBS) PBS is used to support people who present behaviours that may challenge in the most appropriate way. Planning was in place to make sure that nurses were able to revalidate their registration with the Nursing and Midwifery Council. This process ensures that registered nurses can demonstrate that they can practice safely and effectively. Staff described the staff training programme as 'excellent' and said they were supported to attend study days internally and externally such as advanced counselling and advanced communication. A number of staff had been supported to achieve level 3 Health and Social Care Award with a speciality in long-term conditions. This is a nationally recognised qualification which is work based and achieved through assessment and training in which the participant must prove they have the ability to carry out their role to the required standard.

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 the best interests and as least restrictive as possible. All staff had received training in the MCA and staff at all levels had a sound knowledge of their roles and responsibilities in relation to this legislation. Staff understood that when people had the capacity to consent, they had the freedom to make their own decisions and that a person's capacity to consent could change. They also knew that if a person had been assessed as lacking capacity to make a specific decision, a meeting was held with their next of kin or representative, relevant staff and professionals, to make a decision on their behalf and in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The service had made an application to the 'supervisory body' that checked to ensure that the service was acting lawfully in making a restriction on them.

Some people's care records contained 'do not attempt resuscitation' (DNAR) forms. This is a medical order written by a doctor, which instructs health care staff not to resuscitate the person if they stop breathing or their heart stops breathing. The doctor took time with people to explain their condition and answer any questions they may have, to ensure that people and their families made an informed decision.

Outstanding ☆

Is the service caring?

Our findings

Everyone told us that staff were outstandingly kind, caring and compassionate in the support they provided. Comments included, "They treat you as an individual. They could not do a better job"; "It is a wonderful place"; "It is such a wonderful atmosphere here"; and "Nothing is ever too much trouble. They take heed of my choices". We received a compliment about the service which focused on the 'outstanding' level of care provided, "The overwhelming and devoted care that the nurses and staff at the service is outstanding and have given me hope and a memory full of so much love. This service on the face of what I have witnessed is an outstanding service and a model of what outstanding service is and should be".

The service had received a large number of compliments. The themes of these compliments included the service meeting its vision of providing compassionate and professional care; and the holistic approach to supporting the 'whole family' before, during and after a death, which gave many families the strength to continue. Compliments included, "I was blown away by the caring and compassionate attitude and outstanding communication skills of all staff; "Each one of the team demonstrates outstanding empathy, kindness and care"; and "You made such a difference every time you came to see him. It's such a wonderful thing you did to make dad feel better in himself after your little chats, when there was no hope of him getting better".

People had also complimented that the service had supported them with their wishes. Comments included, "He deserved to have his wishes carried out and you all made that possible for him with the endless care, dignity and compassion you gave"; and "He got his last wish to be at home with no extra help, just us!" Staff had gone the 'extra mile' to ensure that people's wishes were realised. One person had wanted to visit a monkey sanctuary, but was too ill to do so. A doctor put out a request on the local radio and the owner of a registered animal sanctuary brought in one of their monkeys and they had their picture taken with the animal. Another person wanted to go to the seaside which was arranged for them, so they could see the sea. A person on the in-patient ward had a favourite science fiction film and staff were arranging to get them cardboard cut-outs or posters of the main characters, which represented an enjoyable experience for them, at the end of their life.

Staff understood the importance of ensuring the well-being of the person as well as their family members. Bereavement support was available for people before and after bereavement. People were offered a range of bereavement support including up to 12 weeks of support by a counselling team of staff and volunteers. Families were invited back to the service following the death of their loved one to a 'bereavement tea', to talk about their experiences. A bereavement group had also been set up, led by a member of staff, where people could explore their feelings in an informal setting and gain support from others with similar experiences.

Family members were offered support in a variety of ways. A family support worker provided support, advice and emotional support on a one to one basis for people on the in-patient unit, their carers and their family members. For people who lived in the community, a befriender scheme was available. This was staffed by volunteers and gave people and/or their carer a friendly face to talk with and could also give carers a short break. Carer's courses were run in partnership with Carers First, on a regular basis which included how to move and handle people safely and to look after themselves. The 'Carers cuppa', was an informal support group for carers, and had been developed from feedback from carers. The service had been further extended, as the result of feedback from carers, to provide regular evening events so that working carers could also attend.

The service had received a number of compliments about the support and advice people had received. Comments included, "The team were extremely helpful to me when Dad was at home, providing me with support and advice"; "We have enjoyed the carer's course very much. We don't know what the future holds for mum, or us, but it doesn't seem quite so scary now knowing a little more about what is out there for us all. "I came along to the carer's course last year and started to come to the carer's cuppa group. We are made to feel so welcome and secure. I have made so many friends and we share our problems and experiences with each other. They have helped me to cope with some of the most difficult times of my life. It has made me become a person in my own right again".

A chaplain was based at the service four days a week and supported by a a team of volunteers. Their aim was to make connections with people of any faith or no faith, to offer a listening ear and give spiritual support. They also gave advice to people about making a will and funeral arrangements. This practical advice to people of faith or no faith was always offered to people in the day service, at a time when they were able to make their own decisions and the topics were introduced in a sensitive manner. If people using the day hospice, also became an in-patient, this trusted relationship was already established and these conversations could be developed further if necessary. The chaplain demonstrated they were passionate and dedicated to their role and they conversed with people in a relaxed and engaging manner. The chaplain had contacts with spiritual leaders of other faiths represented by the local community, who they could call on when needed. As they took the time to get to know people well, they had often been called upon to direct peoples funerals and on occasions to officiate at weddings. This meant that people and their family members received consistent support from a person whom they trusted and knew well.

When people died their body was cared for in a respectful and dignified manner. The service had its own mortuary and private area, so family members could spend time with their loved one after they had died, if they so wished. People found it comforting to know that they could continue to spend time at the service with their loved one after they had died as they were familiar with the environment and staff team.

The service had a chapel where people could go for quiet, peaceful contemplation and reflection. It was available for people with any or no spiritual belief and people were able to light a candle for prayer or remembrance. A 'Memory Tree' was on display in the main area, where people could purchase a small plaque with their loved ones name. There was also an on-line memory book, where people could write the story of their loved ones and add pictures as a way of remembering them. To help people through the grieving process the chaplain arranged a number of memorial services throughout the year. They were arranging a memorial service for 55 people at the weekend. Special services called 'Lights of love' were held near Christmas. There were two services in Gravesend, at the hospice and a church and one at the children's centre in Dartford. This ensured that people could remember and celebrate the lives of loved ones, who are no longer with them.

People's needs in respect of their age and disability were understood by staff and met in a caring way. The provider also manages a service for babies and children with life-limiting illnesses and could access their resources. If children were affected by their parents or grandparents diagnosis and symptoms on their lives, specialist therapists were available. For children who displayed anxieties and distress over the well-being of their adult carer, a play therapist could support them to explore their painful feelings and distressing experiences that they may not be able to say with words. For children with communication difficulties, a music therapist could support them to lower their anxiety and increase their self-esteem. Young people could access the in-patient unit to receive respite care, in a way that met their individual needs and wishes. The in-patient ward offered a number of single rooms and two friends had received respite care at the same time with the theme of a sleep-over, with DVD's. Therefore, the young people were able to undertake an activity which was desirable for people in their age group. They were supported by nurses from the children's team who knew how to care for them in a way that respected their privacy, dignity and specific needs as teenagers.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. They were fully involved in planning their care which included symptom and pain management and end of life care. Discussion with people about their views, wishes and preferences with regards to their care and support, were initiated as soon as the person was known to the service. These 'advanced care plans' gave people the opportunity to let their family, carers and professionals know what was important to them in the future, when they may be unable to make their views know. This included people's preferred place of death, spiritual and family support and decisions about which treatments they would prefer or decline. Staff demonstrated they were clear about any arrangements and decisions people had made before and after death that must be observed.

Ensuring that staff supported people in a caring and compassionate manner was embedded in the service. The values of consideration and compassion were demonstrated by housekeeping and kitchen staff, showing that they were part of the culture of the service. There was a relaxed, homely and calm feeling throughout the service and people were encouraged to chat and they were listened to. Staff were positive and cheerful in their engagement with people and communicated with people in an individual and responsive manner. Staff showed genuine interest in people, valued people's experiences and were passionate about their roles. They explained their enjoyment in not being rushed in their roles, but having the time to care for people and their families and to give them the best care that they deserved. For example, they said that it could take two hours to support someone with a bath, and this was regarded by the staff team as an important and valuable experience. They explained that some people, due to their health and/or disability had not been able to have a bath for many months before coming to the in-patient unit. People opened up and talked to them during this relaxing and pleasurable experience. This was possible because staff displayed a caring manner and genuine interest in listening to people. The two bathrooms on the unit had been furnished in luxurious style with mirrors, wallpaper and a Jacuzzi bath. They looked inviting to use and there was plenty of room to assist people who had limited mobility.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. This was available on the service's website and given to people when they were first known to the service. This included information about the hospice, day hospice, therapies, advanced care planning, carers courses, and patient and family support. The dates of all upcoming events, such as carer's cuppa and carers courses were displayed at the service and on the website, so they were accessible to people who used and did not currently use the service.

The in-patient unit was divided into two sections. One section had a five single, en-suite rooms which enable people to be private at all times. The other section had two bays where people had privacy curtains around their bed to give them privacy when being assisted with personal care. All bathrooms and toilets had privacy curtains and signage on the doors to indicate when rooms were in use. People's relatives and visitors were able to visit at any time and this included overnight stays. There was a separate accommodation suite for family members to stay overnight, which had been furnished to a high standard and included use of an en-suite bathroom and kitchenette. Family members were also able to purchase breakfast and an evening meal from the kitchen staff, if they wished. Therefore, people could be continually supported by people who were important to them.

Outstanding ☆

Is the service responsive?

Our findings

People and their relatives said that the service responded to their needs in all aspects of their care and treatment. A person on the in-patient unit told us, "I have had a year of turmoil, but it is absolutely fantastic here. The staff are available whenever I need them and they answer the call bell immediately". People who attended the day service were extremely complimentary about how the service met their health and social needs. One person told us "I was waiting a long time for a breathlessness appointment, but I got to join in straight away here". Another person told us, "I get a chance to get away from home. I sit and talk to other people and the volunteers and nurses come and talk to me. I could not do without it". Feedback from a commissioner of the service was extremely positive. "I find them one of our most enthusiastic, compassionate and productive providers. We have a brilliant working relationship and I find them extremely responsive, not just with regards to patient care but responsive to our needs as a Clinical Commissioning Group".

The aim of the day service was to improve the quality of life for people in a supportive environment. Everyone told us how important the service was enabling them to meet other people in a similar situation and spend time talking to them. This companionship also reduced the risk of people becoming isolated and lonely. People sat in groups according to their friendships. People said the nurses knew them well, understood their individual health and emotional needs and that the volunteers were always friendly and cheerful. Comments included, "I met this lady next to me here and we have become best friends. We see each other outside the day hospice"; "I talk to other people who are like me. I especially like to chat"; and "I chatted to this person, then that person and then other people at lunchtime. I like a good chat and I get it here".

Day patients also had the opportunity to take part in health and social activities and therapies. The gym gave people the opportunity to have some control over their lives. Breathing exercises were provided by the physiotherapist to help people on a day to day practical basis with their condition. "I go to the exercise and breathless classes and they are helpful", one person told me. Another person said, "The exercises are great. They make me feel better and I can do them at home". Social activities were provided by volunteers and included painting and quizzes. On one day of our visit a 'Pet as therapy dog' visited and another day music was provided by a volunteer playing the organ. Therapies such as aromatherapy and relaxation were available, but not as frequent as the service intended and they were in the process of recruiting additional volunteer therapists.

The service could monitor the health care needs of all day patients as each contact they had with a nurse in the community was added to their record which was held on computer and available to professionals involved in their care. The service responded quickly to one day patients' needs during our visit. A nurse assessed that a person with diabetes was unwell. They carried out appropriate health checks and contacted the doctor. The doctor prescribed the person the emergency medicines that they needed. This medicine was added to a medicines chart and was available in future should it be required. This ensured the person received the health care they needed, in a timely manner.

People could be referred to the in-patient unit by their doctor or the local hospital, but people were also able to self-refer. The service had a consultant who provided cover at the local hospital and therefore many people who moved to the in-patient unit were already known to the service. On admission to the service people were seen by the doctor and an assessment was made of their medical and treatment needs. A meeting was held each day with a multi-professional team to discuss referrals to the in-patient unit. A comprehensive discussion took place regarding the specific needs of each individual and how they could be best met. The meeting included the triage nurse, who was the first point of contact for all referrals. The service aimed to respond to any urgent referrals within 48 hours. However, quality audit showed the majority of people were admitted within 24 hours of a referral.

A crisis support service was available where family members of carers who required additional support to avoid a breakdown, which could lead to a hospital admission for the person. The service had received a compliment about crisis support offered. "You were at the end of the phone and I could call you at any time. The Ellenor Crisis Support was very good. The care he received was excellent".

The service was actively involved in building links with the community which had a positive impact on people's quality of life. Joint working had taken place with the ambulance service. People who used the service had a fridge magnet which said that the person was known to the service. This meant that if an ambulance was called to the person, the crew contacted the service to assess and discuss the best course of action, according to the person's wishes. This could result in a nurse being sent to the person's home, to accompany them to the hospice, and hence avoid any unnecessary hospital admission, prior to their admission to the service. The head of well-being had visited two hospices as part of their induction to share best practice. It was 'Dying matters week' at the time we visited the service. This is an initiative to raise the awareness of the importance of talking about dying, death and bereavement. The service had supported this event and nurses and health care assistants went into the community to local places, such as supermarkets, to talk about the work that they did. There was information about the awareness raising in the service and the poem called, "Waterbugs and Dragonflies" was posted in the information area, which explains death, to young children in the form of a story. This benefitted people using the service by helping the public to feel more confident in talking about death and dying, which may include people's family and friends.

The service had identified that it was not equally used by different groups form the local community. A lead nurse had visited people from the Sikh community and was developing links and relationships to discuss what services people needed and how best these could be provided. There were plans to contact other minority groups in the area. The service had received a compliment about how they met people's cultural needs, "Your staff took the time to learn about our cultural needs and to provide my aunt with the care that she wanted".

People's care and support was planned in partnership with them and their relatives. They were asked about their needs and preferences. These were recorded in their plans of care, and monitored on a daily basis. One person complimented the service on understanding their relatives "individual idiosyncrasies". There was good communication between nursing staff and members of the multi-disciplinary team. A handover took place when there was a change of staff to review the person's health and care needs and pass this information onto the next staff team. Staff talked knowledgeably about people's care and how to provide support for their physical, mental, emotional and spiritual needs. People near the end of their life had a 'Comfort plan' which contained relevant information about people's wishes and preferences. This ensured that people were supported at the end of their life by staff who understood how to support the person to have a comfortable, dignified and pain-free death.

The service had representatives from fundraising based in the in-patient unit. Its aim was to raise funds to ensure the service was able to operate as only 20-25% of the service was funded by the National Health Service. This was achieved through a chain of charity shops and a number of fundraising events throughout the year. This included 'Twilight walks' and 'Secret Gardens, where supporters shared their gardens with friends while raising money for the service. This fundraising helped to provide the money necessary to provide people with the care they needed.

Most people said they did not have any concerns or complaints, but would be able to approach a member of staff if they did. One person told us, "I have no complaints, but if I talked to anyone they would listen". People who had made a complaint said that their views had been listened and acted on. "I complain about the food when I do not like it and they go and give me something else", one person told us, "But I also let them know when I think that it is lovely".

When people were first known to the service they were given an information pack which included information about how to make a comment, compliment or complaint about the service. These leaflets were available around the service. Families were invited back to the service following the death of their loved one and encouraged to share their experience of the care received. Staff knew what they should do if a complaint was raised. Complaints were investigated and the complainant responded to in writing. The service used complaints as a learning experience. For example, a specific complaint was used at an in-patient training day, to discuss what could have been done differently.

Requires Improvement ●

Is the service well-led?

Our findings

People and their relatives were very complimentary about the way the service was managed and their day to day experience of staff and management. "I have been badly treated at hospital, but I cannot fault this service"; another person told us, "There is nothing that needs changing". A commissioner of the service responded that the service was well-led.

Records relating to people's care and treatment, employment records and those relating to the management of the service, such as policies and procedures, were kept securely, accessible by the relevant people and fit for purpose. The exception to this was for people on the in-patient unit. As mentioned previously in the report, there were not clear records in relation to the application of pain patches and topical creams. There was also some inconsistency in the recording between some of these people's computer and paper records. One person had three pressure sores on their skin which had been assessed as requiring treatment and evaluation. Interventions were recorded on the computer system on 7, 8 and 9 May for one of the three wounds but there were no corresponding entries on the paper record. On the 10 May there were two nursing interventions recorded on the paper entry, but none on the computer record. On 11 May the details of the entry on the paper record was different from that on the computer record. In the description of how severe the pressure areas were, there were no entries for two of the wounds. Therefore, records were not accurate in relation to people's daily care interventions.

The inconsistency in maintaining an accurate record in respect to each person's health needs was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The management team consisted of the registered manager and the director of patient care who were led by the chief executive officer. All had a visible presence in the service. Staff were highly complementary about the support they received from the management team. They said there had been a major cultural shift in the service, driven by the new chief executive officer and their supportive management team. They were proud to work for the service. They described the management team as proactive, anticipating problems before they had a significant impact on people, and that new ideas and ways of working had been initiated to improve the service. As a result, the service was better organised and a safer place for them to work and staff had a clearer understanding of their roles and responsibilities.

The chief executive office led by example and was a strong role model. They had taken time to get to know all the roles performed at the hospice, and how important they were in ensuring the delivery of care. For example, they had spent time with the maintenance man and as a volunteer in the day centre supporting people with food and drinks. The registered manager and director of patient care also led by example, both assuming the role of a nurse, supporting people in the in-patient unit. Therefore, the service was led by a team of people who demonstrated the values of the service of professionalism, working as a team and providing compassionate care.

There was an open culture were staff were listened to and valued. Staff meetings and team away days were held to engage staff in the development of the service. Staff said they could make suggestions at staff meetings and they were listened to. Staff had been asked their views about the service using the 'bird song' survey, which was a national staff satisfaction survey, benchmarked by hospice UK. However, the staff team did not feel this survey enabled them to put their views across. The management team therefore created an opportunity for staff to share their views in an open forum. Some staff were satisfied with their role as they had a chance to do things to help other people and make the use of their abilities, but other staff experienced low morale, were concerned about high staff turnover and did not think there were any chances of advancement in their role. The management team responded to these concerns and had started to address them. For example, a number of recruitment days had been held for potential staff to spend a morning at the hospice to see if it was a place where they wanted to work. A clear career path had recently been developed by the registered manager so staff knew how they could progress within the service.

The service encouraged open communication with people and their family members. Families were invited back to the service following the death of their loved one and encouraged to share their experience of the care received. In a survey of the in-patient unit everyone said they would recommend the service to other people that admission process was smooth and well organised and their reason for admission was explained. Surveys had also been carried out of the patient and family support services, the carer's course, maintenance, kitchen and housekeeping. The majority of feedback was positive. For example, in the housekeeping survey everyone agreed about the high quality of cleanliness within the service. Therefore, regular feedback was sought on all aspects of care to ensure it met the required standards.

There was a structured approach to monitoring the quality of service delivery. A comprehensive audit plan was in place which included medicines, safeguarding, staff training, complaints and infection control. The commissioner of the service reported that there had been quality improvements in the areas of infection prevention and control. A governance framework was in place whereby each aspect of the service, such as health and safety, clinical practice and medicines were the discussed in sub groups and their findings were fed to the Board of trustees. The board meet on quarterly basis to set and review the strategic direction of the service. The service had a strategy in place which covered the timescale from 2013 to 2018, which set out what action it intended to take to develop the service further. The majority of these improvements had been completed such as offering crisis support, support for care homes, which was set up through joint working with the Clinical Commission Group, and supporting carers. The quality account for the service was published on the website and clearly outlined the quality of the service and the plans in place to develop the service further. Proposed developments included a one point of referral, achieved by the appointment of a triage nurse; and a rebranding of Ellenor to join together the children's and adult services to minimise confusion for the public and be clearer about the geographical areas that they cover. The reasons for these changes were due to recognition by the service that they did not care for as many of the local population at the end of life as they could and from feedback from the public and other stakeholders. Therefore, there were processes for an on-going assessment and improvement of the service at all times.

The service kept up to date with best practice and was informed about different models of care and ideas for improvement. There was an education centre which was responsible for education, audit and research. The service delivered accredited/nationally recognised qualifications in palliative care. One course was for 16-19 year olds who were interested in a career in health or social care. Students undertook a week's programme which involved them taking part in projects which benefitted people who used the service. During the last course students had organised a reminiscence group and a 'smoothie' workshop where day patients and the students interacted and engaged with one another. Another course was a level 3 Health and Social Care Award in awareness of end of life care with dementia, which was aimed at health care assistants, support workers, nurses and carers. Staff were encouraged to take part in research and this had included the areas of predicting prognosis and the frequency of oral symptoms in people with cancer. This meant that the service used its knowledge and skills in palliative care to inform others and to improve care for people who had palliative care needs. The work on palliative prognosis indicators was presented at the European

Association of Palliative Care Conference by the consultant involved.

Representatives attended 'Gold Standard Framework Meetings for Palliative Care'. In 2015, as part of the South London Hospices Collaboration they presented three posters to the National Association of Palliative Care Educators and two posters to the Hospice UK conference. This was on the work of the collaboration, the volunteer induction programme and Level 5 assistant practitioner training. In 2015 the service had received the Kent Charity Award, Gravesham Community Award, Volunteers 'Best Group' Award and the former chief executive won the Hospice UK Lifetime achievement Award. This helped to ensure that people received support from a service that continuously learnt through experience and research, the most effective ways of meeting their palliative care needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Guidance was not in place for the use of some medicines and creams and waste medicines were not disposed of in a timely manner. Regulation 12 (g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate records were not always kept with respect to each person's individual care. Regulation 17 (2) (c)