Woking Hospice

# Woking Hospice

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This inspection was carried out on 3 and 4 May 2016 by two inspectors, a specialist nurse adviser and a pharmacist inspector. It was an unannounced inspection.

Woking Hospice is a charitable organisation owned by Woking Hospice Trust. It is registered for provision of palliative care to adults over 18 years of age. It offers 10 in-patient beds and a further fifteen day care places. There is a Hospice Care at Home service which provides treatment, care and support for up to 300 people at any one time. The hospice adjoins a local NHS community hospital.

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 also managed the community services, the day hospice service on site and the sister hospice Sam Beare Hospice.

People were kept safe by staff who were trained in the safeguarding of adults and health and safety. They were able to fully describe their responsibilities with regard to keeping people in their care safe from all forms of abuse and harm. It was apparent from discussion with members of the management team that all health and safety issues were taken seriously to ensure people, staff and visitors to the service were kept as safe as possible. There were enough staff on duty to ensure people received safe care. People were given their medicines in the right amounts at the right times by properly trained staff. The recruitment process was robust and the service was as sure as possible that staff employed were suitable and safe to work with people who were cared for in the service.

People's human and civil rights were upheld. The service had taken all necessary action to ensure they were working in a way which recognised and maintained people's rights. The staff team understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager and their predecessor had made the appropriate DoLS referrals to the Local Authority. Clear information about the service, the facilities, and how to complain was provided to people and their relatives. 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.

People's health and well-being needs were met. Staff had built strong relationships with people and they were knowledgeable and knew how to meet people's needs. The service respected people's views and encouraged them to make decisions and choices. Food was nutritious and of good quality. Staff were appropriately trained to meet the needs of people in their care. Staff knew each person well and understood

how people may feel when they were unwell or approaching the end of their life. Overall, the service was responsive to people's needs and was proactive when people's needs changed.

People's feedback was actively sought, encouraged and acted on. People and their relatives were overwhelmingly positive about the service they received. They told us they were satisfied with the staff approach and how the care and treatment was delivered. The staff approach was kind, compassionate and pro-active.

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

The service was well managed. Meeting people's needs was the priority for staff and the registered manager. The management team including members of the board were described by staff as supportive. Emphasis was placed on continuous improvement of the service. Comprehensive audits were carried on all aspects of the service to ensure that policies and procedures were being adhered to. When areas for improvement were identified, action was taken to ensure the quality of the service and care. The service worked effectively in partnership with other organisations.

No concerns were found at our last inspection in December 2013.

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

We always ask the following five questions of services.

### Is the service safe?

Good

The service is safe.

Medicines were given to people correctly by appropriately trained staff.

Staff were properly trained and knew how to protect people from abuse or harm. People felt they were safe being cared for in the service.

Any health and safety or individual risks were identified and action was taken to keep people as safe as possible. The registered manager made sure the staff team learned from any accidents or incidents.

Robust and safe recruitment procedures were followed in practice.

The environment was secure and well maintained.

### Is the service effective?

Good

The service is effective.

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

Staff understood how to uphold people's human and civil rights and took appropriate action if people did not have capacity to make decisions. People were encouraged to make as many decisions and choices as they could.

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?

Good

The service is caring.

People's feedback about staff and the service was positive.

Staff treated people with respect, kindness and dignity at all times.

Staff interacted with people positively, with patience, understanding and respect.

The service and the staff were very flexible and responded quickly to people's complex and changing needs or preferences.

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

## Is the service responsive?

Good

The service is responsive.

People described the service as excellent.

People told us staff were excellent and highly skilled. Staff fully understood and anticipated people's needs which enhanced the quality of their experience.

The service provided person-centred care which was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them.

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.

## Is the service well-led?

Good

The service is well-led.

There was an open and positive culture that placed people and staff at the centre of the service.

The provider, registered manager and staff followed principles based on person-centred care which resulted in an approach which supported working in partnership with people.

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

The service worked in partnership with other organisations to

ensure they kept up to date and provided a high quality service.

# Woking Hospice

**Detailed findings**

## Background to this inspection

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

This inspection was carried out on 3 and 4 May 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor and a pharmacist inspector.

The registered manager had completed a Provider Information Return prior to the visit. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at the premises. We reviewed five sets of records that related to people's care and examined four people's medicines charts. We examined 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 staff handover meeting and the arrangements for storage and the administration of medicines.

We spoke with three people who were in the inpatients unit and three of their relatives. We received telephone feedback from another relative following our visit. In total we spoke with seventeen members of staff. These included medical, nursing, and care staff, a physiotherapist and a counsellor. We also spoke with three members of the community team, the Practice Development Nurse, kitchen staff and some administrative staff. In addition, we spoke with four volunteers.

We spoke with the registered manager and the ward manager at length and spent some time talking with the medical director. We contacted twenty four professionals and organisations such as GP practices who had previous and current contact with the service and received four responses. CQC sent questionnaires to a

range of individuals including people who use the service and their relatives. We received nineteen responses from people and five from their relatives. In addition, there were twelve completed questionnaires received from staff and four from community professionals. A selection of these responses has been incorporated into the body of the report.

Good

# Is the service safe?

## Our findings

People told us that they felt safe in the hospice. One person said, "I feel safe with the staff at the hospice." Another person told us, "I'm 100% safe. I receive medicines on time. They never forget those." In discussion with a nurse they told us "We always make sure that patients are safe." A visiting professional told us they had "Not seen anything that I do not feel comfortable with."

People were protected from any form of abuse or breaches of their human rights by staff who were fully aware of and able to clearly explain their responsibilities with regard to keeping people safe. All clinical and care staff had received safeguarding training so they could recognise any signs of abuse and take effective actions. They were able to tell us what they would do if they had any safeguarding concerns. This included reporting issues to the appropriate authorities outside of the organisation, if necessary. One staff member told us, "I would report my concerns to my manager. If they would not act on it I would go somewhere higher, for example to the CQC. I would document everything I have seen or witnessed." Another staff member provided an example of what they had done when they suspected that abuse was occurring between a family member and a patient of the service. The service had a whistleblowing policy that staff were aware of. Staff were confident that the ward manager and registered manager would take any necessary action to protect people. One member of staff stated there was a clear policy but had never had to use it. She described the service's philosophy as when, "..seeing something that you know is not right, and knowing you can report it to someone."

People's care records demonstrated the provider had assessed the risks relating to people's care and treatment. For example, a record we looked at in the inpatient unit showed skin, pain and nutritional assessments had been carried out and were accompanied by appropriate plans and guidance for staff. Staff told us that they had good communication methods to share information in relation to people's risks through handover meetings and feedback from people's daily reviews. We saw an entry in a set of medical notes that the patient had been transferred to the hospital appropriately for surgical assessment. Risk assessments were required to be formally reviewed and updated every week but we found that not all risk assessments were reviewed at this required frequency in those care plans we saw.

People, staff and visitors were protected from harm by health and safety systems. Regular environmental and health and safety checks were carried out to ensure that the environment was safe and that equipment was fit for use. There were checks to ensure that equipment was in good working order such as hoists, medical vacuum system, suction units and fire equipment. All electrical portable appliances were tested on 15/01/2016. Environmental risk assessments were also in place to minimise the risks of people living and working at the hospice from hazards such as slips, trips and falls, use of chemicals, use of medical equipment and the disposal of waste materials. We saw documentary evidence of reviews dated February 2016 which included a range of actions where required. Risk assessments identified any actions needed, and highlighted the action that needed to be taken to minimise the risks that were presented. Up-to-date maintenance certificates such as gas safety, electrical installations and portable electrical appliance testing were not seen on the day of the inspection but were sent by the provider following the visit.

Escape routes, fire warning systems, emergency lights and fire fighting equipment were checked on a daily basis. Records indicated that fire fighting equipment and emergency lighting had been regularly tested under a service level agreement between the hospice and the health trust. In addition, weekly testing of the audible alarm was undertaken using a programme of activating the call bells on rotation. There was a fire risk assessment in place for the building. We were told about a walk through fire drill that had been undertaken recently following a thorough review which resulted in updating of the fire procedure. There were plans to hold fire drills at least twice per year. The service had emergency plans and checklists in place to assist staff to deal with any unforeseen emergencies.

There were suitable measures in place to lessen the risks of infection and ensure the hospice was clean. The ward manager advised the organisation had a service level agreement (SLA) with the local NHS Trust. She said the SLA covers advice on breakouts, teaching, help with policy development/review, audits and microbiology advice. The premises were clean and in good order, and the bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices. One patient told us, "They are cleaning the bathroom twice a day and it is unbelievable".

There were clearly labelled clinical waste bins, liquid soap, disposable hand towels and foot operated rubbish bins in the relevant areas. There was hand gel at various points in the building for people to use to help protect people from infection. A comprehensive infection control policy was in place and this included schedules for cleaning. These had been agreed with the housekeeping staff so they understood what was expected of them. The schedules were sufficiently detailed to include frequency of cleaning and cleaning products to be used. We checked the cleaning records which confirmed that the equipment in the hospital was cleaned on a regular basis and at the required frequency. Infection control audit feedback identified any actions needed and highlighted the action that needed to be taken to minimise the risks that were presented. For example, the last audit recommended that opened cereal packets needed to be stored in pest proof containers. This had been addressed. We saw that the five star food safety rating was displayed at the kitchen door.

The provider ensured they 'learned' lessons from any accidents and incidents that occurred. Accident and incident reports were electronically recorded and reviewed monthly at the Clinical Health and Safety meeting. These were not closed until all necessary identified actions had been completed. We saw that all accidents or incidents described what action was taken and any further action or learning needed. Records that were kept and monitored included, number of falls and pressure ulcers whether acquired or inherited and were monitored for trends and trigger factors. If necessary, individual care plans were reviewed and amended. Body maps and post falls monitoring forms were in place to assist staff to identify any on going issues for people. Action taken by the provider to reduce the likelihood of falls included the use of high-low beds.

Appropriate arrangements were in place for ordering and receiving medicines. On admission, people's own medicines were initially used. A local hospital supplied other medicines and there was a clinical pharmacy service to the hospice. Medicines were stored securely in either a locked room or secured medicines trolley, and access to medicines was restricted appropriately. However, the area used to store fluids for injection was not always locked and could be accessed by unauthorised people; the registered manager agreed to address this promptly. Staff told us about the process for ensuring medicines were not used past their expiry date, however, there were no records to show that this had been completed. The ward manager undertook to implement such a record without delay. Medicines requiring refrigeration were stored in a locked fridge, and temperatures were monitored and recorded daily to ensure these medicines were stored within the recommended temperature ranges to maintain their effectiveness.

Suitable arrangements were in place for the ordering, storage, recording and destruction of Controlled Drugs (CDs). Staff conducted regular balance checks to make sure these medicines were looked after safely. Unwanted medicines were stored securely and disposed of appropriately.

Prescribing was undertaken by in-house doctors along with an in-house consultant. On admission, people were prescribed a range of medicines to ensure they had access to appropriate medicines whenever they were needed. A clinical pharmacist visited the hospice once a week. The pharmacist recorded their interventions on the prescription charts to help staff give people their medicines safely. We saw that people's medicines had been reconciled by the pharmacist; this involved reviewing and confirming the prescriptions for people on first admission to the hospice, to reduce the risk from discrepancies in medicines prescribed.

We checked prescription and administration charts for four people, which were completed appropriately. We saw that medicines were given at the appropriate time, and people had access to 'when required' medicines. However, specific information to guide staff was not available to support staff with the safe administration of some 'when required' medicines for individual people. This increased the risk that people would not receive these medicines in a safe and consistent way. The ward manager told us that the medicine charts were currently under review and 'when required' medicines would be addressed as part of this.

Qualified nurses were responsible for looking after and giving people their medicines. Appropriately trained healthcare assistants supported the nurses with the administration of some medicines. Staff had good access to up to date medicines reference sources to answer queries. Medicines incidents were recorded and analysed within the service. We saw evidence of a robust process to report, investigate, review and learn from incidents. Staff described a positive reporting culture. This enabled staff to learn from events and change practice to reduce the likelihood of a similar event occurring again.

Staff were suitable and safe to work with people because the service had a robust recruitment procedure. These procedures included requesting and validating references, criminal records checks, ensuring candidates had permission to work visas and checks on people's identity. Application forms were completed and now included a full past employment history. Revised forms had been implemented during 2015 to ensure that full employment histories were obtained for all new starters. An explanation for any 'gaps' in employment history was now fully noted on the file. The recruitment of volunteers was undertaken separately and included a comprehensive interview process and criminal record checks. The provider had a robust disciplinary policy. Records showed the service had dealt appropriately with personnel matters according to the provider's policies using a wide range of disciplinary actions.

People's care was delivered safely by a suitable number of staff. Staff working on the ward, in the day hospice and in the community told us that there were enough staff to enable them to carry out their roles fully. People told us there were always staff available to help them if they needed assistance. One staff member told us, "That's one of the joys here, the staffing levels are so good. We are able to provide relatives and patients with one to one care. We are able to sit and to talk to them". In the case of shortages staff worked additional hours or bank staff were deployed who were familiar with the service. Less frequently agency staff were deployed but wherever possible only individuals familiar with the service were used. Nursing staffing levels were described by the ward manager as "much improved". She explained that staffing numbers had been difficult over the past 24 months, but they were now down by just two registered nurses. The unit had physical capacity for ten patients, but current capacity due to reduced medical staffing levels indicated a maximum of seven patients. The medical director explained that medical staff availability was improving again with a doctor returning to work this week. An advert was also placed for a palliative

medicine speciality doctor. We were told that on going recruitment for all grades of staff was in place.

We saw that people's needs were attended to promptly. They said that call bells were answered very quickly. One patient told us, "You've got a buzzer and they are here in second", another said, "Doctors and staff are always somewhere around". There was a minimum of two nursing staff and four health care assistants during the day. Two nursing staff and one health care assistant were available during the night. These levels were reviewed on a daily basis according to the needs of the people being cared for. The service used a recognised assessment tool to determine dependency levels and the numbers of staff required. This was used at six monthly intervals. The ward manager explained how the numbers of patients admitted each day takes consideration of safe staffing levels, i.e. there is not pressure to admit if staffing levels are compromised. The staff team were supported by a range of ancillary staff, senior managers and the registered manager. Rotas for the previous month showed that the staffing levels did not drop below those stated as minimum. The service used a large number of volunteers to carry out different aspects of work such as reception duties, gardening, working at the front desk and fund-raising.

Good

# Is the service effective?

## Our findings

People told us they received excellent care from skilled staff. One person said, "Staff have skills and knowledge. Even cleaning staff do everything so thoroughly." Other people spoken with commented, "I feel very blessed to be in the care of Woking Hospice. All the staff and volunteers are fabulous" and "The doctors and specialist pain control nurse have all been excellent and thorough". One of the relatives said, "I am very impressed with the staff and their professionalism." Another said, "They were excellent with [my family member] who was very stubborn. They were patient and caring." A health professional commented, ''The Woking Hospice staff are fantastic, approachable and always go the extra mile for their patients. The doctors are extremely knowledgeable and go out of their way to support and train others". Another said, "We do not visit the hospice in person very often but we have excellent feedback from our patients and their families."

People's health and well-being needs were met by staff who helped them to stay as comfortable and free from pain as possible. Each person's healthcare needs were described in their care plans. There was an approach to individual care that took account of the person as a whole, their family and friends and the aspirations they might have for their care and life goals. Staff told us that information about people's individual needs including pain management was sufficient to enable them to provide the most appropriate care for each person.

People were supported by staff who understood consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The ward manager told us that most people who were cared for in the service had capacity. People's capacity was reviewed on an individual need basis at the point of admission and throughout their stay. All staff had received Mental capacity Act 2005 and DoLS training. Staff had a good understanding of what a deprivation of liberty was, what constituted restraint and when a DoLS referral might be necessary. They recognised that people's capacity may vary depending on circumstances such as time, mood and well-being. The ward manager demonstrated a good knowledge of Deprivation of Liberty Safeguards. She indicated the service makes approximately four to six DoLs referrals per year. She gave an example of an appropriate DoLs referral the hospice had made.

It was noted that there was documentation in the nursing notes for one patient who was sometimes not being turned for pressure area care because of the family's request. The clinical scenario would suggest that this was appropriate as the patient was very close to dying and comfort would be the presiding factor. But the nursing staff had not recorded this as a 'best interests' situation which would have made clear the decision had not been made as a response to family wishes.

People were encouraged to make decisions and choices for themselves. People's consent to care was

obtained and was noted in their care plan along with other relevant areas such as information sharing. Staff gave people time to make decisions for themselves and used the methods described in their care plans to support them to make choices.

People told us they enjoyed the food provided to them at the hospice. We observed the lunchtime meal and saw that food served on the day looked appetising and people were encouraged to have a meal by the staff. Where people required assistance with eating, staff spent sufficient time to ensure they ate enough food. Kitchen staff we spoke with told us in detail about the individual requirements of people's diets. For example, the kitchen volunteer told us which people were on a special diet and which foods people preferred. Where people found it difficult to eat due to loss of appetite, staff encouraged people to eat an alternative meal or suggested they could try to eat later. People were able to bring their own snacks and drinks into the hospice with them as there was a small fridge provided in each room. We also saw people were frequently being offered refreshments throughout the day by staff and volunteers.

The food was provided from the hospital kitchen. Families were offered food with no charge to enable them to stay with their relative and to join them for a meal in a supportive and familiar way. People and their families were able to choose meals from a menu provided to them the day before. The hospice had facilities so that people could be offered boiled eggs, toast and sandwiches as alternatives. People were asked about the quality of food by staff and more formally in the quality assurance questionnaire. People told us they had no complaints about the food. Comments from people included, "The food is fantastic comparing it to hospitals". "The food is excellent", "I'm diabetic which is difficult but we are coping really well with it here". One relative told us, "It's a nice variety of food. Even at night staff provided us with tea as they knew we did not want to leave [our family member]"

The registered manager told us that the provision of meals was an area that had been under review and development. The arrangements, which had started on the day of the inspection, included a 'chill and heat' system of providing food which was sourced from an external contractor. Initial feedback had been positive with people and staff reporting that the food was nutritious and plentiful. Nutritional assessments, weight, food and fluid charts were completed for individuals, if necessary. We saw a certificate issued by the local Environmental Health Department which had awarded a five star (maximum) rating for the safe handling of food.

The service employed a range of healthcare professionals including a team of doctors who worked across all services and visited people in the in-patient unit, the hospice day service, at home and in out-patient clinics. There were community nurses who visited people in their homes. There were therapists, psychologists, a social worker (being appointed) and family and spiritual support staff. A fund raising office was sited elsewhere which was staffed by a dedicated team of fund raisers. The volunteers where supported by a dedicated volunteer co-ordinator who met with them individually on a regular basis. All new volunteers where provided with an orientation programme and mandatory training.

People were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and to the care of individuals. The staff told us that they received all the training that was required to work effectively and to provide the best quality of care. 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 needs and wishes. Senior members of staff told us that new members of staff shadowed them for some time as a routine. That period of time would be determined or extended if a new staff member was not sufficiently confident in their role.

Nursing staff described excellent support for professional development. This included an active professional

development team (2 nurses) who supported staff with training and organised the in-house education initiatives. Training was delivered by a variety of methods which included e– learning, classroom based and external trainers. We were informed that some nurses had undertaken distance learning programmes regarding dementia. This had arisen as a result of increasing numbers of patients with dementia. Folders had also been developed to support nursing staff with the new National Midwifery Council (NMC) revalidation requirements. There was an induction programme for newly appointed nurses that included an induction day, induction checklist, induction booklet, and 2 weeks supernumerary practice. The ward manager told us that degree level study was supported and one of the ward sisters was currently studying for a Master's degree. A list of all nursing staff registered with the National Midwifery Council was maintained, updated and monitored.

We were provided with a training matrix which covered staff employed throughout the two hospice sites (including Sam Beare Hospice) and the community hospice service. A wide range of training was on offer from mandatory training for all staff such as fire safety awareness, equality and diversity and moving and handling. There was specific clinical practice training such as medication, resuscitation and pressure ulcer training for relevant clinical staff. Other training provided included post incident management, lone working, therapeutic interventions and supervision and appraisal which were undertaken by relevant staff according to their role and responsibilities. The ward manager told us that two health care assistants were currently undertaking an 'Assistant Practitioner' course. This would enable them to undertake wider responsibilities including checking medicines and undertaking wound care etc. We saw that two nurses had been supported by the Hospice and had achieved an award from the Queen's Nursing Institute for patient care, learning and leadership. This afforded them the title of Queen's Nurse.

We saw evidence of a number of themed training days being organised (listed on the practice development team's whiteboard). The ward manager also described these. Themes included 'Palliative Care Update', 'Palliative Care Emergencies' and 'Dementia'. We were informed that medical staff worked in collaboration with Princess Alice Hospice in terms of holding bi-monthly consultant meetings, which facilitated professional discussion and peer support. This collaboration also linked to a weekly shared education meeting and a weekly shared journal club. Evidence was seen of training provided in the administration of medicines, including intravenous drug administration and the use of syringe drivers. Although records of competency assessments were not available for all staff, the Practice Development team had a programme to address this.

The staff had a handover for in-patients at each shift change. These meetings were used to plan care and to pass on medical and health information within the staff team. Each patient was discussed in detail including information about their family, primary diagnoses, medical issues and other important health care needs. We observed the nursing midday handover. The appropriate level of information (including current problems and tasks that needed to be completed that day) were shared and discussed in order to facilitate safe care for the proceeding shift. The incoming staff had ample opportunity to ask questions and to seek clarification about tasks that needed to be undertaken. This system ensured that the continuity of care was maximized for individuals. The volunteers told us the communication between them and staff was satisfactory and that they were always aware of what was happening on the previous and current shifts.

All members of staff were supported through regular supervision meetings at least every eight weeks with their line manager. Staff spoke highly of the opportunities they were provided with and found the one to one meetings and annual appraisals useful. They enabled them to identify their training needs and to contribute to the improvement of the service. Staff felt supported to meet the needs of people and offer what they described as, ''excellent care''. Staff told us clinical supervision was in place for clinical staff where matters could be discussed with a supervising practitioner. They said that feedback about their performance was

given regularly and in a helpful and constructive way. Staff told us this helped as they were able to get specialist support when required. Staff told us that they received excellent support from their colleagues and line manager. We were told that staff had completed an appraisal this year. There were regular and separate recorded team meetings for nurses and non nurse qualified support staff on the inpatient unit. We were told that there was a weekly multi-disciplinary meeting for both the in-patient unit and the community palliative care team. Records to support these meetings were seen.

People told us the hospice was always warm, clean and comfortable. One relative described the facilities as "very clean". A visiting relative told us, "The hospice is always clean and hygienic." The facilities provided were spacious and included a range of communal and meeting rooms. People had individual rooms with ensuite washing and toileting facilities. Specialist bathing and mobility equipment was provided to support those people with increasing mobility needs.

Good

# Is the service caring?

## Our findings

People described staff as, "excellent". One person said, '"My family is able to see me whenever they want to see me. Yesterday I had visitors and I spent time with them in the conservatory. It is a lovely place." Another person told us, "It feels more like home. The food, the staff… I could not fault any of it", and "Staff are fantastic. They know my needs and they come here and chat to me so we get to know each other. They ask me about my work, what I've done in the past, about my family." Relatives we spoke with told us, "It's an amazing place. It's so friendly. Staff can't do enough." And another said "You wouldn't need to come. All I have to answer is excellent and excellent." Other comments from relatives included, "It's first class here. They are always around." and, "It's not just the care that (my family member) is receiving but also the care we receive. They can't do enough for us."

Staff were happy with the approach and working practices at the hospice. Staff provided comments such as, "It's about personal choices. Their wishes are carried out." and, "What is important is having trust in your peers, that they share the same values and care towards each and every patient. I believe that exists in the hospice." A volunteer told us, "We treat them as we would treat you." A visiting professional told us, "All our referrals are being handled with the patient's best interests and with dignity."

The service had policies in place to maintain and promote people's privacy and dignity. We observed that care was delivered in an individual manner and centred on each person. Staff had a good understanding of people's needs and provided care with kindness and compassion. They knew how to provide care with respect and how to maintain people's dignity. For example, when one person was visited by a doctor staff used signage on doors to indicate that the room was in use, so that the person was not disturbed. During our inspection we saw that after the shift change, the late shift staff came and introduced themselves to people advising them that they are going to assist them that afternoon. All staff had received dignity in care training.

Staff were aware of the content of people's care plans and knew about their preferences, daily routines, likes and dislikes. People were able to make choices and decisions about all aspects of their lives including, choosing to take part in activities, what they ate and when to get up and go to sleep. Care plans included instructions for staff to follow when helping people with eating, drinking, or with their personal care needs. Additionally, staff described how they made sure that people were supported by the staff member they were most comfortable with, particularly for intimate tasks, wherever possible. Relatives were actively involved in care and decision making when appropriate. There was detailed documentation of discussions with families about the patient's condition and plans for their care within the care plans we reviewed. People told us that staff helped them to do as much as they could for themselves. People's emotional, cultural, life choices and spiritual needs were noted in their care plans. Staff received equality and human rights training. People's end of life wishes were recorded and clear detailed plans for end of life care were in place. Do not attempt resuscitation (DNAR) forms were in place where appropriate.

People were provided with information about the service and what they could expect. There was a range of information leaflets available. People and relatives told us that medical and nursing staff always discussed

treatment options with them and involved them in making decisions about treatment plans. They said they were able to take time and ask questions about the proposals and they felt they were listened to by all staff.

People were supported to maintain relationships with people who were important to them. People told us that their friends and relatives visited regularly and were welcomed to the hospice. There were no restrictions on times or lengths of visits. A relative told us they visited whenever they wanted and at whatever time they wanted. One person told us, "My family can stay here if they want to. They are able to visit me anytime."

There was a chaplaincy service available to offer support to people if they wanted this. It aimed to meet multi-denominational spiritual needs of people and their family members. The multi-faith room was available for people of all beliefs. The environment could be adapted to display religious objects specific to people's individual faith. The registered manager told us, that the service had established a positive relationship with the local Muslim community. This had helped people of a Muslim faith to feel comfortable using the service. Members of that community wanted to help the hospice with fundraising and promoting their culture.

Bereavement support was available to people and their families or friends. This provided emotional support to those who required it. A pre-bereavement, post-bereavement and counselling service was offered to all people and their families as appropriate. The bereavement support was provided by 28 counsellors who were either fully qualified or at the end of their psychotherapy training. Bereavement support was provided initially for 6 weeks but could be extended for as long as needed. The counsellors were helping to run support groups for family members whose loved ones had passed away in the hospice. There were different support groups according to the needs and age of family members. Family members who used the groups expressed very positive views on the support that helped them to overcome and manage a very difficult time for them.

Good

# Is the service responsive?

## Our findings

People told us they received care and treatment which met their individual needs. People told us they felt staff listened to them and their treatment plans were tailored for them. They added that staff valued their opinions and that they were encouraged to express their views freely. Feedback from people, their relatives, staff and community professionals indicated that the service was responsive to people's needs. People told us that the way staff responded to their needs was, "excellent", and, "They asked me all my needs and what my likes are. They asked my family as well." People told us that staff were always available if they needed anything. There was a pro-active approach to meeting people's needs which involved staff constantly checking to see how people were. During the visit we observed staff anticipating and responding to people's requests and needs quickly and positively. Staff, whatever their role, worked with each other as a team to minimise the time people had to wait for requests for attention or assistance. Several staff told us how team work was so important in meeting people's needs in a timely manner. A health professional commented, ''I find they are exceptional in their helpful and timely responses, from the doctors to the director of nursing."

A thorough assessment was carried out at the commencement of a person's referral to the hospice. The assessments took account of people's personal needs, such as helping them with personal care, mobility, nutrition, wound care and medicines. The admission procedure to the in-patient unit was designed so that people received a management plan in relation to their symptoms, emotional and spiritual support, pain relief and specialist care. People's wishes were at the centre of their care planning. Care plans included sections for recording by the community palliative care team when people had been seen in the community. This included a comprehensive holistic assessment. The notes included entries that demonstrated changes that had been made to medicines in response to pain management through regular reassessment. There were good individualised care plans, such as good detail about what the patient's pain problem was and what the plans were to try and manage the symptom. Discussions with people about their wishes and their consent about any changes in their treatment were recorded. We saw examples of clear medical admission assessments. One of the nursing admission assessments did not have all sections completed. The ward manager confirmed that the sections would be completed during the admission as more information became known.

The provider delivered considerate and person-centred care and support that had a positive effect on people. People were asked about their needs and preferences by the staff. People had detailed individualised care plans which described their needs, personal histories, preferences and choices. Staff were able to demonstrate their understanding of how to give people personalised care. People's choices and wishes were recorded to guide other staff about how to care for them according to their individual needs. The care given to people followed the care described in their care plan. However, people told us the staff were very flexible and always listened to them if they wanted things changed or done a different way. Staff shared people's information with other relevant people at the hospice. For example, information about people's diets and preferences was shared with the kitchen staff. Information about other aspects of care was shared with the appropriate members of the multi-disciplinary team.

There was a range of documentation designed to ensure that reviews of people's clinical needs were

undertaken regularly and recorded. There was a form used, in addition to the main care plan, for some patients, which was referred to by nursing staff as the 'end of life care plan'. It provided a checklist designed to be used as a prompt to ensure that the key priorities for care of the dying person had been achieved. The form identified priorities for individual patients which were to be reviewed on a daily basis. We saw that there were some gaps of several days in some records which could mean that clinical assessments were not undertaken as required. We were assured by the ward manager that clinical assessments were an on going process and recording was being reviewed to reflect this.

One patient was identified as requiring a care plan to manage their skin integrity but this care plan had not been initiated. The ward manager and ward sister agreed one should be in place and think the error occurred because the patient had a wound care plan in place which covered some (but not all) aspects of the skin integrity care plan. There was no evidence from written evaluations or progress notes to suggest that this had led to care not being provided as required or that there had been any adverse impact on the patient. The current practice was to review the records of three patients discharged from the hospice every three months. We received an action plan and draft audit template for records review following the inspection visit. The service planned to implement a weekly review of all patient records by the end of the month in parallel with discussion/support sessions for relevant staff which addressed all issues brought to their attention.

Arrangements were in place to enable people to take their own medicines if they wished to self-administer, however, staff told us that this was not used frequently due to the condition of most people at the hospice. Staff described effective processes for the supply of medicines on discharge from the hospice and when on day leave.

We noted that the in-patient unit was compliant with National Institute for Health and Care Excellence guidance in relation to having a seven day per week community clinical nurse specialist service that could provide face to face contact at weekends. In addition, the unit had 24 hour telephone access for advice from palliative medicine consultants. The medical cover was provided through a partnership and collaboration arrangement with another hospice. The unit mainly admitted patients from Monday to Friday but could also admit emergency patients at weekends and in the evenings. The unit instigated 'quiet times' at patients' request and ran an open visiting policy for relatives and friends.

The day service was run three times a week. On Mondays people who were bed bound and less mobile had an opportunity to participate in activities provided by the hospice, for example, music, board games and art and craft. During one of the art and craft sessions they had added pictures and written quotes about favourite moments in their lives which had been made into a material collage. The mat was displayed in the conservatory. The day service planned to introduce tai-chi as the next activity available for people on Mondays. On Wednesdays people using the day service were able to use mobility equipment including a specialist bath in order to attend to their personal care needs. Friday's activities included the running of a drop in clinic.

People, relatives and staff were encouraged to comment on the way care was being provided. People told us they were aware of how to make a complaint and who to raise their concerns with. They said that they felt their concerns would be taken seriously and acted upon. There was a robust complaints procedure in place. Staff, people and their relatives told us they would be comfortable to complain and would do so if necessary. One person told us, ""I know how to complain. It's enough if I tell one of the nurses and they sort it out for me." Another said, "I know how to report my concerns. Just call for staff and they deal with it." We noted that there had been three complaints during the period December 2015 to March 2016 which covered both the Woking Hospice and the Sam Beare Hospice. It was not immediately possible to determine which

complaint related to which location. However, one of the complaints related to the community service. We saw that each complaint had been addressed and that appropriate action had been taken. There was an audit process to ensure that a comprehensive review of the complaints and compliments recording systems was undertaken.

We were told that transition between services and the community or other services were undertaken in close communication and collaboration with other professionals involved with people's care. One visiting professional told us, "All staff have clearly wanted to engage in what is a challenging subject, i.e. the move on from children's services." A GP told us of their experience, "Woking Hospice is an invaluable service for my patients. The advice from consultants and MacMillan nurses is always excellent. I couldn't rate the service higher as it is crucial to the palliative care of my patients."

Good

# Is the service well-led?

## Our findings

There was an open and positive culture which focussed on people. People and their relatives told us, "It has to be managed really well to keep it rolling at that level." and, "The place seems to be well managed." Staff and volunteers told us that the registered manager was very approachable and would listen to their concerns and act upon them if needed. All staff spoken with said they were well supported and managed by all members of the management team. One member of staff said "I really like the organisation." She further expanded that her line manager was "very good" and that she was "well supported." Another member of staff stated "my line manager is very supportive...and she will also listen and take action." A third member of staff said "I'm given a lot of autonomy by my manager to develop new things". We were told by one member of staff that the "clinical leadership is good." This was in response to questions about the medical and nursing hierarchy. Comments received about the senior management and executive team were positive.

We were informed that non executives were invited to present issues to the executive team e.g. to discuss capacity levels for admitting patients. We were informed that the Director of Nursing was good at providing feedback from Executive meetings. They all said 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. 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. One visiting professional told us, when referring to engagement and transitional work with young people, with all levels of the hospice, "My experience is this has come from the top and therefore the leadership has created this culture for a caring, responsive and well led service."

The registered manager was registered in October 2015. They are responsible for the operational management of the inpatient unit, the day hospice and specialist community teams covering the area of North Surrey. In addition, she was registered as the manager for the Sam Beare Hospice which was located in Weybridge, Surrey. The registered manager was open and transparent. She consistently notified the Care Quality Commission of any significant events that affected people or the service. The registered manager sent us an action plan addressing all areas brought to her attention by the inspection team together with supporting documentation and timescales for completion. Areas to be addressed and improved included documentation completion, care planning and review, photographs of wounds, medicines audits and appropriate guidance for staff.

People, staff and other interested parties were listened to by the management team of the service. The service conducted formal 'patient surveys'. These included both people and their relatives. Every patient was given service quality questionnaires upon their admission. People were asked, for example questions regarding the quality of care received, their involvement in decision making, counselling, complementary therapies and spiritual care. The survey results for the period December 2015 to March 2016 were seen and covered both the Woking Hospice and the Sam Beare Hospice. During this period 33 formal written compliments had been received covering both hospices. We saw the staff survey summary results for 2014 which included an action plan based upon an analysis of the results. Overall, comments were positive with some areas including communication and staff morale, which required further work, were detailed in the action plan. We also saw an overview of a patient survey for the community team covering the period

September 2014 to April 2015. There had been a 44% response rate where all respondents had indicated that the community team had met their expectations in regard to the care for the patient and support for the their relatives.

The hospice had a range of up-to-date policies and procedures in place for the management of medicines. However, there were some processes not described within the policies; for example, there was no policy on administering medicines through feeding tubes. This meant there were not always clear and transparent processes in place for staff to follow. The registered manager agreed to address this. There were no records of completion of any regular medicines audits at the hospice, and the quarterly external CD audit by the pharmacist was overdue. We were provided with an action plan and supporting documentation to address omissions in the current medicines auditing system by the registered manager following the inspection visit. Alerts issued by the Medicines & Healthcare products Regulatory Agency (MHRA) were acted on.

There were regular one to one and group meetings with line managers and an extensive range of meetings with other stakeholders to ensure that good practice developments were kept up to date and were in line with current guidance. They were also designed to support staff at all levels of the organisation. Staff told us, "We have regular team meetings. Some were about organisational issues, internal changes and new policies. Another was on issues from the communication folder or things brought to our attention". Some examples of group meetings included a monthly clinical leads meeting with the director of nursing, and attendance and involvement at a specialist regional Hospice education group by the director of nursing ensuring peer review, sharing of best practice and collaborative working. We saw that there was participation in the North West Surrey End of Life Care Steering Group attended by the medical director and Director of nursing. In addition, there was a regular programme of clinical supervision and accountability and responsibility training for all registered professionals. All staff received annual appraisals and individual development plans.

The practice development team worked clinically on the ward with nursing staff regularly to ensure that they experienced practice in action and the challenges faced. There was a monthly Journal club where a range of topics were explored. Staff debriefings with a trained counsellor were available if and when required. Monitoring and feedback on complaints and incidents to relevant staff with any performance management issues being addressed were undertaken when necessary. There were monthly health and safety meetings, quarterly clinical governance meetings and bi-monthly clinical services committee meetings attended by board members. There were regular staff meetings led by the Chief Executive Officer. Regular team meetings were arranged together with a staff involvement group. Introduction of corporate health and safety and governance meetings had been undertaken and the service was about to start mindfulness sessions.

The service's reviewing and monitoring systems were designed to ensure that the quality of care they offered people was maintained and improved. Areas included medicine management, catheter care, falls risk management and safety engineered equipment. Audits and checks were completed locally at determined intervals on most aspects of the care being provided. Examples, included a range of documentation, hand washing, beds, medicines audits and recruitment. Other audits seen covered Mental Capacity Act, slings, falls and equipment servicing.

People, staff and visitors were aware of the accountabilities and responsibilities of the management team. The registered manager was given the authority to make decisions to ensure the safety and comfort of the people who stayed in the hospice and attended the day services. These included emergency maintenance and repair issues and ensuring staffing levels could meet people's immediate needs, safely. The service made sure there was a senior or experienced staff member on-call at all times.

We were told that the hospice and community staff related well to other services and health care professionals. We received feedback from outside professionals that the hospice worked co-operatively with them in the interests of people receiving care. One professional told us, "Staff at the hospice communicate well with the Community Nursing Service. We are always able to seek advice on behalf of our patients". We saw information which confirmed that staff provided a range of external talks and presentations including a Cancer Health and Wellbeing day directed at patients, carers and families. There had also been a session on Palliative Oxygen Therapy for GP's. We noted that the Community Team had received an award for their end of life care from NHS North West Surrey Clinical Commissioning Group. They had also been designated as an 'End of Life Champion" by the National Council for Palliative Care.

Records relating to people who stayed in the service were of a good quality and content. They were accurate and detailed. 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. Care plans gave staff clear directions about how to meet people's needs safely and in the way they preferred. Records relating to other aspects of the running of the service were mostly well kept and up-to-date. It was noted that some staff signing sheets within care plans were not fully completed and that clinical and risk assessment reviews were not always recorded according to the frequencies indicated. The registered manager undertook to raise this at the clinical leads monthly meeting, specifically in relation to reviewing the system.