

Medway Community Healthcare C.I.C

Wisdom Hospice

Inspection report

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Ratings

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 April and was unannounced. Wisdom Hospice is one of a range of services provided by Medway Community Healthcare. The hospice offers specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver physical, emotional and holistic care through a multi-disciplinary team of nurses, doctors, counsellors, social workers, occupational therapists, physiotherapists, spiritual leaders and a range of volunteers. The service cares for people in four types of settings: at the hospice in a 15 bedded 'In-Patient Unit'; in the 'Hospice day service'; in people's own homes; and in hospital, where people received care from the hospital palliative care team, based at Medway Foundation Trust. The service was providing services for 392 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.

People said that they felt at ease receiving care from the service and relatives reported that people were in safe hands. Ensuring that staff understood how to safeguard adults and children was central to the running of the service. Staff received training and regular updates throughout the year and demonstrated that they knew how to recognise and report potential abuse.

Assessments of risk were individual to people's specific needs and identified how risks could be minimised. Environmental and health and safety checks were carried out to ensure that the environment was safe and that equipment was in good working order. There were systems in place to review accidents and incidents and make any relevant improvements.

Checks were carried out on all staff at the service, to ensure that they were fit and suitable for their role.

People said that there were enough staff available to promptly attend to their needs. The numbers of staff and volunteers available meant that staff had time to give people one to one attention.

Safe systems were in place for the ordering, storage, administration, recording and disposal of medicines.

New staff received a comprehensive induction and received effective support from a mentor. Training was provided which was necessary to their roles and included specialist training in bereavement and end of life care to make sure that they had the right knowledge and skills to meet people's needs effectively.

People's health, medical, nutritional and hydration needs were assessed and closely monitored. People's needs were individually discussed and effectively communicated when the staff team changed on the in patient unit. 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.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). The service manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The service had made applications under DoLS to ensure that people were not deprived of their liberty unlawfully.

The service provided a relaxed, comfortable and clean environment. There were a range of areas available for people and their visitors to sit and for day patients to undertake activities.

The service had received a large number of compliments concerning the kind, compassionate and caring manner of the staff team. Staff spend time listening and talking to people and people said they were treated as individuals.

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

People's individual wishes with regards to their care were recorded and the staff team advocated for people when necessary to ensure these were met. People and family members were involved in planning their care and treatment and were confident that staff explained everything to them clearly. Care plans were detailed, reviewed and updated on a daily basis.

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

Peoples' psychosocial, spiritual and therapeutic needs were catered for. The day hospice offered a creative and innovative programme of activities that ensured people were treated as active and valued members of the community. They were given opportunities to express their feelings and emotions through a variety of outlets including creative writing, art, photography and a quilting project.

The service and the charity which supported it, had built links with other hospices and the local community through offering services and fundraising events. Further improvements were planned for this area of development for the benefit of people.

People were able to make their views known and knew how to make a complaint or raise a concern. People were able to make their concerns known by immediately 'texting' them to the service, therefore, making it easier for them to do so. When complaints had been received, these had been investigated and forums held so that lessons were learned to improve the service.

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

The service had a clear management structure and lines of accountability. There was a robust programme of clinical governance and audit to identify any shortfalls. When this occurred action plans were put in place with timescales to address these areas and monitored until completion. Therefore, there was a process of continuous improvement of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

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.

Protecting people from potential abuse was a priority in the service. Staff were trained in safeguarding adults and children and knew the action to take if they were concerned that abuse might be taking place.

People were supported to take risks in order to realise their wishes and choices.

People's medicines were managed safely.

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

Is the service effective?

Good ●

The service was effective.

Staff were trained to ensure that they had the skills and additional specialist knowledge to care and support people at the end of their lives, and to provide on-going care and support to their families.

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 they were encouraged to eat as little or as much of anything they wanted. Meal times were significant social events, which could be shared with other people, staff and/or family members.

The hospice used a multi-disciplinary approach to meet people's health needs. This included providing people and their families with information, practical assistance and 24 hour telephone support, so that they were able to seek advice at any time.

Is the service caring?

The service was caring.

Staff were friendly, kind, caring and passionate and supported people in a calm and gentle manner. They knew people well and advocated on behalf of people to ensure their individual wishes were taken into account.

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

Providing support to people, and their family members, was key to the service. This included people's spiritual and emotional needs.

A range of support was available to people's families and children. It included counselling and bereavement services and support groups, which continued after the death of their loved one.

Is the service responsive?

The service was exceptionally responsive.

People were fully involved in planning their care, treatment and support, which reflected their choices and preferences. Advanced care plans detailed where and how people wanted to receive their care. Staff went 'the extra mile' to respond to people's psychological needs.

The service had received a large number of compliments about the outstanding way it had responded to people's needs. At the end of life, people were enabled to experience a comfortable, dignified and pain-free death.

Staff knew how to respond to people's emotional needs and enhance their sense of creativity and self-esteem. Innovative and creative activities were offered which helped people reflect on and plan their lives through the use of art, creative writing and memories.

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

Outstanding 

Is the service well-led?

There was an open culture where people and their relatives were asked for their experiences and they felt supported.

There was a clear management structure. Staff understood the vision and values of the service and how to put these into practice. They felt well supported and were motivated to provide individual care to people at the end stage of their lives.

There was a robust system to maintain and monitor the quality of the service which was effective in driving continuous improvement. When shortfalls were identified, action was taken to improve the quality of service and care.

Wisdom 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 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 13 and 14 April and was unannounced. The inspection team consisted of two inspectors on both days of the inspection and a pharmacist and a specialist nurse on the first day of the inspection.

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 six people who used the service, two visitors and two relatives. We also spoke with twenty five staff, including the three senior managers, four nurses, two pharmacists, consultant, the volunteer manager, five volunteers, a social worker, a bereavement counsellor, four health care assistants, a housekeeper, a laundry assistant and a maintenance person. The service was undergoing a process of restructure and change. One of the senior managers had applied to be the registered manager for the service and was present on both days of the inspection.

We spent time on the in-patient unit and in the day hospice. We looked at ten people's care plans and checked how their care was planned and delivered.

We viewed a number of records including ten staff recruitment records; the staff training programme; five people's medicine records; medicines, infection control and fire evacuation policy; health and safety records; risk assessments and audits; compliments and complaints logs and quality assurance questionnaires.

Is the service safe?

Our findings

People said that they felt comfortable in their surroundings and that there were enough staff available to keep them safe. Comments included, "There are always lots of staff around" and "The staff are there when you need them. They respect you and they are not in your way all the time". Relatives were also positive about the safety of the service. One relative stated in their feedback to the service that, "I always felt that my sister was in safe hands. From the moment that I walked through the door of the hospice any fears or concerns that I had were dispelled".

Ensuring that staff understood how to safeguard people was at the heart of the service. One nurse was responsible for overseeing all safeguarding concerns. All staff received training in safeguarding children and adults at induction and via yearly updates. In addition staff received, from the social work team, regular updates on how to recognise and respond to potential abuse. Staff demonstrated that the training was effective in ensuring that people were kept safe. They knew in which circumstances they should report a concern and to whom. Staff were aware of the service's whistle blowing policy and were confident about the circumstances when they might "blow the whistle". This is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith. If the service did not act on their concerns, staff had the contact numbers of other agencies so that they could report these concerns without delay.

People and staff said that there were sufficient numbers of staff available to meet people's needs. During the inspection there were sufficient staff available on the in-patient unit and in the day hospice to respond quickly to people's care and treatment needs. A designated senior nurse was responsible for the day to day running of the inpatient unit 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 nurse who was supported by an assistant and volunteers. Community services were provided by experienced trained staff.

Volunteers worked on the reception, in serving food and drinks, spending time talking to people and their family members, transporting people to the day hospice and providing activities and therapies. In addition the service employed a multi-disciplinary team of health and social care professionals that included social workers, bereavement counsellors, occupational therapists and physiotherapists. These professionals supported people and their families using the hospice and also people who lived in the community. Therefore, there was a range of skilled and experienced staff available for people to meet their needs and provide regular one to one support.

There were suitable arrangements on the unit to ensure staff covered absences and existing staff covered each other. When this was not possible, bank staff were used who were familiar with the running of the service and the needs of people who used it. Staff told us this system was efficient to ensure people's safety.

There were robust recruitment procedures in place for staff and volunteers. This 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. Disclosure and Barring Service (DBS) criminal checks were completed before staff started to support people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Volunteers were shadowed until these checks were completed.

Risk assessments were centred on the needs of the individual. These related to skin integrity, levels of mobility and risks of falling. These assessments were undertaken at the time the person was first known to the service. They were reviewed on a regular basis and for people on the in-patient unit this was daily due to their changing needs. Control measures to minimise risks to people 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.

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, the nurse call system and fire equipment. 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.

There was a clear procedure to record and respond to any accidents, incidents or near misses. These were investigated to see if there were any patterns or root causes. For example, if a person fell in the in-patient unit, a record was made of where they fell. This information was analysed to identify if one area of the in-patient unit presented a particular hazard. The patient safety team was responsible for identifying any trends, which they reported to the Board, together with any recommendations to promote a safer environment.

The service had a business continuity plan for emergency situations such as flooding, or a gas or electricity failure. This policy was tested on the second day of the inspection when the provider, MCH, were alerted by NHS England of a scenario to work through. Staff assessed which people would need to be evacuated from the affected area in the scenario, be kept safe. This was to ensure that staff knew what action to take in the event of any emergency.

The service was clean throughout on the two days of the inspection. One room on in patient unit was prepared for a new person. The room was cleaned from floor to ceiling and every soft furnishing was replaced. Housekeeping staff understood their roles and responsibilities and followed schedules of cleaning to ensure all areas of the service were cleaned to the same standard. A comprehensive infection control policy was in place and there was a lead nurse for infection control to ensure this guidance was followed consistently. Bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices. There was hand gel at various points in the building for staff and visitors to use to help protect people from infection. Infection control audits were regularly carried out to ensure all areas of the hospice were sufficiently clean and to reduce the risk of infection.

People's medicines were kept securely. Appropriate arrangements were in place for ensuring medicines were kept at the right temperature and not used past their expiry date. Emergency medicines and oxygen cylinders were available when they were needed. 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.

During the medicines round nurses monitored syringe drivers to ensure people received the correct amount of medicines. This is a system which allows medicine to be administered by slow release over a period of 24 hours. Staff had good access to up to date resources which they may need for medicines administration, including guidance on the use of a syringe drivers. Staff were able to clearly explain information people were given about unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms).

Prescribing was undertaken by in-house doctors and consultants. Processes were in place to ensure that medicines for management of pain were administered in a safe and timely manner. People's prescription and administration charts were fully completed, including the reasons for any missed doses and people's allergies. The service had effective processes in place to allow people to continue to take their medicines safely when on day leave. There was regular monitoring of, and response to people's symptoms, including pain. The consultant provided clear examples of personalised prescribing. The service had designed a leaflet for people and their families to take home, prior to discharge, to ensure they understood what their medicines were for and how to take them.

Staff had received training and their competency had been assessed in how to administer medicines, including syringe drivers, safely. Staff had good knowledge of how to report any medicines errors and demonstrated learning from previous events. The service regularly undertook audits of medicines including medicines management and controlled drugs.

Is the service effective?

Our findings

People, relatives and visitors indicated that the service was effective and that staff had the skills and knowledge to give them the care, treatment and support they needed. A relative told us, "Staff are very good and aware of what a difficult time it is for us". A relative who provided feedback to the service said, "Staff and volunteers are compassionate and highly professional". People said they had access to health care professionals they needed. One person who lived in the community told us, "The hospice occupational therapist has already been out and made suggestions to help assist me around my home".

New staff received a comprehensive staff induction programme according to their specific role. Each staff member was assigned a mentor whom they shadowed until they could demonstrate they had attained the level of competency required for their role. The 'Care Certificate' had been introduced for all new staff. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes and hospices are expected to uphold. Staff valued the support and guidance offered by the mentoring programme and told us that their induction prepared them well for their role.

There was an on-going programme of training for staff, provided by e-learning and face to face training. This was monitored by head office to ensure that staff kept up to date with the skills and knowledge they required. This included health and safety, fire awareness, moving and handling, emergency first aid, infection control and safeguarding adults. All staff had received training in palliative/end of life care and bereavement. Medical staff and half of the nursing team had received specialist training in pain management. Staff told us that the training in 'conflict resolution' had been particularly useful in it helping them to liaise with families in very stressful circumstances. Nurses undertook specialist training in tissue viability, continence, nutrition and hydration which are specific to the care of people with life limiting illness. 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 told us that they received excellent support from their colleagues and manager. Support was achieved through regular individual and group supervision sessions and an annual appraisal. The support of staff was made a priority of the service. There was a long overlap between the morning and afternoon shift which gave staff the opportunity for supervision, support and reflective practice. This reflective practice was available to care and non-care staff. This 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.

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 had a staff at all levels had a sound knowledge of their roles and responsibilities in relation to this legislation. Staff were motivated about ensuring that

people's individual decisions were listened to and were followed. They understood that when people had the capacity to consent, they had the freedom to make their own decisions.

Staff were aware 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 social workers, 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. A large number of applications had been applied to a 'supervisory body' to be considered and checked to ensure that the service was acting lawfully.

At the front of some people's care records, so that it was easily seen, there was a 'do not attempt resuscitation' (DNAR) form. A hospice doctor had discussed this decision with the person and their relatives, so that everyone was aware of the person's wishes. A regular audit of DNAR's was undertaken to ensure that these forms had been completed appropriately.

Health care for people was provided by a multi-disciplinary team made up of consultants, doctors, clinical nurse specialists, nurses, health care assistants, occupational therapists and physiotherapists. Each person on the in-patient unit had a named nurse with special responsibilities for making sure their individual needs were met and to provide continuity of care. People's care records showed in detail how they were supported with their medical and health care. Staff recognised that the people's healthcare needs could change and demonstrated awareness of how these can be reported and effectively acted upon. There were effective handovers between each team of nurses. These meetings were used to plan care and to pass on medical and health information within the staff team. They gave clear and precise information about each person's individual medical and health needs and the short term plans for their care. Therefore, people could be assured that all professionals understood their individual health needs. The physiotherapy department ran 'breathing well, living well' groups for people in the community and their carers. These helped people with managing symptoms of their conditions.

The hospice managed a team of community nurses whose role was to visit people in the community who had palliative care needs. These people remained under the care of their named GP and the service worked closely with them to support the person to remain in their own home. There was a 24 hour, seven days per week telephone advice service operated by a duty nurse on the in-patient unit. There was a clear protocol in place whereby issues could be escalated to the palliative care team, or 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. For people on the in-patient unit, these needs were reassessed on a daily basis and the focus was on people's preferences and access to food and drinks. Staff responsible for preparing food understood the importance of presenting small quantities of food to meet these aims. Family members had access to a separate kitchen and so were able to prepare any other foods that their relatives chose and to share a meal. People in the community with more complex nutritional needs could be seen by the dietician, who was part of the multi-disciplinary team. The service also made referrals to a 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 in the day hospice were provided with a lunchtime meal. The food was provided by an external catering company and heated on site by staff. In addition fresh salad was also available. This meal was a focal point for people to come together and socialise and staff ensured that it was a special occasion. They had placed wine glasses, napkins and a tablecloth on the lunch table, so it looked as though people were having a meal at a restaurant. People were asked where they would like to sit and helped to sit. One person told us, "I won't eat out anymore. I worry about missing my mouth. But I enjoy eating here."

The service provided a range of communal and private rooms to meet the needs of people who used the service and their visitors. Accommodation on in patient unit consisted of bays with a number of beds, where privacy curtains were provided and single en-suite rooms. People and their visitors had access to a quiet area, a kitchen area where they could prepare snacks and simple meals and a multi-faith room. There was also a garden to the rear of the service which was well tended by a volunteer gardener. The day service consisted of a main lounge where people could sit and chat. There was a separate art and craft room; a hairdressing room with a sink that could be lowered and raised so it could be used for people with limited mobility; a quiet room for private conversations; and therapy room. The service also had an on-site gym to promote people's health and well-being, so that they could remain mobile and active. The gym was staffed by physiotherapists and each person had an individual programme. There were processes in place for reporting any maintenance issues to ensure people and their visitors were supported in an environment that met their needs. The service had improved its appearance by new flooring being provided throughout.

Is the service caring?

Our findings

Every person we spoke with told us that the staff were kind, caring and compassionate in the support they provided. Comments from people included, "The staff are wonderful"; "The staff are lovely"; and "The staff always have time to talk and listen to me". Relatives/visitors told us, "The approach of all the staff is commendable"; and 'Sometimes there are new staff, but they are always friendly and helpful'. The service had received a large number of compliments about the excellent care, high quality of support they received and the professionalism of staff and volunteers. Comments included, "I felt cared for and help was only a phone call away"; "What wonderful staff, so gentle and caring – 10 stars"; "They cared for her with great care, with dignity and were a great support to myself, especially in the dark hours of the night. Truly angels who will always be remembered".

Staff understood the importance of ensuring the well-being of the person as well as their family members. One relative complimented the service on the value of this support stating, "The staff were 'extremely' respectful and caring to my husband and myself, - the support has continued for me and my children, what an exceptional place with dedicated staff".

Bereavement support was available for children. For children bereavement support commenced when main carer, such as a parent or grandparent, was diagnosed with a life threatening illness. The child was helped to work through their own feelings, the practical impact that an ill carer would have on their lives, to gain understanding into the signs and symptoms of the illness and to prepare the child for their death.

Families were invited back to the service following the death of their loved one to talk about their experience. At this visit family members were given additional information and an assessment was made of people identified as at moderate and high risk in relation to their bereavement. Referrals or joint working took place with the mental health team as appropriate. Group and individual bereavement counselling was provided. Individual counselling was provided for six weeks, but could be extended if this was needed.

The service had its own mortuary and chapel/private area, so family members could spend time with their loved one after they had died, if they so wished. Staff had detailed knowledge of the arrangements after death of people from different cultures, who were represented by the local community. This ensured that the body of a person who had died was cared for in a culturally sensitive and dignified way. 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.

Ensuring that staff supported people in a caring and compassionate manner was embedded in the service. Staff were asked as part of their supervision and appraisal to give examples from their practice when they had demonstrated being caring and compassionate. The provider, who is responsible for a number of community and hospital services, had created a staff excellence award and a number of staff and volunteers at the service were winners and runners up in the caring and compassionate category. The charity that supports the service ran a 'Pride of Wisdom award', and supporters of the charity are asked to nominate volunteers and staff for this award. A senior staff nurse had won the caring award and went on to be

nominated in the Pride of Medway awards run by the local news group. This meant people were supported by staff that were valued by the service and the local community.

There was a relaxed and homely feel throughout the service and people were encouraged to chat if they wished, and they were listened to. Staff were positive and cheerful in their engagement with people. They communicated with people in an individual and responsive manner. They laughed and joked with some people and talked quietly at other times. Staff took time to sit with people; engaging them in conversation and listening to them with genuine interest. "I like to talk to people and I made a good friend here", one person told us. Staff knew people well and had a good understanding of their personal histories. In the day hospice people had the opportunity to create their own life story in creative writing or in a quilted square, which represented the things that were important to them in their life. Staff valued people's experiences and this helped to increase people's self-esteem.

When supporting someone to move from a wheelchair to a chair, staff spoke to the person quietly, gained their consent and then explained what they were going to do. The staff member was calm and discrete and the person being supported looked visibly relaxed whilst this was happening.

People's needs in respect of their age, disability, religion and race were responded to appropriately. People told us that staff treated everyone the same, despite their differences. One person told us, "No one is treated differently here". Another person complimented the service on a similar theme, "It is nice to be treated as a person. I think the service should be proud of what it does because I am proud of everyone". The spiritual care provided by volunteers, reflected the needs of the local community. Spiritual leaders worked together to ensure one of them was always available at the service and the service had links with the main religious groups present in the geographical area that it covered.

Action to relieve people's distress and discomfort was based on the individual. When people had symptoms of pain, the consultant took into consideration the person's medical condition, their verbalisation of their discomfort and also their facial expression, as part of their assessment in how to effectively manage their pain relief.

The social work team gave examples of how they were passionate about advocating on behalf of people and used creative ways of ensuring that their wishes and choices were met. For example, one person wished to go home, but due to their physical disability, they were not able to gain access to their home. The service liaised with the fire department, which transferred the person to their home, ensuring that they died in their own safe and familiar surroundings as they wished.

People's care plans contained detailed information about their advanced care wishes called 'My Wishes'. This included people's preferred place of care, preferred place of death and preferences regarding decision making and information giving. Staff demonstrated that they were clear about any arrangements and decisions people had made before and after death that must be observed. Staff were sensitive in the manner in which they informed us of a death of a person during our visit.

People had privacy curtains around their bed and these were used to give people privacy when being assisted with personal care. Bays had a single sex policy and people and their visitors had access to quiet private areas. Staff used signage on doors to indicate when rooms were in use, such as for private meetings, counselling and therapies, so that people were not disturbed. People's relatives and visitors were able to visit at any time and this included overnight stays. Therefore, people could be continually supported by people who were important to them.

Is the service responsive?

Our findings

People and their relatives said that the service responded extremely well to their needs. They complimented the volunteer drivers who enabled them to get to the service. One relative told us, "I had difficulty getting here due to the cost of a taxi, but they arranged for a car to collect me". A person using the day hospice said, "I get picked up and taken home. I do not have to worry about it". People were very highly complimentary about the activities offered by the day service and how the experience motivated and valued them. Compliments included, "WOW and DOUBLE WOW!!! I am not sure how to express my thanks for my lovely pamper session"; "Your attention and love was overwhelming"; "It was so good to relax and have my hair washed without being in pain, and to have a sweet smelling hand massage and nicely painted nails"; "Thank you for the really special day, the beautiful finale- tea at the Ritz and all the wonderful treatments and a lovely goody bag"; and "Tuesdays, when I visit the day hospice, are probably the only day I want to get up out of bed".

Feedback from a commissioner of the service was that the service was responsive. It was open to all people with end of life care needs and not just cancer; advanced care planning and the end of life register was routinely discussed with people; and the service was looking into developing a more open access, self-referral approach.

An overarching aim of the service was to provide psychosocial and therapeutic care for people and their families. Psychosocial support is where a person is helped to be an 'active survivor', rather than a 'passive victim'. Therefore, the service supported people in innovative and creative ways to take control over their lives, and think positively about themselves, at a time when, due to their health, many aspects of their lives were not in their direct control. People were encouraged to express and understand themselves and their emotions, by reflecting on the past and projecting to the future. This was achieved through a variety of activities to meet people's individual needs and preferences. This included creative writing and poems which were beautifully printed and displayed. People also used photographs and recorded their personal stories on an 'i-pad'. This use of technology meant that people could record their own personal story with minimal assistance from other people, and so help take control of their life.

A 'life quilting project' was in progress, organised by the volunteers whereby a discussion took place with each person who wanted to participate, about their life history and things that were important to them. The person was then supported to design and make a quilted square which represented these things. These quilted squares were displayed in the day service, to represent the lives and achievements of people who had or were using the service. Information about the project was displayed in the entrance area so all people visiting the hospice were aware of its importance to people. The day hospice manager explained that the project benefitted people by helping them to work through their lives and emotions; and the process of undertaking the activity was more important than the end result. People valued the project. When one person had passed away when part way through making a quilted square, people who used the service and volunteers had completed the square on their behalf. This helped people to grieve for the person and ensure that there was a lasting memory of their life.

People were encouraged to try new skills and their achievements were valued. One person was painting a watercolour on the first day of our visit. They said that a volunteer artist had helped them, but that they had never painted before they came to the service. One of their pictures was on the wall of the day centre and this person said that many staff had told them how good it was, even though they did not think so.

The day service was exceedingly well organised, and exceptionally responsive. It was run by dedicated staff and volunteers, to meet and reflected the differing needs of the local community. There were specific days for groups of people with similar needs. For example, one day a week provided a service for people with neurological/physical needs and another day was a pamper session, where people and their carer could be completely spoilt. There were a range of therapies available which included massage, reflexology and hypnotherapy. These sessions made people and their carers feel valued and increased their self-esteem. People were also encouraged to participate in the local community, and supported to join the local library and a book club.

The service promoted people's physical well-being by providing an on-site gym to people on the in-patient unit and the day hospice. This benefitted people as it was an everyday activity that people enjoyed, it helped maintain people's mobility for as long as possible, and it gave people the opportunity to have independence and control over their lives. Breathing exercises were also provided by the physiotherapist to help people on a day to day practical basis with their condition and improve their quality of life.

People said the day service offered them a regular opportunity for companionship. It also reduced the risk of people becoming isolated and lonely. One person told us, "It is good to come here and get away from home. It is the change of scenery I need. It also gives my carer a break". Another person told us that there were many activities on offer, but they liked to sit and talk to people and this choice was respected. They said there was always someone around to talk to and we observed staff talking to this person during our visit.

People were referred to the hospice by their doctor or the local hospital. The service had a team of clinical nurse specialists based at the hospital 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. They were often accompanied by their family members who could discuss any concerns they may have. The service aimed to respond to any urgent referrals within 48 hours. However, audits indicated that the service had exceeded this target with the majority of people who require an urgent response being seen the same day. The service had received a compliment about their initial contact with the service. "I was very impressed by the way it was all explained to me, in a very relaxed manner, which encouraged confidence and thorough professional presentation overall. The nurse who came to see me was very caring and understanding."

People's care and support was planned in partnership with them and their relatives. They were asked about their needs and preferences and these were recorded in their plans of care, to guide staff about how to care for them according to their individual needs. Individual preferences and differences were respected. Nursing staff communicated people's information with appropriate members of the multi-disciplinary team. Staff talked knowledgeably about people's care and how to provide support for their physical, mental, emotional and spiritual needs. People's changing needs were monitored and observed by staff on a daily basis and a record was made in their medical notes. This information was detailed, contemporaneous and indicated delivery of a high quality of care. Each person had a 'My Plan' section which was signed by and agreed with the person and/or their carer. Each person had a 'Comfort plan' for people near the end of their life and this contained detailed and 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.

People said that staff had an excellent understanding of their social and cultural diversity. One person told us, "No one is treated differently here". The service had received a compliment from a member of an ethnic minority group, about the manner in which they had been supported by staff. "We do get judged, but we were treated the same as everyone else: with respect and as others would not treat us".

Palliative care planning empowered people to make choices and to have as much control and independence as possible. The service was flexible and responsive to people's individual needs and wishes. For example, the service had advocated on behalf of one person who wanted to return home for their last days. There were concerns about this person's safety, as they had been identified at high risk of burns due to smoking tobacco in bed. The service had contacted the fire department to acquire a fire blanket and specialist ash tray to minimise the risk of them starting a fire. This meant that the person's was enabled to live as full a life as possible, in the place of their choosing.

The service had identified areas of improvement to ensure it took a key role in the local community and was actively involved in building further links. There 'SAFE programme' (Support, Advice, Fun, and Empowerment) ran twice a year to support carers and build resilience so they could develop coping strategies. These programmes were patient-led. Partnerships had been developed with other teams so the programme could be extended to support marginalised groups in the service, such as older carers and people with dementia. The service had started to provide support for people, who would benefit from the day hospice, but who were not currently under the care of the service. The service had joint worked with the 'respiratory team patient and carer group' to give people a series of taster days, to participate in therapeutic days, advanced care planning and practical support such as advice on benefits. Therefore, people could be introduced to hospice services in a non-threatening way. There was joint working with other hospices. For example, there was a joint agreement that if a person received care at one hospice, but their relative lived in the catchment area of another that the local hospice would provide the relative with bereavement support if it was needed. This meant that people could receive continuity of support, without having to travel long distances.

The service was supported by a charity called, 'The Friends of the Wisdom Hospice' whose aim is to raise funds to ensure the service was able to operate and provide 'little extras' for people and their carers. They hold a number of fundraising events throughout the year, the most recent being 'Colour me Purple', a fun run in April, organised in partnership with Swale Borough Council. This involved people running, whilst getting covered head-to-toe in multi-coloured paint.

They also arranged a special services called 'Lights for Love', where people from the local community came together at Rochester Cathedral and Minster Abbey to remember and celebrate the lives of loved ones, who are no longer with them. Relatives therefore, continued to receive support with their grieving process from the service.

People and relatives 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 about any of the staff". A relative told us, "I would know who to talk to if I needed to report anything that I did not like". There was a range of ways that people could feedback about their experience of the service. When people were first known to the service they were given a 'Patient, carer and experience survey card' in their information pack to complete about their view of 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.

The service had listened to people and taken their needs into consideration when developing its complaints process. They had devised an innovative, but simple way for people on in patient unit, many of whom were seriously ill, to raise a concern. People were able to use their mobile phone to text a concern to the service.

This had been successful in other services operated by the provider and it enabled people to voice their concerns, as soon as they arose. Information about how to make a complaint about the service, via text, in writing and verbally, was displayed on posters around the service. There were also details about how to provide feedback, comments or complaints on the provider's website. People were informed of their right to take their complaint to the ombudsman if they were not satisfied with the outcome. Therefore, there were a number of options available for people, to encourage them to raise a concern they had about the quality of the service.

Staff were knowledgeable about the complaints procedure and 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. After receiving a complaint, the management team held a case reflection with all staff involved and identified the issues involved and areas for improvement. Staff were trained in resolving conflicts and given guidance on how to respond to complaints and pass them on to the relevant person.

Is the service well-led?

Our findings

People and their relatives/visitors were very complimentary about the way the service was managed and their day to day experience of staff and management. The overwhelming majority of feedbacks from surveys carried out by the service were that people would recommend the service. One person stated, "I have been much satisfied with the staff and management of MCH (the provider, Medway Community Healthcare). The friendly atmosphere and opportunity to interact with the people is greatly appreciated". Another person commented, "I regard your service as excellent". Compliments about the service focused on the excellent care and professionalism of the staff and volunteers, their feeling of support, the quality of the food and cleanliness of the building. Feedback from a commissioner of the service was that the last quality visit to the service was really positive and engaging with lots of examples of excellent practice. Staff responded they were well supported, listened to, were part of a team and received clinical supervision and reflective practice. They reported they were proud to work for the service.

The service encouraged open communication with people and their family members. The views of people and their carers and/family members were sought when people first started to use 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. The experiences of people were monitored via the customer care coordinator and any complaints or concerns could be directly reported to the coordinator in office hours.

Staff were complimentary about the support they received from the management team. There was an open culture and staff said they were all treated equally. There was a low staff turnover and staff felt well regarded and valued by the service. Staff were clear about their responsibilities and the aims, visions and values of the service. They said that people were at the heart of everything they did. The values of the organisation were developed with staff and these values were used to recruit new staff and as part of staff appraisal. These included providing personalised care and treating people with dignity and staff put these values into practice when supporting people.

'Schwartz rounds' had been introduced whereby staff came together and talked about the emotional and social challenges of caring for people in a safe environment. This gave staff the opportunity to share their stories and offer support to one another. The service was due to be restructured and all staff had been invited to a meeting to discuss these changes. Staff morale was good. As the provider was a social enterprise, staff had the opportunity to be a shareholder and to be elected to work with the Board, so they could influence decisions, recruit and appoint non-executive directors and lead on key pieces of work.

There was a clear management structure that was visible at all levels. The service was led by a management team consisting of an associate director of independent services, head of service (palliative care), associate director of clinical quality and the registered manager. The registered manager was not present at the inspection. The associate director of independent services was present and had applied to become the registered manager, due to the restructuring of the provider. Some of this management team were at head office. They visited the service and there were clear reporting structures in place so that they were knowledgeable about the specific aspects of service for which they were responsible. The service manager

was based at the service and was supported by a specialist palliative care team with team leaders for clinical and non-clinical teams.

The service had a structured approach to monitoring the quality of its service delivery. There was a governance framework and annual quality improvement programme to help drive improvement. This included clinical audit, people's experience, practice development, and research. The quality account is published on the provider's website and clearly outlines the quality of the service. There were clear formal reporting systems in place for all aspects of governance from the staff team. A comprehensive audit plan was in place which included medicines, safeguarding, infection control, staff training, equipment and complaints. This showed that there were processes for an on-going assessment and improvement of the service at all times.

The provider had introduced 'GAINing Insights' which replicated the CQC model of inspection to ensure service level delivery was of good quality. This was undertaken in November 2014 and an action plan was developed for areas which required improvement. This action plan had been completed and a quality summit was held to ensure good practice observed was shared. For example, it had been identified that the volunteer reception staff were not always welcoming to visiting staff. This had immediately resulted in a reorganisation of reception staff and an area for further development had been identified for professional telephonist to be the first point of contact into the service.

The service kept up to date with best practice and was informed about different model of care and ideas for improvement. The service was involved in a national initiative to enhance people's health outcomes and reduce resistance to antibiotics. Representatives from the community palliative care team attended 'Gold Standard Framework Meetings for Palliative Care'. Members of the senior management team attended annual Hospice UK conferences. At the conference in November 2015 they presented two posters, one which was a collaborative piece of work with other Kent hospices and Canterbury Christchurch University. The provider Board won 'Board of the Year' for 'Recognising Excellence award for Care and Compassion' at the Kent, Surrey, Sussex Leadership award. The service had an education centre and provided palliative care training to staff from local care homes. A nurse had recently been appointed to undertake research to share best practice. 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.