

## Ellenor Lions Hospices

# Ellenor Gravesend

### Inspection report

Coldharbour Road  
Northfleet  
Gravesend  
Kent  
DA11 7HQ

Tel: 01474320007  
Website: [www.ellenorlions.org](http://www.ellenorlions.org)

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### Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Good 

# Summary of findings

## Overall summary

The inspection took place on 25, 26 and 27 July and was announced. 48 hours' notice of the inspection was given because the children community service was office based and we needed to be sure that the manager and staff were available and to arrange visits to families in the community.

At our last inspection to the service on 11 and 12 May 2016 Ellenor Gravesend provided specialist palliative care, advice and clinical support for adults with life limiting illness and their families. Since this inspection, the service has been registered as one service with Ellenor's children services and now provides palliative care for babies, children and adults. They deliver personal, emotional and holistic care through a multi-disciplinary team of nurses, doctors, counsellors, physiotherapists, therapists, spiritual leaders and a range of volunteers. On site the 15 bedded 'Inpatient Ward' admits people from 14 years to adulthood and the 'Hospice day service' provides support for up to twenty adults. Community teams provide services for babies, children and adults. There are two adult teams: 'The Hospice at home' for people in their own homes and the 'Care Home Support team' for people in care and nursing homes. Children's services include a respite service for parents/carers; cancer care for children so they can receive chemotherapy in their own homes and a range of clubs and activities. The service was providing support for around 1420 people and their families 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.

At the last inspection on 11 May 2016, we asked the provider to take action to make improvements in the management of medicines and record keeping with regards to the care and treatment. This was with regards to adults in the Inpatient Ward. Guidance was not in place for the use of some medicines and creams and waste medicines were not disposed of in a timely manner. Accurate records were not always kept with respect to each person's individual care. The breaches were of Regulation 12, Safe care and treatment and Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan in August 2016 which stated that they would comply with all Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by the end of September 2016.

At this inspection on 25, 26 and 27 July 2017 improvements had been made to the management of medicines in the Inpatient ward and people's records with regards to their care and treatment.

There were safe systems in place for the administration, recording, handling, storage and disposal of medicines. Staff were trained in how to give medicines safely, a pharmacy technician ensured medicines were available when people needed them, and a community pharmacist provided a clinical review of people's prescribed medicines.

Since the last inspection to the adult service on 11 and 12 May 2016 and the children's service on 19 and 20 July 2016 the service had maintained standards of care and continuously strived towards developing creative and innovative ways of supporting children, adults and their family members.

In the children's service there had been a major cultural shift led by the head of children's nursing. Staff reported that the head of children's nursing had been very brave in the changes and developments within the team, and this had resulted in them having a shared understanding of the aims of the service. This benefitted children and their carers as they were able to take assessed risks and positively engage the whole family, by directing their resources where they were most needed. This had included designing and implementing a tool for children transitioning to adulthood which proactively encouraged partnerships with other teams in the community and across the organisation. Young people could access the Inpatient Ward to receive respite care in a way that met their individual needs and wishes as teenagers such as themed sleep-overs. When young people transitioning had not meet the eligibility criteria for the adult service, the multi-disciplinary team had held a brain storming session and came up with lots of ideas about how existing adult day services and groups could be adapted to meet their needs. This is a national issue and ensured the service continued to offer support and remain in contact with the young person until the time when they would meet the criteria.

The adult service had built on and further developed its services and management and staff reported that they had started to reap the benefits of these initiatives. They had continued to work towards closer relationships with people from local communities that were underrepresented in the service such as Black, Asian and Ethnic groups to discuss how to engage them in palliative care services. This work had been effective as during the inspection a nurse was called to the home of a person from one of these groups and stayed with them until their death, to ensure they died at home as per their wishes and those of their family. The head of well-being was new to their position at the last inspection, but was now established in post. They had further developed the range of health, social and therapeutic activities available as a direct response to the needs of children and adults. Groups included music for well-being, cooking, poetry, meditation and breathlessness, gardening, spiritual reflection, an after school club and a tea and movie night. The service had taken the basis of a Schwartz round and developed it in an innovative and creative way to focus on the experiences of people who used services, rather than those of staff. The Schwartz round which took place during the inspection was called, "From the horse's mouth- what it is really like to be referred to Ellenor".

Commissioners said the service had been effective in reducing the numbers of children and adults admitted into hospital. A children's commissioner told us, "Ellenor have prevented the children in their care from being admitted into hospital through the innovative interventions they have put in place in the child's home". A Commissioner for adult services said, "The service has made such a difference to people in care homes, supporting them to keep them in the community and out of hospital. Patient care is their priority and they work with us to ensure this".

In the adult service initiatives had been undertaken to make contact with people with palliative care needs so interventions and support could commence for the person as soon as possible, rather than in their last few days. The 'Care Home Support team' had contacted all nursing homes in the local area to identify each adult with a life-limiting condition. It had grown from supporting 140 people in January 2017 to 770 people at the time of the inspection. The service had met with all GPs in the local area and through this process had identified over 300 people whom they could offer support to help them to remain in their own homes, in preference to spending their last days in hospital.

Bereavement services were tailored to children and adults' individual needs, provided over a significant

period of time after death and were continually developed to meet local need. These included therapeutic sessions led by a play therapist for small groups of siblings and children of adults who had died at the service and 'drop in' sessions for their carers.

Relatives spoke overwhelmingly of the positive support their child or adult family member received from the service. Adults, children and their family members valued their relationships with the staff team and felt that they often went 'the extra mile' for them, when providing care and support. They were full of praise for the staff in terms of their kindness, compassion and individual responses to their family member's needs. The service viewed supporting the person or child and their family members as seen as a key to people's well-being.

People and relatives said they or their family member felt safe and well looked after when receiving care from the service. Ensuring people were safeguarded was at the centre of the service. All staff had received training in safeguarding adults and children and understood the importance of protecting people, visitors and themselves.

The service provided outstanding end of life care where children and adults were enabled to experience a comfortable, dignified and pain-free death in the place of their choice when possible. Staff embodied the values of the service which included providing compassionate and professional care and supporting the 'whole family' before, during and after a death.

Staff were motivated and keen to convey to inspectors their pride in working at the service. Staff were listened to, empowered with training and fully supported in their roles. The provider was mindful of the emotional challenges staff experienced and had developed strategies and opportunities for reflection and resilience. This included Schwartz rounds and a journal club to enable staff to have the support they required to continue to provide caring and compassionate care.

Adults and children were supported by a multi-disciplinary team who put them and their family members at the centre. Joint working with other professionals was central to how care was delivered and in identifying people who would benefit from their services. Adults and children's nutritional and hydration needs were assessed and guidance was in place about how to meet them. Food provided by the service was appetising and nutritious and staff took care in ensuring their likes and dislikes were respected.

Staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The service had made applications under DoLS to ensure that people were not unlawfully deprived of their liberty.

Adults, children and their relatives were able to make their views known and knew how to make a complaint or raise a concern. When complaints had been received, these had been investigated and used as lessons learned to improve the service.

The service was led by a management team who led by example and had created an open culture where staff were listened to and valued.

Quality monitoring systems were being further developed to ensure they were effective. The views of children, adults and their family members were continuously sought and used to drive forward improvements in 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.

People's medicines were stored safely and improvements had been made to the administration of medicines to ensure people received them as prescribed.

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 in their role.

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

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

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

### Is the service effective?

Good ●

The service was effective.

The service worked in partnership with other organisations to deliver staff training which followed best practice in supporting children and adults with long-term illness or who approached the end of their lives.

The service worked continuously towards identifying and supporting people in the community with palliative care needs which had resulted in less hospital admissions.

Adults and children were supported by a multi-disciplinary team and experienced care and treatment that was appropriate and promoted their well-being.

Staff understood the importance of people's nutritional needs and staff ensured people's preferences were met.

Staff understood their responsibilities in relation to the Mental

### Is the service caring?

The service was exceptionally caring.

Adults and children were supported by staff who were exceptionally compassionate, understanding, enabling and caring. Staff relationships were valued and they went the 'extra mile' to meet the needs of children and adults.

The service was highly complimented for the manner in which it consistently treated everyone as individuals and with dignity and respect.

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

Outstanding 

### Is the service responsive?

The service was exceptionally responsive.

Children and adults' care and support was planned proactively with them and reflected their choices and preferences. Advanced care plans detailed where and how adults and children wanted to receive their care.

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

Children and adults were given opportunities to engage in a wide variety of activities and therapies that included companionship and socialising with their peers.

The service had developed links with other professionals and the community in order to improve and develop it for the benefit of children, adults and carers.

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

Outstanding 

### Is the service well-led?

The service was well led.

Good 

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

The management team disseminated the vision and values of the service to the staff team. A cultural shift had taken place in the children's service which ensured that all staff were motivated to provide personalised care.

There were systems of governance and audit in place which effectively monitored the quality of the service.

Education, research and training were undertaken to help make improvements to the lives of children and adults with palliative care needs.

# Ellenor Gravesend

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. At our last inspection in 2016 we found the children's service met legal requirements, but the adults' service required improvements.

This inspection took place on 25, 26 and 27 July 2017 and was announced. The inspection team consisted of two inspectors, a specialist adult nurse, a specialist children palliative care nurse, two medicines inspectors and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for family members

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 spoke with twelve adults who used the service, seven relatives and 39 staff. We spoke with the management team including the heads of department for patient care, community services, education and research, wellbeing, human resources, quality, ward sister and children nursing. We also spoke with staff that included the pharmacist, family support worker, play therapist, seventeen nurses, four health care assistants, two housekeeping staff, cook, two volunteers, chaplain and an administrator.

Home visits were undertaken with consent to two adults who received support from the community team; and one child with their parents. We spent time on the Inpatient Ward talking to people, relatives and staff and observed medicines being administered to people. In the adult day hospice we joined some people for lunch and in undertaking an activity. We attended the children multi-disciplinary meeting, a multi-disciplinary meeting at a local GP surgery and a Schwartz round. This is where staff come together to talk about the emotional and social challenges of caring for people. We also received feedback from two children's commissioners of the service, a commissioner and quality lead for the adult services, a paramedic

and nursing home manager.

During the inspection we viewed three children's and six adults care plans and notes to check how their care was planned and delivered. We also looked at eight staff recruitment records; the staff training programme; staff rotas; meeting minutes; six people's medicine records; health and safety records; risk assessments and audits; compliments and complaints logs and quality assurance questionnaires.

## Is the service safe?

### Our findings

People said the staff team made them feel safe when receiving the service. One person told us, "I find the staff very supportive: all of them. The nurses make me feel very comfortable and nothing is a problem: wonderful people". Another person said, "Just sitting and lighting a candle I feel safe and quiet". Relatives said they had the upmost trust for the staff team who cared for their adult family member or child. People said the environment at the hospice was conducive to their feeling of safety. Comments included, "You can have a cry here and sit and think. You can feel good here and feel safe"; "There are lots of calm places to sit. There is a fairy garden and a tree to remember people"; and "The chapel is nice, you don't have to be religious just to sit and chat and think and think of someone".

At our last inspection on 11 and 12 May 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the safe management of medicines. We asked the provider to take action to make improvements. The provider sent us an action plan in August 2016 which stated that they would comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by the end of September 2016.

At this inspection we found that improvements had been made to the administration, recording, handling, storage and disposal of medicines to keep people safe.

The service had reviewed and updated its medicines policies and changes had been communicated to staff. Medicines were stored securely on the Inpatient Ward and only relevant staff had access. A secure storage facility was available to store people's own medicines visiting the day care unit. All medicines, including emergency medicines and oxygen were stored appropriately and were within their expiry date. Staff monitored room and fridge temperatures where medicines were stored; these were within the required range and were safe to use.

Controlled drugs were stored safely. Staff checked stock levels of controlled drugs (medicines requiring closer monitoring and extra security) daily and records were made in the controlled drugs register. Staff disposed of all medicines safely and kept appropriate records.

A community pharmacist visited the service three days a week to provide a clinical review of people's prescribed medicines. A pharmacy technician provided a top-up service to ensure there were sufficient quantities of medicines available when people needed them and stock lists were reviewed regularly. The pharmacist had carried out an audit of medicines processes and the management of controlled drugs. Staff were implementing an action plan to improve upon areas that had been identified through the audit.

Most staff had received medicines training. Although competency checks of some nurses for the safe administration of medicines via a syringe driver (device that administers medicines slowly) were incomplete, we were told that these nurses were not currently administering medicines via syringe drivers. Staff were knowledgeable about the medicines they administered and made a number of checks throughout the process to ensure safety was maintained. The process was methodical and hygienic and staff took time to

reassure people and check that they were comfortable. Documentation was completed appropriately after medicines were given.

Medicines were prescribed by speciality doctors and one nurse had undertaken extra training to prescribe. Medicine charts were legible. Prescribers had included indications for the use of medicines and medicines prescribed on a 'when required' basis had information about the frequency that doses could be given. Some people were prescribed medicines administered in a patch. Staff recorded where on the body these were applied. This meant staff could check that they were still attached to the person and new patches could be applied to a different area of the body to prevent skin irritation.

In the day care unit people's medicines were prescribed and stored appropriately and a separate room was used to administer medicines to ensure people's privacy and dignity was maintained. Staff reported medicine incidents and these were reviewed by the manager and shared at medicine group meetings. Medicine safety alerts (national alerts about faulty products) were received by the service and appropriate action was taken.

Safeguarding was at the centre of the organisation. There was a separate safeguarding lead nurse for children and adults whose roles were to oversee all safeguarding concerns. The leads gave examples of how they had contacted and worked with other professionals when they had received concerns and a child or adults safety. Safeguarding was discussed at each multi-disciplinary team meeting. At the children's meeting, a discussion took place about a family that was under pressure in caring for their child. The service had been involved in other meetings about this child and had helped them to get additional services and input to support the family and ensure the child could safely remain in their care.

There were safeguarding and whistle-blowing policies and procedures for children and adults. Whistle blowing is where staff report any poor practice at the service without any fear of recrimination. Staff demonstrated they understood the importance of following these procedures to keep everyone safe. They gave examples of when they had identified safeguarding concerns and the action they had taken to raise them in the service or make immediate referrals to other professionals. The policies set out the different types of abuse, staff's responsibility to act on and report any concerns, and the circumstances when the local authority, police or medical services should be contacted. All staff, including those not directly involved in people's care, such as retail staff, received training in safeguarding children and adults. For care, nursing and clinical staff, this was provided at induction and via yearly updates and included discussing scenarios to ensure staff knew how to relate safeguarding policy to day to day practice.

Risks to children and adults were appropriately assessed, effectively managed and regularly reviewed. These areas of risk included any potential hazards in the environment and in relation to nutrition, medicines, falls, nutrition, skin integrity, mobility and behaviours that may challenge others. Staff understood the control measures in place to help minimise the identified risks. For example, for children and adults assessed as at risk of choking guidance was in place giving clear directions about how to support them to eat and any specific diet they required. Children and adults at risk of developing pressure ulcers had the specialist equipment they required and guidance was in place about how often they needed to be moved position to keep their skin healthy.

There was a clear procedure to record and respond to any accidents, incidents or near misses such as if a person fell, developed a pressure sore or there was a medication error. Staff were asked to reflect on the event and to record why they believed it happened and what they were going to do to minimise its reoccurrence. An administrator had been appointed to oversee all clinical incidents. Events were investigated and reviewed by the appropriate senior member of staff, such as the wound care lead or falls

lead, dependent on the issues involved. Significant events were discussed at governance and board meetings to see what the root causes were and any lessons to be learned. Staff attended Child Death Overview Panels. This is where the appropriateness of professionals' response and any other relevant factors were assessed to consider how an unexpected child's death might be prevented in the future.

A programme of audit, improvement and review was in place to ensure the safety of the environment for people, staff and visitors. The lead for health and safety had regular meetings with other heads of department to ensure that assessments of risk were suitable and up to date and reported on progress to the risk governance group. Policies and procedures in relation to health and safety had been summarised so that each member of staff knew their aim and which procedures applied to them. Regular checks were undertaken of equipment and services such as gas, water, electricity, fire equipment, hoists, beds and medical devices. Fire drills were held to ensure all staff were confident and knew their individual responsibilities in evacuating the building and keeping people safe.

The service had a business continuity plan for emergency situations such as if there was flooding, gas or electricity failure or a major incident. This plan was tested by the use of a scenario that a nearby petrol station was on fire. Staff assessed the action they needed to make people safe, such as evacuating people or moving them to a place of safety. After the event reflection took place on what staff did well and any lessons learned. This was to ensure that staff knew what action to take in the event of any emergency.

People and relatives said there were sufficient numbers of staff available to meet their needs. "If I pop my head out of the room there is always someone around to help me", a relative in the Inpatient Ward told us. The service used a specialist tool to assess staffing levels. The staffing rota was consistent and reflected the staff on duty on the days of the inspection. During the inspection there was ample staff available on the Inpatient Ward and in the day hospice to respond quickly to people's care and treatment needs. A ward manager was responsible for the day to day running of the Inpatient Ward and they were supported by registered nurses and health care assistants. The day hospice was managed by a team of nurses and health care assistants. Community services for children and adults each had a lead and were organised around geographical patches to ensure continuity of care. Each community service consisted of teams of experienced, specialist nursing staff and health care assistants. Nurses were available for core hours and there was an on-call rota so assistance and support was available when needed.

The service employed some nurses and health care assistants on a flexible basis to ensure there were staff available to cover absences and vacancies. Agency staff were used to cover any shortfalls in the in-patient unit and a stable team was used to ensure consistency of care. Nurses said they were able to move and support a different team if they needed more staff at a particular time. In the children's service staffing hours were flexible to meet children's needs. Health care assistants were employed to cover seven days a week including evenings. This meant that parents could receive respite care at the times they required.

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

Disciplinary procedures were set out in the staff handbook. They included the expected standards of staff performance and behaviours and what performance and behaviour may lead to disciplinary action. The service had followed these procedures to ensure that staff working at the service were of good character and

had the necessary skills and knowledge to carry out their duties.

There was a lead nurse for infection control whose responsibilities were to identify and monitor the effectiveness of infection control procedures in the service. Two health care assistants had been identified as leads on the Inpatient Ward and carried out monthly infection control audits such as handwashing, commodes, catheter care and mattresses. An infection control audit was carried out yearly and an action plan was in place which identified areas for improvement. Hand wash gel and sanitiser was available throughout the In Ward and day service and staff used this throughout their day. Community staff said personal protective equipment was available and accessible.

The service was clean throughout the three days of the inspection. Housekeeping staff took pride in the quality of their work, understood their roles and responsibilities, followed schedules of cleaning and undertook regular checks to ensure all areas of the service were cleaned to the same standard. A new piece of equipment had been purchased to more effectively undertake deep cleans. Staff understood how to effectively manage any outbreaks of infection or spillages. These checks helped ensure all service were sufficiently clean and to reduce the risk of infection.

## Is the service effective?

### Our findings

People and relatives said the service was effective as staff had the skills and knowledge to give them the individual care, treatment and support they needed. One person told us, "Staff are all so experienced you don't mind asking them anything. Sometimes you can feel a bit silly about some of the stuff that can worry you but the staff just make you feel okay and always seem to know the answers". A relative said, "We know mum is being looked after by really skilled staff. The nurses and volunteers, they are fantastic".

Commissioners told us the service focused on the continuous professional development of the staff team. One commissioner said, "The service advocates the importance of staff reflection and supervision and ensures staff are up-skilled".

The culture of the service focused on ensuring staff received the support they required to provide a quality service. This included reflective practice where staff personally and critically reflected on their work, on what they are doing well and what they need to do better, to ensure continuous learning. Schwartz rounds' were regular events and open to care and non-care staff. These offered staff a safe place to talk or to just listen to staff's experiences and emotions of caring for people and to support one another. Each session looked at a different issue such as 'The care never stops- carers who care at home and at work' and 'The family I will never forget'. The events were excellently facilitated by the wellbeing lead who ensured everyone's feelings and comments were valued and pulled together key themes to conclude the meeting. A journal club had been jointly set up with the children's and adult's service to provide reflective and self-care strategies for staff. The club was based on national research which identified how staff stress could have a negative influence on the care staff provided and ways to minimise this risk through self-care strategies. Staff shared learning across the organisation by reading set articles and discussing them. The paper for the next meeting was, 'I can't tell my child they are dying: Helping parents have conversations with their child'. Weekly team debriefs were available with the head of well-being team and individual debriefings could take place when required. Each staff member was allocated a supervisor from whom they received clinical supervision. An external supervisor with extensive experience in children's palliative care had been sought to support children's nurses. Children's nurses said this gave them specialist support they needed, from a person who was independent of the service. Staff appraisals had been booked for all staff and the majority had been completed.

The service worked in partnership with other organisations to make sure they were training staff to follow best practice and where possible, contribute to the development of best practice. The service was the first hospice in Kent to deliver Level 3 End of life care and dementia training in health and social care. It demonstrated partnership working with the local Alzheimer's and Dementia group in delivering this programme. This included regular action learning sets and reflection on practice. This meant that adults who were known to the service could continue to receive care and treatment from staff who had the specialist skills to support them at the end of their lives. In partnership with Health Education England the service offered a range of training including compassion awareness, 'sage and thyme' and verification of expected death. 'Sage and thyme' trains staff how to effectively communicate and respond to people who are distressed or concerned by actively listening and prompting the person to consider their own solutions. Nurses who undertake verification of expected death training and assessed as competent are able to verify

expected deaths at a person's home. This negates the need for a medical practitioner to attend after a death and so family members benefit from less professional intervention at this emotional time.

The service sought to continually improve the care and treatment of children and adults by identifying and implementing best practice in end of life care. Commissioners said the service had been effective in reducing the numbers of children and adults admitted into hospital. One commissioner told us, "Ellenor have prevented the children in their care from being admitted into hospital through the innovative interventions they have put in place in the child's home. This empowers the family and gives them the reassurance and confidence to manage their child's condition themselves without impacting on high end and costly services and most importantly enables the child to remain in the local community". Another commissioner told us, "The service has made such a difference to people in care homes, supporting them to keep them in the community and out of hospital. Patient care is their priority and they work with us to ensure this".

People experienced good healthcare outcomes as staff actively ensured they reached people in the community who would benefit from their services. The 'Care Home Support team' had undertaken a pilot project to contact all nursing homes in the local area to identify each adult with a life-limiting condition. This meant the service was able to offer advice and support in the early stages of their care. The team continued to be available to people in residential care homes for advice and support through the referral process. All referrals were triaged and any people referred from residential homes were usually seen on the same day the referral was received. The team had grown from supporting 140 people in January 2017 to 770 people at the time of the inspection. A pharmacist had joined the team whose role was to review people's medicines which could become quite complex at their end of their lives. They were also able to prescribe medicines, which were essential in people's last days to ensure they had effective pain relief and as comfortable a death as possible. This meant the team provided specialist holistic care without the need for further referrals which may be time consuming at these vital and emotional times.

Through a pilot scheme the service had met with all GPs in the local area to identify people with end of life care needs so they could offer the appropriate care and support. Through this process the service had identified over 300 people whom they could offer support and so help them to remain in their own homes, in preference to spending their last days in hospital. There was an ongoing positive and effective relationship with GP's which meant the service's nurses and GP's had regular discussions about people's care needs and the best ways to meet them.

The service had a head of education who was responsible for overseeing staff training and development. There was an on-going, classroom based programme of staff training which helped to embed staff's knowledge through the use of practical scenarios. New staff received a comprehensive staff induction and training for their specific role. This training plan depended on whether the staff members were clinical or non-clinical and if they had direct contact with adults or children using the service. For example, volunteer programmes included customer care and children's health care assistants included oxygen therapy and emergency medicines. All staff had received training in supporting people at the end of their lives and bereavement. For volunteers this was an awareness of the impact of illness and loss. The training programme for 2017 included training in medical gases, wound care assessment, nutrition and hydration and first aid. Lunch and learn sessions took place on a regular basis where staff discussed a number of relevant topics such as pain and symptom control, issues about resuscitation, sedation and cancer pain management. Nurses were supported 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.

The service had developing a clear career progression for health care assistants who were all trained to Level 3 Health and Social Care Award with a speciality in long-term conditions. A Level 5 Assistant

Practitioner Diploma was run in partnership with Croydon College. One staff member had commenced the two year course and another had completed it. The service had confidence in these staff members and invested in them for the benefit of children and adults. The staff member who had completed the course was competently managing the children's respite service. National palliative care guidance by the Royal College of Nursing had been followed to create a pathway to develop Clinical Nurse Specialists (CNS). A palliative care CNS is an expert at diagnosing and treating people with life-limiting conditions. This involved a package of training and competency assessments and additional support and supervision. One children's nurse had qualified as a CNS and another nurse was undergoing this training.

Health care for children and adults was provided by a multi-disciplinary team made up of a consultant, specialist doctor, specialist children and adult palliative care nurses, physiotherapist and health care assistants. Referrals to other healthcare professionals were made as necessary including dietician, speech and language therapist, occupational therapist and tissue viability nurse. Children's nurses had strong working relationships with other professionals and regularly undertook joint home visits. Weekly multi-disciplinary meetings (MDT) were held for children and adults with a clear agenda which included discussing their needs, joint working to ensure these were being met, and to prioritise actions. At the inspection the children's MDT was attended by the whole team, and the local community teams joined at the end for additional discussions. The doctor from the adult team and the head of well-being attended to offer support. The meeting was professional, well organised and the child and their whole family was put at the centre in considering what the service may be able to offer.

People were complimentary about how the service encouraged them to eat and gave them food choices. One person told us, "The food is very good. There is a choice and you can change your mind. They cook it here and nothing is any trouble. The dining area is so well looked after and all the volunteers serve you". Another person told us, "It is like a hotel. I love the lunch as there is always a good choice". A relative told us, "We have been so worried with mum at home and not eating properly. They have got that sorted here".

Children and adults' nutrition and hydration needs were assessed and the individual support they required was included in their plans of care. People in the Inpatient Ward were offered hourly comfort checks, which involved offering drinks and mouth care. Children's plans included their likes and dislikes, dietary needs, ability to feed themselves and whether they experienced nausea or sickness. Advice was sought from other professionals about the consistency of a person's diet and fluids, to aid their swallowing. Therefore, children and adults had access to the specialist support they required to ensure they had adequate nutrition.

Catering staff were flexible in their approach to providing meals due to people's changing health and preferences and went out of their way to meet them. For example, the cook described how they had cooked three breakfasts for one patient on the day of the inspection. The person had requested the first two breakfasts, but they only felt like eating when they were given the third choice. Special events such as birthdays and weddings were celebrated according to people's specific requirements. Staff understood the importance of presenting food that was appetising and nutritious and understood people's likes, dislikes and patterns of eating and drinking. The cook explained that one day-patient only liked omelettes and chips so they always prepared this meal for them. A Sunday roast was always provided at the weekend and was available to people and their family members so people could eat and spend time together as they would as if they were at home. There was a microwave for families to use, should they wish to bring in food for people which they had prepared.

Meals were provided on the Inpatient Ward, in the day hospice and at some children's activities. The lunchtime meal in the day hospice was a focal point for people to come together and socialise, and was presented as a special occasion. The tables were beautifully laid with flowers from the garden that

volunteers had picked. There was a calm and pleasant ambience where people engaged in conversation with staff and one another. People who required assistance were supported by staff in a respectful and dignified manner.

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 principles of the MCA and understood their roles and responsibilities in relation to this legislation. When a person had been assessed as lacking mental capacity to make a specific decision, a meeting had been held with their next of kin or representative, relevant staff and professionals, to make a decision on their behalf and in their best interests. For children under 16, staff gained parents' consent, but also gained children's consent when they believed the child understood what was involved in their care and treatment.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to hospices. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The service had made applications to the 'supervisory body' to ensure it was not acting unlawfully in making a restriction on people. This included when people were unable to leave the Inpatient Ward unaccompanied or were subject to constant supervision. Staff had considered the least restrictive options.

Some people's care records contained 'do not attempt resuscitation' (DNAR) forms. This is a medical order written by a doctor, which records instructions relevant to resuscitation. A copy was kept in people's electronic records to alert staff. This information was also shared with the ambulance service so the crew could contact the service to prevent people from unnecessarily being taken to hospital. During home visits nurses explained what a DNAR involved in an informative and extremely empathetic manner. They encouraged all members of the family to be involved in the decision as it would have an impact on them. There were on-going discussions about DNAR's as people sometimes changed their minds in relation to this important decision.

## Is the service caring?

### Our findings

Everyone told us that staff were exceptionally kind, caring and compassionate in the support they provided. Comments from people included, "I was referred here for emotional support as I was in such a state but everyone is so respectful. I wondered how staff would treat me here and what the future held, but they make you feel very special"; and "I find staff here so caring and thoughtful. They cannot do enough: They make you feel special and respect me". Relatives explained how staff enabled their family members to relax in their presence and to be themselves. "Our main children's nurse is a guardian angel and a friendly voice on the phone", one relative told us. Another relative described how the caring nature of the service permeated the whole staff team. "They are caring from the point you enter reception all the way to the Inpatient Ward. The cleaners are always here, asking us not to move [while they carried out their tasks] and chatting with us". They described how a staff member had held their hand when discussing and explaining their family member's last few hours and how this had reassured them and made them feel less afraid. People also said the environment in the Inpatient Ward was set out in a way which enabled them to have privacy. One person told us, "There are lots of calm places to sit. There is a fairy garden and a tree to remember people"; and another person said, "The chapel is nice, you don't have to be religious just to sit and chat and think and think of someone".

The service continued to be exceptionally caring, had maintained these practices since our last inspection and had continuously worked towards further developing and nurturing these areas for the benefit of children, adults and their family members.

The service had used the Schwartz round as a basis and developed it in an innovative and creative way to focus on the experiences of people who used services, rather than those of staff. The Schwartz round which took place during the inspection was called, "From the horse's mouth- what it is really like to be referred to Ellenor". In this meeting, people who used services and relatives were given the opportunity to share their story and their emotions, to help staff see things from their point of view. The session clearly empowered people and enabled staff who attended to understand their emotions and the areas in which they were supporting people extremely well. People who attended were asked for their feedback about what they had learned and how it would inform their practice for the benefit of people. This demonstrated that the service had a strong, visible person-centred culture and was exceptional at helping people to express their views.

Bereavement services were tailored to childrens' and adults' individual needs, were provided over a significant period of time after death and were continually developed to meet local need. The service had extended the 'Bereavement cuppa's' meetings from Dartford and Gravesend to Swanley. This is where people could explore their feelings in a safe, informal setting and gain support from others with similar experiences. Although the sessions were open to people who had cared for someone with palliative care needs, when people who did not fit this criteria had attended, they had been welcomed and integrated into the group. This meant that all people who may be affected by someone's death were embraced by staff who were empathetic and inclusive. Bereavement support was available for adults before and after bereavement by a counselling team of staff and volunteers. Families were invited back to the service following the death of their loved one to a 'bereavement tea', to talk about their experiences.

A play therapist supported children with exploring painful feelings and distressing experiences that they may not be able to say with words, through play. A play and music room was available at the service that was used for that purpose. 'Grief: Every memory is special' bereavement days were held for small groups of siblings and children of adults who had died at the service. These were therapeutic sessions involving fun activities, food and music. Feedback from parents about these sessions was very positive. One parent feedback, "We have been looking for this for our daughter since x passed away. She needed to know she was not alone about losing someone special. I was reassured by the sound of laughter and giggles". Each child who was grieving was given a soft toy elephant representing the service. There were also a number of bereavement 'drop in' days and plans were in place to extend these to include grandparents in addition to parents and siblings in response to local need.

Adults, children and their family members valued their relationships with the staff team and felt they often went 'the extra mile' for them, when providing care and support. As a result adults, children and their family members felt really cared for. The service held special events at the service if people were not able to attend them in the community due to their health. This included a special meal for one person which was set up as though they were in a favourite restaurant; a mock wedding complete with a pretend wedding dress and cake; and a fancy dress party for one person's special birthday which was arranged at the family home, but moved into the service at short notice. Children's nurses gave examples of how they had given support in a caring, compassionate and individual manner, based on the child's and families wishes. They supported young people to express their wishes and help them come true. One young person wanted to attend a specific sporting event in London. The service obtained a special family seating enabling them to view the show and transported them to the event. An adult person had had to cancel a trip to an animal park due to ill health so staff suggested bringing the animals to the hospice so they could see them. This person was excited about the idea and asked the staff member to follow it up for them.

The provider was mindful of the emotional challenges staff experienced and understood that a resilient and valued team was essential to ensuring staff remain caring. A journal club had been jointly set up with the children and adult service based on national research into self-care strategies. At the meeting staff shared learning across the organisation by reading set articles and discussing them. The paper for the next meeting was, 'I can't tell my child they are dying: Helping parents have conversations with their child'. Therefore, the service recognised that staff stress could have a negative influence on the care staff provided and had strategies in place to ensure staff were effectively supported to enable them to provide caring and compassionate care.

Relatives said staff were thoughtful and exceptional at communicating with children and adults in a way they could understand. They said staff explained how they were going to support a child or adult even if they were not able to respond verbally. One relative said staff were excellent at explaining their family member's plan of care and the different treatments and whether they would benefit them. Any requests made with regards to people's care was attended to and nothing was too much trouble. "It is the little things that make a difference", a relative told us, and "My wife prefers to lie in bed on one side. We told a member of staff one evening and the next morning she was lying on that side". Another relative told us, "Mum has only been here about an hour and staff are just settling her in. She has already been given her favourite food; a bowl of custard. She loves it and staff remembered". A commissioner told us. "The service has a heart. Patient care is their priority".

The service had received compliments and feedback which demonstrated the service was meeting its vision of providing compassionate and professional care and supporting the 'whole family' before, during and after a death. Comments included, "Thank you for the compassion and kindness"; "Like a comfort blanket of care"; "You were a team of professionals"; "I don't know how we would have managed without the constant

advice, support, compassion, understanding and listening ear"; and, "Thank you so much for all the help, advice and support you have given my child and us as a family. It made life just that little bit easier".

Ensuring that staff supported people in a caring and compassionate manner was embedded in the service. The values of consideration and compassion were demonstrated by all staff including non-care staff such as cleaning and kitchen staff, showing that they were part of the culture of the service. Staff were passionate about their roles and described these in positive terms such as 'a privilege', 'rewarding' and 'enabling me to give something back'. They described their enjoyment in not being rushed but having the time to care for adults, children and their families and giving them "the best care that they deserved." Staff interactions with people throughout the service were warm and staff showed genuine empathy and interest in people's well-being. For example, in the day service if a person was sitting by themselves, a staff member or volunteer would discreetly move towards them to provide companionship if they wished. They were very skilled at continuing with the conversation if the person wanted to engage or blending into the background if the person wanted to remain with their own thoughts. During home visits children and adult nurses demonstrated they were skilled at communicating with people and their family members in a way which gained their trust and respect. Staff described situations with challenging family dynamics and how they had worked hard to overcome these to ensure the child or adult was put at the centre.

Family support was seen as key to children and adults wellbeing. The family support worker provided support, advice and emotional support to adults, their relatives and carers. Carer's courses were run in partnership with a charity which provided bespoke support for carers. These courses were run on a regular basis and included how to move and handle people safely, what does it feel to be like a carer, 'what does dying look like', nutrition and finance. Feedback from these sessions was that people benefitted from the support from each other and therefore the 'Carers cuppa' developed. This is an informal support group for carers run with the support of volunteers. The 'carer's cuppa' then developed into the 'bereavement cuppa' in accordance with people's needs. Family members were able to stay overnight in the Inpatient Ward, either in their room or in separate en-suite accommodation. They were also able to purchase breakfast and an evening meal from the kitchen staff, if they wished. Therefore, relatives were enabled to offer continuous support and comfort to their loved ones at the end of their lives.

A new chaplain had been appointed to the service but had not commenced employment at the time of the inspection. The volunteer chaplain explained the aim of the chaplain's role in making connections with people of any faith or none, to offer a listening ear and give spiritual support. They explained how they endeavoured to read people's body language to understand how people were feeling and assess whether it was a good time to chat, or to come back later. The chaplain put people at ease and was guided by the person as to whether they wanted to talk about their religious beliefs or if they just wanted to them to listen to their talking about their emotions and feelings. They had contacts with spiritual leaders of other faiths represented by the local community, who they could call on when needed. The chaplain took time to get to know people well and had been asked to undertake blessings for families when they had not been able to attend church. There was a chapel where people could go for quiet, peaceful contemplation and reflection and they could light a candle for prayer or remembrance. A 'Memory Tree' was on display in the main area, where people could purchase a small plaque with their loved ones name. There was also an on-line memory book, where people could write the story of their loved ones and add pictures as a way of remembering them. A laughter tree was on display in the Inpatient lounge where people had written about things that made them happy. To help people through the grieving process a number of memorial services were held throughout the year, including a 'Lights of love' at Christmas. This ensured that people could remember and celebrate the lives of loved ones, who were no longer with them.

## Is the service responsive?

### Our findings

People and their relatives said that the service responded extremely well to their needs in all aspects of their care and treatment. They said the service provided continuous care for adults as it supported them in the community and continued to do so if they moved to a care or nursing home or into the Inpatient Ward. One adult told us, "I wasn't sure about a hospice and thought 'what's that all about?' Now I feel so different about it. There is so much going on and everyone listens to you. But you don't have to talk about stuff if you don't want to". One relative told us, "If we need anything sorting out, such as getting results from the local hospital or arranging equipment, the children's nurses will sort it out for us".

The service continued to be exceptionally responsive since our last inspection and had continuously worked towards further developing these areas for the benefit of children, adults and their family members.

Feedback from commissioners was that people received care that was personalised and responsive to their needs. They said staff sought people's views, acted on them, and signposted them to other services if they were unable to meet all their needs. One commissioner told us, "Listening to the views of their patients is very important to Ellenor and this helps them to continuously improve on the services they provide". Another commissioner told us, "Satisfaction surveys clearly demonstrate an outstanding standard level of care". A children's commissioner gave an example of how improvements to the food were being made at children's activities as a direct result of feedback from parents. Children, adults and their family member's views were sought with regards to all aspects of care so the service could respond to them. For example, before purchasing new chairs for the day service people were asked to review a selection of chairs in order to decide which ones were most suitable. As a result, people felt involved in decisions and that their opinions mattered.

Adults and parents were extremely complimentary about the social, complimentary and therapeutic activities available which met individual needs and had a positive impact on their well-being. They said these events enabled them to meet other people in a similar situation, gave them companionship and reduced the risk of them becoming isolated. Comments included, "I come here most weeks. It is good fun. Staff make it okay so you feel you can join in"; "It is good to have a stretch as it makes you feel better"; and "I am learning to do a shimmy. I will be dancing soon!" and, "Good variety of activities for the children to do. We had time to relax, chat and have coffee and cake". Children were asked what they liked best about the activities they took part in and one responded, "Having a pizza for lunch".

The service had developed an extensive range of health, social and therapeutic activities available as a direct response to the needs of children and adults. There was a structured programme of activities, some of which needed to be booked in advance due to their popularity. Complimentary therapy, such as aromatherapy, was offered on an individual basis. Groups included music for well-being, cooking, poetry, meditation and breathlessness, gardening, spiritual reflection, an after school club and a tea and movie night. Activities offered respite for carers who were able to leave their relative in safe hands. Some activities involved children or adults and their carers. For adults this included gardening, relaxation and art groups. Family drop-ins were held in school holidays and gave parents and carers a chance to meet other families,

to exchange experiences and share some mutual support and fun. As families were enabled to meet other in similar situations, they felt less isolated as they supported each other.

A major piece of work had taken place in the children's service to design and implement a transition tool to support early identification of needs and assist with proactive planning for adulthood. This was based on research and a core care pathway for children with life-limiting life-threatening conditions. It involved the service proactively encouraging partnerships with other teams in the community and across the organisation. The pathway had begun to be implemented at the time of the inspection and as a result a home visit on one day of the inspection involved the children's nurse, transitional worker and assistant practitioner meeting with a family. This was to jointly discuss and agree their needs and goals in a measurable way which included answers to the questions what could be done, why was it needed and who was responsible for ensuring happened. A new framework had been developed in line with national guidance to ensure there were stronger links to neo-natal services so families with unborn babies with life limiting conditions were fully supported. The service employed nursery nurses to undertake the care of young babies.

Services took into consideration the needs of young people and those transitioning from children's to adult services. Young people could access the Inpatient Ward to receive respite care, in a way that met their individual needs and wishes as teenagers. This could include activities and themed sleep-overs. One young person had received support from the children's service, but did not meet the eligibility criteria for the adult service. This is a national issue in hospice care with young people transitioning between children and adult services. The multi-disciplinary team held a brain storming session and came up with lots of ideas about how existing adult day services and groups could be adapted to meet their needs, so they continued to offer some support, until the young person met the criteria.

There were a number of initiatives to engage local communities that were underrepresented in the service. As members of the Learning Alliance for Palliative Care and End of Life Care, the service had participated in a one day event aimed at Black, Asian and Minority Ethnic groups to discuss how to engage them in palliative care services. A second event was planned in September for Eastern Europeans and Travellers. Work continued to engage the Sikh community. During the inspection the service had a call from the ambulance crew about a member of this community. A nurse went to the person's home and stayed with them until their death, to ensure they died at home as per their wishes and those of their family. Tours of the Inpatient Ward had been provided in Chinese to help people understand the philosophy of the service and the facilities and services it could offer.

Staff responded to people's specific cultural and spiritual needs in order to enhance their sense of well-being. A person from Eastern Europe was admitted to the Inpatient Ward, but they did not speak any English. A member of staff was able to provide translation services when necessary. Their food preferences were sought and a special meal of their choice was prepared at Christmas which consisted of fish rather than turkey. The cook said the person communicated their enjoyment and appreciation of the meal by giving two 'thumbs up'. Staff ensured they maintained a relationship with their family through social media. Another person resided at a care home which provided care for people with specific spiritual needs where they did not receive any medical interventions. The service developed a bespoke package of training for the staff team so they could recognise the signs of dying and provide people with the spiritual support at the time they needed it.

The service responded to local need and was actively involved in building links with the community which had a positive impact on people's quality of life. Staff thought of a creative way to improve communication with emergency services and respond to people's needs. For example, adults who used the service were

provided with a fridge magnet stating they were known to the service and were flagged in ambulance records so the service was immediately contacted if an ambulance was called. The service was continuously educating ambulance staff about this and had provided them with key rings and phone stickers with their contact details. As a result there had been a reduction in people known to the service being admitted to hospital, without other alternatives first being considered.

A home nursing service for children and young people with cancer was available who were undergoing active treatment at their specialist hospital, which was located in central London and Surrey. This enabled the child to live as normal life as possible, receiving treatment in the comfort and familiarity of their own home from a nurse who they knew well and prevented frequent long travelling times.

There was a rapid response to children and adults changing care needs as advice on care and support was available around the clock. A duty nurse was allocated in the children's and adult's team to be on-call who had access to their medical records and notes which were held on a computer system. The aims of the children's duty system had been reviewed and as a result was more responsive to the needs of the child and their parents. Adults and children's records flagged any risks or important information and these were shared and discussed at MDT's. A clear protocol was in place whereby issues could be escalated to the clinical nurse specialist, doctor or consultant. This gave people the assurance that they or their family members could seek medical support or advice at any time and enabled people to remain at home, according to their wishes.

Adults and young people's care and support was planned in partnership with them and their family members. Assessments of need were carried out which looked at the person as a whole and included all aspects of their physical, mental, emotional and spiritual needs. The needs of carers were included in this process and this information was used to develop services which responded to their need, such as carer's courses and 'cuppas'. They were also actively signposted to other relevant organisations which may be able to support them such as Alzheimer's Society, and 'dementia and young carers'. Advance care plans were developed which let the person's family, carers and professionals know what was important to them in the future, when they may be unable to make their views known. This included people's preferred place of death, symptom and pain management, spiritual and family support and decisions about which treatments they would prefer or decline. Young people were empowered to be as fully involved in this process as they were able. A pain score tool was used to monitor pain so their medicines could be adjusted accordingly. Where children or adults were not able to verbalise their pain, staff used non-verbal clues and feedback from relatives, to evaluate the level of discomfort the person was experiencing. Staff talked knowledgeably about children's and adults care, about how to provide individual support, and were aware of decisions they had made before death that must be respected. These plans were regularly reviewed and evaluated to reflect changing needs. This ensured that children and adults were supported at the end of their life by staff who understood how to support them to have a comfortable, dignified and pain-free death.

The service took part in initiatives to raise awareness of the importance of talking about dying, death and bereavement, such as 'Dying matters week'. This involved nurses and health care assistants talking about the work they did in the community. This benefitted people using the service by helping the public to feel more confident in talking about death and dying, which may include people's family and friends.

People and their relatives said they did not have any concerns or complaints about the service, but said they would feel confident to approach any member of staff if they needed to. One relative told us, "Staff are fantastic here they just cannot do enough. When we are worried about something we just say and they do something about it". When people were first known to the service they were given an information pack which included information about how to make a comment, compliment or complaint about the service.

These leaflets were available around the service. Staff knew what they should do if a complaint was raised. The service's complaints process had been reviewed by the clinical commissioning group quality team and learning points had been identified which the service was addressing. Any complaint raised had been investigated and the complainant had been informed of the outcome. This included root cause analysis investigations as appropriate. An analysis of all complaints, including non-clinical complaints was undertaken to assess if there were any patterns, trends or lessons learned. The service used complaints as a learning experience and additional staff training and reflective practice had taken place to minimise the recurrence of a similar complaint being raised. Complaints had been reviewed by the clinical commissioning quality team and changes had been made to the process. Commissioners told us they had not received any complaints about the service.

## Is the service well-led?

### Our findings

People and their relatives were very complimentary about the way the service was managed and their day to day experience of staff and management. Everyone told us they would have no hesitation in recommending the service to others. Commissioners of the service praised the service for the quality of care it provided children and adults with life limiting conditions and at the end of their lives. One commissioner told us, "Ellenor are solutions focussed and forward thinking and are always looking at ways of improving their services either through innovative use of IT or researching new thinking". Another commissioner told us, "Our relationship with the service is so refreshing. We discuss a gap in end of life care and Ellenor look at it and put forward a proposal. They then carry it through for the benefit of people".

At our last inspection on 11 and 12 May 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always kept accurate records in relation to people's care and treatment. There had been inconsistencies between paper and computer held records with regards to the care and treatment of people in the Inpatient Ward. We asked the provider to take action to make improvements. The provider sent us an action plan in August 2016 which stated that they had reviewed and made changes to the way people's records were maintained and would comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by the end of September 2016.

At this inspection we found that care and treatment records for children and adults in the community continued to be well maintained and that improvements had been made to records for people on the Inpatient Ward. Assessments of need were undertaken for people in the Inpatient Ward and a record was made of all associated nursing interventions and evaluations, such as if a person was given fluids, moved position or if a dressing was changed. There remained some inconsistency over where staff recorded this information, but overall records accurately reflected the care and treatment people received to meet their needs.

There was clear management structure, designation of roles and responsibilities and levels of accountability. The chief executive officer was a visible presence and had a programme of structured visits to each service department in order to gain an overview of the service and identify and issues of areas of improvement. Their last visit had been to the children's team in June 2017 when they had given positive feedback to staff due to their continued development of the service.

The registered manager and head of children's nursing were passionate about their roles and highly motivated to continuously drive improvements in the service. There had been a major cultural shift in children's service led by the head of children's nursing. Comments included, "The team was very static for a long time, but we are now going forward as a team"; "The head of children's nursing has been very brave in some of the changes and developments within the team, but it has made a happier team"; and "The team was a bit rocky last year, but now it is much more positive and exciting". As a result, staff had a shared understanding of the aims of the service in engaging the whole family; what services they were able to offer and the reasons why they were not able to offer some services; and an agreed understanding of how each

element of care was provided, reviewed and delivered. The registered manager had an open door policy and had arranged structured open sessions with staff when they had identified that they were finding things more difficult than usual.

Staff were proud to work for the service and understood its mission, visions and values which included involvement, compassion, dignity, independence and respect and they were consistently put into practice. They said they had the confidence to question and challenge the practice of colleagues and managers. Communication with staff was viewed as essential and there was an open culture where staff were listened to and valued. Regular meetings were held with all heads of departments and a general staff meeting was held quarterly. Staff were also kept up to date with what was going on in the service by a monthly staff bulletin. Staff were asked for their views about the services and these were acted on. An action plan had been developed as a result of the staff survey in 2016 and delivered to staff in focus groups. 'You said, We did' was on display at the service and clearly set out what staff had requested and the service's responses. For example, staff said they wanted to be paid fairly and the service had reviewed the pay policy and held surgeries for staff so they could understand the changes. The 2017 staff survey had been launched based on the 'bird song' survey, which was a national staff satisfaction survey, benchmarked by hospice UK. Staff were also kept up to date with what was going on at the service through a monthly staff bulletin.

The service encouraged open communication with children, adults and their family members. They were asked about their experiences of each aspect of the service through survey questionnaires and face to face discussions so any improvements could be identified and acted on. This included the Inpatient Ward, carer's course, and activities and therapies for children and adults. Families were always invited back to the service following the death of their loved one and encouraged to share their experience of the care received. Surveys had also been carried out of support services such as housekeeping, maintenance and catering. The overwhelming majority of feedback was positive.

A governance framework was in place whereby each aspect of the service, such as health and safety, clinical practice and medicines were discussed in sub groups and their findings were fed to the Board of trustees. A comprehensive audit plan was in place which included medicines, safeguarding, staff training, complaints and infection control. A role of quality lead had been developed with the aim of ensuring care practices were standardised across the service. As a result specific groups for wound care, medicines and nutrition had been set up to identify and disseminate areas of good practice throughout the service. The board of trustees set and reviewed the strategic direction of the service. The service had completed or was working towards all areas identified in the plan which covered the timescale from 2013 to 2018.

The service strived for excellence through consultation, research and working in partnership with other organisations to ensure they are following current practice and providing a high-quality service. The service delivered accredited/nationally recognised qualifications in palliative care. This included a week's programme for 16-19 year olds who were interested in a career in health or social care. The students undertook activities and projects which benefitted people who used the service. The service had provided training in palliative care and related areas to GP's, paramedics and nursing and care staff. The service belonged to numerous organisations to share best practice and help develop services in palliative care. They also attended national conferences. As part of the West Kent Research Collaborative the service delivered two posters and an oral presentation as part of this collaboration entitled, 'Poised for Take Off' and 'Research Activity within the Hospice'. At the Kent, Surrey and Sussex Workforce development event staff gave an oral presentation on how they encouraged school leavers into a career in care. A number of awards had been received which recognised the service's strive towards excellence. These included in 2017 the 'Social Care Award for Best Terminal Illness Support', 'NHS Provider and Patient Partnership Award' and 'Kent Care Award'.

