

Greenwich & Bexley Community Hospice Ltd

Greenwich and Bexley

Community Hospice

Inspection report

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Date of inspection visit:

28 September 2016

12 October 2016

Date of publication:

06 March 2017

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

This inspection took place on 28 September and 12 October 2016 and was unannounced. The service last had an inspection on 5 March 2014 and found that the regulations we checked were met.

Greenwich and Bexley Community Hospice provides specialist palliative care and support within the Greenwich and Bexley Boroughs. We refer to the service in this report as the Hospice. The Hospice has a 19 bedded inpatient ward and provides a community hospice service to people in the London boroughs of Bexley and Greenwich. It also provides a day hospice service, a rehabilitation service, hospital based palliative care service, care homes support service and a counselling service.

On the first day of our visit there were 17 people using the inpatient ward. The provider informed us that 543 people were receiving a service from the hospice at the time of the inspection. This number included people under the care of the inpatient unit, day hospice, community services, hospital palliative care team, counselling team, rehabilitation and the social worker.

At the time of the inspection the service did not have a registered manager. A new manager had been appointed and they had applied to become the registered manager. 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.

Staff were recruited carefully so people could be confident that the staff who cared for them were suitable to do so. The hospice had a number of volunteers who were also appropriately recruited and who received relevant training to fulfil a range of duties.

People were cared for by sufficient numbers of staff to meet their needs promptly. Staff were caring and understood people's and their relatives' concerns. People's privacy, dignity and confidentiality were protected. Staff were well supported and trained for their jobs and people benefitted from their care.

Hospice staff worked well with other health professionals and people benefitted from the coordinated healthcare. Staff promoted the importance of good nutrition and hydration. They supported people to eat meals they enjoyed, to drink enough and to maintain a balanced diet where possible.

Staff were trained in the principles of the Mental Capacity Act 2005 (MCA) and knew when to apply these. People's rights were respected and when necessary decisions were made in people's best interests.

Care planning took people's needs and preferences into account and advance care plans were created as required according to people's wishes and preferences. The provider arranged for a number of social and recreational activities to take place in the day hospice which people using the Hospice services, including in-patients could access.

The Hospice had various initiatives to encourage people with end of life care needs to use their services. These could be people who might not have been referred to or thought of using the hospice's services and included people with dementia, older people within the community and people with diverse needs.

People and relatives had the opportunity to give their views about the quality of the service. They were listened to by staff and managers and people's feedback was used to improve services. The provider had an effective complaints process that people using the service were aware of.

Managers carried out regular audits and made reports to senior managers so they could monitor the quality of the Hospice's services and make improvements where they were judged necessary.

The Hospice was involved in various projects and was part of various groups and initiatives to advance the provision of and improve the delivery of quality end of life care to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. People were looked after by staff who were knowledgeable about how to recognise abuse and the action to take if they suspected people were at risk of harm.

There were enough staff to care for people. The recruitment procedures were thorough and made sure staff were suitable to provide care. Medicines were handled safely and people received their medicines as prescribed.

The building was clean and hygienic. Staff were knowledgeable about the prevention and control of infection.

Good ●

Is the service effective?

The service was effective. Staff were trained and supported to carry out their work. People enjoyed the meals and they were designed to meet their medical and nutritional needs.

People benefitted from the close working relationships between Hospice, GPs, community nurses, hospital staff and a range of specialists involved with people's care.

Staff were knowledgeable about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Good ●

Is the service caring?

The service was caring. People and their relatives found the staff supportive, kind and caring.

People's dignity, privacy and confidentiality were protected.

Health and social care professionals commented positively about the care people were shown by Hospice staff.

Good ●

Is the service responsive?

The service was responsive. People had the opportunity to take part in care planning and staff were familiar with their views and wishes for their care. There was an emphasis on helping people to achieve their final wishes through advance care planning. In

Outstanding ☆

some cases, staff demonstrated that they 'went the extra mile' to meet people's wishes about their lives.

The provider had various initiatives where they took into account the needs of the local community and various diverse groups to make sure all people who needed end of life care, received the care and support they needed.

People were familiar with the complaints procedure and it was well publicised. Complaints were taken seriously and used as an opportunity to improve services.

Is the service well-led?

The service was well led. There were clear management systems which were aimed at achieving good quality care for people. Audits and reviews took place to maintain standards and identify areas for improvement.

Management arrangements were open and staff's views were sought so they could be taken into account when reviewing the quality of the service. The contribution of staff and volunteers to the organisation and care of people who used services was recognised and valued.

Good ●

Greenwich and Bexley Community Hospice

Detailed findings

Background to this inspection

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

The inspection took place on 28 September and 12 October 2016 and was unannounced. An inspector, a pharmacist inspector and a specialist advisor carried out the inspection. The specialist advisor is a nurse with experience of working with people with palliative care needs

Before the inspection we reviewed the information we held about the service. This included the Provider Information Return (PIR) which the provider had completed and sent to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications sent to us by the service. A notification is information about important events, which the service is required to send us by law.

We spoke with six people in the inpatient unit and with three relatives who were visiting. We spoke with the manager, an associate specialist doctor, the estates manager, the chief executive and twelve other people who worked for the Hospice. These included care staff and nurses from the inpatient and community team, human resources staff and two volunteers.

We looked at personal care and support records for six people. We looked at other records relating to the management of the service, including medicines records, audits, complaints and compliments, health and safety records. We also looked at records relating to human resources, including recruitment records for staff. We looked at results of surveys that had been carried out.

Is the service safe?

Our findings

People told us they felt safe being cared for at the Hospice. One person said "I feel safe here." People felt confident to raise concerns about their care with staff, including the manager who visited the inpatient wards frequently and knew these would be taken seriously and addressed.

When concerns were raised they were dealt with quickly and action was taken without delay to keep people safe. For example we heard of a situation where a patient had described the care they received from a temporary worker as "rough". The manager took appropriate and prompt action, ensuring the worker was no longer working with people, reassuring the patient and making a report of the person's work to their employing agency so the person did not work again at the hospice. Relatives told us they felt their family members were well looked after and they felt confident in the staff providing the care.

All staff received mandatory training in safeguarding issues. They were knowledgeable about how to recognise all forms of abuse and the action to take in response to allegations of abuse. Staff understood whistleblowing procedures and how to raise concerns about colleagues' care and work practices, if they had any concerns. One member of staff said, "I know my patients, and I would have no problem whistleblowing if I saw something wrong. Their care comes first".

There were arrangements to protect people from risks associated with their health conditions. Assessments were made of people's risk of developing pressure ulcers. Guidelines were in place for staff to deal with potential risks and necessary equipment such as pressure relieving mattresses were provided. A staff member told us "We take pressure sores and wounds seriously. Sometimes people come with them, but we work hard to heal them or stop them getting worse." There was a proactive approach to ensure signs of problems developing were acted on quickly. A staff member told us: "We regularly check skin during personal hygiene time, and we look for any problems. Then we would work to limit progress of problems and aim for recovery of good skin integrity."

People who were at risk of falling were assessed to identify factors which needed managing to reduce the risks. Falls prevention work had been undertaken and changes to the environment had been made to ensure environmental risks were minimised, for example non slip treads had been added to decking in the garden. We noted that floors were kept clear and clutter free so people's safety while walking was maintained.

When people needed assistance to move, staff demonstrated skilled moving and handling techniques. Assessments of people's moving and handling needs were carried out and recorded. Equipment to move people, including hoists were used when necessary. The correct number of staff to assist people to move was also identified and recorded to ensure the person's safety.

People were protected from risks of fires as the provider had a range of fire safety and fire prevention strategies. The London Fire and Emergency Planning Authority visited the service every six months to assess fire safety and when necessary make recommendations. There were refuge areas within the building where

it had been judged people would be safest to stay in the event of a fire until emergency services arrived. Fire equipment was serviced and tested regularly to ensure it remained in working order. Each day a fire warden was assigned in the service and they would take overall responsibility to coordinate fire emergency procedures in the event of a fire.

The provider had carried out assessments and had plans for responding to emergencies and untoward events. Managers had worked with local authority emergency planning staff to ensure the service was equipped and prepared for an emergency either at the Hospice site or if they were ever required to provide assistance in an emergency elsewhere. A planning exercise was attended by key Hospice staff and representatives from partner organisations including members of the emergency services, local authority, NHS services and the Red Cross. This demonstrated the service had anticipated how they could best respond in an emergency to keep people safe and provide appropriate care.

Adequate numbers of appropriately skilled staff were available to meet people's needs. The service used a dependency tool to assess the necessary staffing levels. People told us they felt there were sufficient staff to assist them. One person said "They [staff] respond promptly", and another told us, "You press the button [call bell] and they come running." A third person told us, "Yes there are enough staff." We heard very few call bells being operated when we visited and those that we did hear were answered quickly.

The provider had recruitment procedures which were designed to help protect people against unsuitable staff working with them. The procedures included comprehensive checks of job applicants' suitability to work at the Hospice. Applicants for posts were required to provide a full employment history with explanations for gaps in their work history, and had to undergo a criminal records check. References, including those from previous employers, were requested, and checked to make sure of applicants' suitability. The on-going competence and suitability of staff was monitored by the provider's management systems. This included checking that staff remained registered with professional bodies, such as the Nursing and Midwifery Council and worked in accordance with their codes of practice. The provider confirmed staff in post when they had successfully completed a probation period of at least six months.

There was a large team of volunteers working for the Hospice, and approximately 90 of them had contact with people who use the service. The volunteers were also required to complete a comprehensive recruitment process which included criminal records checks, references and interviews.

People were protected from risks associated with medicines because there were suitable arrangements to keep them safe. Medicines (including medical gases and controlled drugs (CDs)) were stored securely. Medicines were stored in the clinical room cupboards or in medicines lockers by people's bedsides. The clinical room was clean, spacious and had hand washing facilities.

Medicines were supplied as stock medicines or on a named patient basis from the local hospital pharmacy via a service level agreement. A pharmacist from the local hospital visited the Hospice twice a week for half a day on each visit. Outside of those times, staff could request medicines via telephone or fax from the local hospital.

Staff monitored the current medicines fridge temperature daily. However they did not record the minimum and maximum temperatures of this fridge, nor did they reset the fridge thermometer. The maximum fridge temperature reading on the day of inspection was 21°C. However, we were unable to establish when and for how long the fridge had been at that temperature. The management of the hospice said they would address this matter promptly and make sure the medicines fridge temperature was appropriately monitored and recorded and action taken where necessary should the temperature falls outside of the acceptable range.

Staff did not monitor the ambient temperature of the clinical room where medicines were stored. This meant there was no assurance that these medicines were being stored below 25°C as per the recommendations of many medicines manufacturers to ensure that their medicines remain effective. During the inspection we spoke to a member of staff about this and a thermometer was installed in the clinical room immediately.

There were robust systems for the management of CDs in line with legislation. CDs were transported in tamper proof boxes and stored in locked CD cabinets. CDs were checked daily by two registered nurses. A CD audit was conducted by the pharmacist. The pharmacist was involved in the destruction of CDs and this activity was documented. There was also a robust procedure for the disposal of other unwanted medicines and sharps. There were appropriate procedures for the administration of CD's that staff followed.

Emergency medicines were available in the clinical room in an unlocked cupboard. This was to aid timely access to them should they be required in an emergency. These were monitored closely to ensure they remained in date and were always available.

We checked the prescription charts for five people. Each prescription chart had information on people's allergies. Each chart was clearly written and had been reviewed by the pharmacist. The charts were signed as needed to provide assurance that medicines were given as prescribed. Medicines were reviewed on a daily basis by doctors, and the pharmacist reviewed the prescription charts regularly.

At the time of inspection, no one had their medicines administered covertly but staff were aware of the process to follow should people require their medicines to be given covertly. When medicines are given covertly, it means that they are hidden in food or drink without the knowledge of the person.

When people brought their own medicines into the Hospice, staff assessed the suitability for their use. They did this using a medicines checklist. If a person wanted to self-administer their medicines there was a process to allow for this to happen. This included an assessment form that was signed by the person, a doctor and a nurse. The CD accountable officer (CDAO) was informed if any CDs were to be self-administered. Medicines policies were available to staff and when new policies were published, they were sent to staff to read and staff signed to confirm that they had read them.

People were protected from the risk of infection by the practices within the service. People said they liked the cleanliness, one person said, "It's very clean, they mop the floor and keep it nice". A health and social care professional who visited the service described it as "clean and comfortable" and another commented that during their visits they "had always been impressed by the facilities' cleanliness".

The service was visually very clean in all areas. All care and nursing staff, including those working in the community, were trained in infection prevention and control. A health and social care professional who worked with people who received care from community based staff from the Hospice told us, "Carers have demonstrated very good clinical knowledge especially with topics such as infection risks and pressure sore risks."

Items of personal protective clothing, such as disposable aprons and gloves, were available and used when necessary. We observed staff cleaning their hands before giving care. There were anti-bacterial cleansing gels throughout the building. The Hospice also has a nominated infection control lead who conducts regular audits in conjunction with a Hospice Trustee to help ensure good practice in relation to infection prevention and control was adhered to. Staff had access to an infection control team at a nearby acute hospital (Queen

Elizabeth Hospital in Woolwich) for specialist advice, if that was needed.

Food hygiene was managed well to reduce the risk of infection associated with food. Environmental health officers assessed the food preparation facilities at the service in June 2016. They awarded a rating of five stars which showed the food preparation facilities in the service were well managed and had high standards of hygiene.

Is the service effective?

Our findings

People were cared for by staff who were well trained and supported to do their jobs. Staff confirmed their training was comprehensive and up to date.

The training staff received included a range of health and safety courses such as safe moving and handling, fire safety, food hygiene, emergency aid and infection control. Training related to the needs of people using the service included palliative care, pain and symptom management, dementia care, person centred care, malnutrition, assistance with eating, and bereavement training in confidentiality and diversity was mandatory for all staff. A high proportion of staff had a qualification in palliative care. Nurses received training before they were allowed to administer any medicines (including injectable medicines). This training was followed up by competency assessments. Staff were supported to undertake further education within palliative care. The Hospice had an Advancing Practice Team responsible for ensuring Hospice staff had access to external and internal training.

In addition to peer support, staff had access to an occupational health service (provided externally) as well as an external Employee Assistance Programme to provide confidential advice, support and counselling to staff who might need this on a range of issues in relation to their work or their personal life.

All volunteers received an induction to the service which had a training course covering essential topics including safeguarding, confidentiality and, if appropriate, manual handling. They received a handbook which had a quick guide to topics and information about where to seek additional help when necessary. In addition, the hospice has provided training through a two day training programme to 66 'patient facing' volunteers in the last year. Where possible each new volunteer was introduced to an experienced volunteer for support and guidance and every volunteer has a clear point of contact and regular one to one meeting or group support from a paid member of staff.

The hospice is part of the South London Hospice Education Collaborative (SLHEC) which was formed by eight hospices working together to develop training resources. The members of SLHEC have developed a training course for volunteers who work with people in the hospice sector. In addition to this, training had been developed for assistant practitioners working in End of Life Care (in hospices and care homes). Course were also available to a range of health and social care professionals working with people at end of life in primary care, care homes, hospitals, learning disability services and prisons. The manager also informed us that the Hospice has also led the development of a staff nurse end of life/ cancer/ older people's rotation programme which is about to commence.

Wherever possible people decided their care goals in conjunction with staff and were asked if they wished to consent to receive care and support. The Mental Capacity Act 2005 (MCA) provides protection for people who may not have the capacity or ability to make some decisions for themselves. The provider had policies in place to comply with the MCA and with the Deprivation of Liberty Safeguards (DoLS) to ensure no one was unlawfully deprived of their liberty. Staff followed and understood the requirements of the MCA and DoLS. The majority of staff had been trained in MCA and DoLS and a programme was in place to ensure that all

staff received the training to ensure they were knowledgeable about the legislation and confident in its application. Best interests meetings were held when if people were not able to give consent and decisions needed to be made about a person's treatment and care.

A nutritional assessment tool was used for people staying in the Hospice. It was designed to take account of people's nutritional needs, the impact of their illness on their appetite and their tastes and preferences. People told us they enjoyed the meals provided at the service and they suited their needs. One person described the meals as "absolutely fantastic" and said they were given choices at meals, saying, "The chef comes to see us and ask if we want any changes [to the menu]." They added, "We are so well fed." They said the times they were served meals and snacks were flexible, "You can have a cooked breakfast or whatever you want. ...you can also have snacks, I have them in the middle of the night sometimes." Another person praised the meals saying, "The food is good, the chef comes around and asks what you would like." People said meals were tailored to their individual needs, with one person saying "I can't eat very much, but I have the soup, it's lovely."

People benefitted from close working relationships between Hospice staff and other healthcare providers involved in their care. The Hospice worked in collaboration with Queen Elizabeth Hospital in Woolwich and with community based healthcare services, including GPs and District Nurses. The Hospice staff were able to provide advice to other healthcare professionals on pain and symptom control.

We received positive feedback from healthcare professionals in the community about how they had found working with staff from the service. One healthcare professional told us they worked closely with the Hospice and they felt the staff had "a culture of excellent care." They also said the service was "quick to respond to referrals and I have always valued their input and advice."

A second healthcare professional told us that the hospice staff had worked collaboratively with community medical staff to benefit people. The healthcare professional said hospice staff "alerted me or district nursing teams swiftly when they are worried a problem may be developing. This means that, often, their effective practice has enabled me to put in new care planning or alert for GP assistance". They told us the input of staff from the Hospice has helped people living at home and enabled them to receive more effective community support.

The Hospice had suitable premises for people to stay as in-patients. It is located in a wooded area and has attractive grounds. The garden had been made accessible to people with mobility needs, including those who use wheelchairs. There was access to and views of the garden from the wards. People told us they found the garden an attractive and restful space and enjoyed spending time there. Changes to the building had been made taking into account feedback received from people who use the services and staff. They had also worked with the Centre for the Healing Environment so their expertise was used to inform changes to the building.

Lifts allowed access to all parts of the building and corridors and doorways were wide enough to allow easy access. In response to user feedback, best practice guidance and changes in the hospice population a rehabilitation gym had been established and this had enabled the Hospice rehabilitation team to provide a range of activities and work with people to maintain and improve their independence and quality of life through structured rehabilitation delivered on a one to one basis and in groups.

Is the service caring?

Our findings

People told us they were well looked after by the staff and felt cared for. One person said, "Staff are so nice" and "They can't do enough for you." They added that staff gave them emotional support to deal with their situation, saying, "They are really good at helping you to adjust."

Relatives praised the care their family members received. The relative of someone who had been cared for by hospice staff described the staff as "wonderful" and said they had shown everyone "kindness". One told us they were kept in touch with their family member's condition by staff and this had helped them when their relative was staying at the Hospice. Another relative had reported to the Hospice that, the community team, "are all great they are jolly, caring and lovely people, just what is needed at this time".

A health and social care professional told us, "Staff ... engage with family members making them feel at ease, [staff] are relaxed and cheerful and therefore allowing family members the comfort of feeling at ease but at the same time keeping families informed about their loved one and their condition." Another professional commended, "The caring attitude of the staff and the high quality customer service."

Staff told us they enjoyed their work particularly as there were opportunities to build supportive relationships with people because working patterns allowed time to talk. One nurse told us they "love" working at the Hospice because, "you get longer to talk to [people] and that's what it is all about". They said this aspect of the work was satisfying as they felt they could make a difference to people at an important time in their lives.

People were supported to express their views and make decisions about their wishes for their care and treatment. The Hospice had a team of trained volunteers to support people with advanced care planning (ACP). This process promoted early discussion and planning around people's choices and helped to ensure that staff in the Hospice and in other agencies were aware of each person's wishes.

In June 2016, the Hospice led the development and roll out of an 'end of life charter' working with other partners across health and social care as well as members of the public to raise the profile of people facing the end of life. The charter included commitments to treating everyone with respect, compassion and dignity and ensuring people and people important to them received practical, emotional and spiritual support. All of the interactions we observed between staff and people were respectful, kind and maintained people's dignity. A health and social care professional told us, "All encounters I've had with their staff, be they specialist nurses, doctors or managers, their culture of excellent care, warmth and patient and family centred care has been evident."

People were assured that their confidentiality was protected. All staff and volunteers were committed to protecting people's personal information. People who used the service received leaflets about their right to confidentiality at their first meeting with staff. Records were kept safely in places where only staff had access. The provider observed the requirements of data protection legislation.

People, their relatives and friends had the opportunity to access a range of resources from which they could choose to approach for emotional and spiritual support. A Chaplain was appointed to the Hospice and they worked with a team of volunteers and local faith leaders to provide spiritual support to people and their relatives. A psychological care team and counselling support service was also available at the Hospice. There was a multi-faith room and ablution facilities which people, their visitors and staff could use for quiet reflection if they wished. The Hospice arranged a series of memorial services for friends and relatives to remember their loved ones. These included religious and non-denominational services.

The Hospice provided a drop in session called 'Stepping Stones. It was a drop-in service for people with a life limiting illness, their relatives and for people who were recently bereaved. This was a forum for mutual support between people and they were able to talk with volunteers and staff at the sessions so they could provide further assistance. One of the people who completed a questionnaire for the hospice said, "Stepping Stones has been a great help to me and my [relative]. Staff and volunteers have been very supportive and I am very grateful."

Is the service responsive?

Our findings

The Hospice provided care and support to people and their families in a way that targeted their individual needs. All referrals were received through a single point access called the Assessment and Co-ordination Team. It consists of a triage nurse who assesses each person's needs and then works with the multi-disciplinary team to ensure that the person is passed to the appropriate hospice service. In most situations, and always in urgent situations, the referral is reviewed on the day of receipt. Where a referral is made out of normal office hours, a clinical nurse specialist is responsible for reviewing referrals and ensuring that the right care is provided in a timely fashion. The Hospice inpatient unit accepts admissions seven days a week and in urgent cases, out of normal office hours. People who are admitted to the inpatient unit for support have a range of needs in relation to pain and symptom control, end of life care, complex psychological and social needs as well as respite care.

People were reassured that they had the opportunity to make their needs and preferences known as part of the assessment process and so received care that was responsive to their needs and wishes. People's preferences and needs were considered as part of the assessment. A tool had been developed so the assessment was holistic and took account of the full range of a person and their family's needs. A person told us that, "They [staff] visited me at home." Staff discussed with them and their family carer the care and treatment that was needed and what their wishes and preferences were. There was an emphasis on the importance of people's wishes and doing everything possible to achieve them.

Staff wrote people's care plans using the information gained through the assessments to reflect people's individual wishes. They included care focussing on their physical, social and emotional needs. People told us they felt their needs were met by the care provided. One person said that they received "very good pain control". Another said, "If you have to be in a hospice, it is a very good place to be."

People were supported to maintain relationships and keep in contact with their relatives and friends. There was open visiting to the inpatient units as long as people who were staying wanted visitors. There was also the possibility for people to maintain contact with their relatives and friends through electronic means such as Skype, for example where relatives and friends were far away and unable to visit.

The Hospice used tools to measure outcomes for people (palliative care outcome scale and phase of Illness) routinely within the inpatient unit to help ensure staff were able to demonstrate the impact of their interventions and to highlight areas of care for each individual which require further attention. The measures were in the process of being introduced in the community service. This helped to ensure that people received the best possible care that met their needs and expectations.

Advance care planning decisions to take account of people's wishes and preferences around end of life care could be made with staff or with the support of members of the team of trained volunteers who assisted with this. The Hospice has recognised this to be an important aspect of end of life care and was among the first hospices to implement a new initiative where the hospice has trained a group of volunteers who can visit people at home to increase the opportunity for people to develop advance care plans. This ensures

people's and their relative's wishes and preferences in regards to end of life care are ascertained at an early stage and are taken into account. The decisions people consider and make often included issues around resuscitation, the places people chose to receive care, including at the end of their lives.

Care planning and reviews were ongoing as staff were alert to changes in people's conditions. Discussions between doctors and nurses took place frequently so treatment plans could be reviewed and amended in response to changes. On the inpatient unit the doctors and nurse in charge conducted full ward rounds twice a week and smaller daily rounds. On the inpatient unit handover meetings between shifts were tape recorded to free up time for staff to care for people as well as to providing a record of discussions for other of the team to refer to. The community team out of hours work was shared with day staff at a morning handover. The information shared allowed managers to review staffing levels and skill mix in response to people's changing needs.

There was a daily handover meeting for carers working in the community to share information on the progress of people receiving personal care at home with each other and their team leader, care plans including frequency of visits are then reviewed accordingly. Additionally, The Hospice has weekly multidisciplinary meetings to provide an opportunity for doctors, nurses and other health professionals to come together to review people's needs and care plans. These meetings focus on reviewing the care of people who are new to the service, as well as routine reviews, reviews of people with very complex needs and reviews of the care of people who have died. The meetings are seen as a way to share information, make decisions and learn from the experiences of the wider team.

People's diverse needs were considered as part of the provision of care and treatment. Where the need had been identified translation services were available for people whose first language was not English. There was also a list of languages spoken by staff within the Hospice. This enabled staff to be called on, when necessary, to act as interpreters for people who required this.

The service had identified that black, Asian and minority ethnic groups had a low level of involvement in the Hospice. The Hospice chaplain was working with local faith leaders and Black, Asian and Minority Ethnic (BAME) groups to develop understanding of the service available to the whole community and to increase access to the Hospice services for these groups. They also supported staff to have a better awareness of people's cultural and spiritual needs and how they might better meet the needs of the diverse community. The manager told us that over the next year the service hoped to ensure their services were more welcoming to lesbian, gay, bisexual and transgender (LGBT) people and had begun discussions with a local organisation to work towards this goal.

The Hospice assisted people to follow a range of activities which took into account their health needs. A range of activities was provided in the day hospice including games and quizzes, relaxation and counselling groups, exercise groups, arts activities including mosaic making, visiting birds of prey, visiting PAT dogs, visiting musicians, talks about managing money and consumer issues and groups of school children coming to visit. These activities were available for people resident on the inpatient unit who were well enough to attend. Some people who had dementia had benefitted from specialist equipment purchased for a programme of activities called Namaste. This was designed to improve the quality of life for people with dementia. If people had pets, wherever possible, and if the person wished, their relatives and friends were encouraged to bring them to visit.

The provider gave us examples where the staff have gone the extra mile to meet people's last wishes. They told us that the staff have supported people to get married or to have a civil ceremony, sometimes at very short notice, if that were people's wishes. In these cases staff made the necessary arrangements for these

events to take place and to be successful. They have also held receptions for people where there were events to celebrate, so people had an opportunity that they might never have again, to take part in these events.

The Hospice responded to the needs of the local community in relation to end of life care needs and people with any life limiting illness. The provider informed us of the work with the prisons in Greenwich and their healthcare providers to improve the end of life care for prisoners with palliative and end of life care needs. The provider has worked in partnership with the prison and healthcare professionals to develop an end of life care strategy for use in the prison and there is a dedicated community nurse who ensures prisoner's needs are met. The provider reported that they had delivered the Quality End of Life Care for All (QELCA is an education programme, designed originally by St Christopher's Hospice in London, to be delivered by hospices for nurses working in other healthcare settings) training to the prison healthcare staff. The Hospice planned to share their experience of caring for people with end of life care living in prisons with the National End of Life Care in Prisons Community of Practice event in 2017, to promote learning in this area.

The Hospice appointed a nurse consultant in 2015 to focus on the needs of older people in the local area who are likely to benefit from the Hospice services. Through this role and by working with the local NHS hospitals and health care professionals, the Hospice has increased the number of people accessing services across the board, including a 33% increase in the number of people over 85 years who accessed hospice services. This meant a higher proportion of the local population had access to quality end of life care, that they might not have received without this intervention.

The provider told us that the number of people referred to the hospice with dementia had increased nearly twofold, because the staff had become more aware of the needs of people in the community living with dementia who need end of life care. That means that people who previously were not benefiting from the hospice service were now in a position to access this service. With the support provided by the clinical nurse specialist for people with advanced dementia, the staff are able to be more responsive to people's end of life care needs as needed. The provider informed us that the Hospice has received an award from the Health Improvement Network to recognise their work in this area.

The Hospice had recently established a new immediate home support service to respond to people in crisis or those who need urgent care at home with the aim of providing the best possible support for them. One of the nurses providing this service described how someone was referred to the service urgently, following a discharge from hospital the previous day. The person had been discharged with no pain relief and the GP out of hours service had prescribed a medicine which lead to some medical complications. The nurse helped to stabilise the person's condition as they were aware of the person's medical history and supported the person to stay at home instead of being admitted to hospital. They also made the appropriate arrangements for a care package for the person and their relative. As a result, the person was able to remain at home, as were their wishes, with appropriate care to keep them safe and comfortable.

People were informed about the complaints procedure. They received a leaflet about it at their first meeting with staff and information about the procedure was displayed in the Hospice. People said they were confident to speak with staff about concerns if they needed to. Records of complaints showed they were taken seriously by managers. Complainants were sent a letter of acknowledgement and where their complaints were substantiated, people also received an apology and explanation. When improvements to the service were found necessary changes were implemented. One person said if they had any complaints, "I would talk to someone but I haven't had any complaints."

People and relatives and carers had the opportunity to give their views about the service through

complaints, compliments and surveys. The surveys included the 'Views of Informal Carers – Evaluation of Services' (VOICES). It was an accepted tool used across the country as a 'proxy' measure for patient satisfaction with the care provided by the Hospice. The survey covered a range of topics including pain relief, the protection of people's dignity and respect and the quality of care. The most recent survey results from 2015-16 showed a high satisfaction level with the service. In addition, the Hospice carried out regular Friends and Family Test surveys and the results of this were positive.

Is the service well-led?

Our findings

People were protected by management systems which aimed to ensure that the service was well led. There was an open culture at the Hospice where managers, staff and volunteers shared a goal to improve the care and support available to people in Greenwich and Bexley who have a life limiting illness.

The service did not have a registered manager in post as required by the provider's registration with the Care Quality Commission (CQC). A new manager had however been appointed and they were in the process of being registered. The manager was seen around the Hospice on our inspection days and we observed that she had a good rapport with people and staff. She knew people and staff individually. Staff were positive about the manager's style and said she was "approachable" and the senior management team was "supportive". The manager and the provider met the requirements of the hospice's registration and made notifications to the Care Quality Commission as required.

Staff reported they felt able to make suggestions and raise concerns and they felt listened to and valued. Formal systems to consult with staff included individual and team meetings and a staff survey was conducted every two years. The Hospice had an annual staff and volunteers awards programme to recognise achievements and areas of excellence.

The Chief Executive was based at the Hospice and was accessible to staff and volunteers. She reported to the chairman of the voluntary board of trustees. The board included people with a range of clinical and management skills and had a sub-committee structure covering quality and safety, finance and remuneration, voluntary income generation and information governance. The governance arrangements ensured that the trustees were involved with the overall management of the service. Members of the board visited the hospice to ensure they were aware of the day to day operation of the organisation. They were also involved with audits and monitoring as part of their role, for example the vice-chairman of the board carried out infection control audits with the manager.

The Hospice had a quality monitoring system which the provider used to review aspects of care including falls, incidents and accidents, pressure ulcers and medicines incidents. The monitoring had the aim of identifying trends and patterns to prevent recurrence and to ensure the safety and well-being of people. This monitoring also enables the Hospice to benchmark their care with other providers as it is carried out through the National Benchmarking Audit of patient Safety. The safety report is discussed regularly at the Hospice's quality and safety committee.

We saw that medicines incidents (including near misses) were dealt with appropriately and practice was amended where necessary. Learning from these events was shared across teams. National medicines alerts were received by a senior member of staff and were actioned accordingly. The quality and safety committee was responsible for clinical performance and health and safety and reports from quality monitoring were submitted to them to consider if changes were required to make any improvements.

The Hospice was involved with local and national bodies which promoted good practice in palliative and

end of life care to ensure they were also up to date and provided evidence based practice to people using the service. These included Hospice UK, South London Hospices Education Collaborative and the Cicely Saunders Institute of Palliative Care. The Hospice was not only involved with these bodies to remain up to date and provide evidence based practice in the service, but also to inform National Policy and influence practice elsewhere and sharing learning

The Hospice Chief Executive is a member of various groups and initiatives to promote good practice within end of life care. For example she was the London Advisory Council Representative for Hospice UK, a member of the NHS London End of Life Care Clinical Network. She was also a board member of the Health Innovation Network, the Academic Health Sciences Network for South London representing all South London Hospice providers.

The Hospice also played an active role in the ongoing education of healthcare professionals on topics related to end of life care. The hospice has led on the development of the South London Hospices Education Collaborative and has helped to secure funding to deliver end of life training to health and social care professionals across the patch. The Hospice has links with University of Greenwich and King's College London, Cicely Saunders Institute and is working to develop stronger research links through these networks.

Locally the Hospice is an active member of the Oxleas NHS Trust End of Life Group, The Lewisham and Greenwich NHS Trust End of Life Group and the NHS Bexley CCG Cancer and End of Life Care Clinical Roundtable. The Hospice is well represented in the Bexley, Greenwich and Lewisham Urgent Care System through the participation of the nurse consultant and in the Local Care Network Board for Bexley through the participation of the Chief Executive.