Five Towns Plus Hospice Fund Limited

The Prince of Wales Hospice

Inspection report

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Ratings

Overall rating for this service	Good ●

Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Good** ●
Is the service responsive?	**Good** ●
Is the service well-led?	**Requires Improvement** ●

Summary of findings

Overall summary

We inspected The Prince of Wales Hospice on 03 and 04 October 2016. The first day of the inspection was unannounced, which meant the service did not know we were coming.

The hospice was last inspected in October 2013. We found it was compliant in all the aspects of care we inspected at that time.

The Prince of Wales Hospice provides specialist palliative care, including symptom control, respite, and end of life care for people with life limiting diseases and other progressive illnesses. The hospice is run by a registered charity which has a volunteer board of trustees. There are 14 inpatient beds and a day care service; care staff also provide a 24 hour/seven day a week advice line for people living in the community, carers and healthcare professionals. On the first day of our inspection there were six inpatients; two more were admitted on the second day.

The hospice is located in a residential area of Pontefract. The building is all on ground floor level. There is a car park and reception area to the front of the building, with separate areas for day care, inpatients and administrative activities. All inpatient bedrooms are ensuite and had French doors to allow patients to access a patio and garden area.

During summer 2016 the hospice had undergone significant refurbishment and improvement. At the time of our inspection this work was nearly complete, with nine inpatient beds available. The service planned to have the other five inpatient beds ready for admissions within the week following our inspection.

There was no registered manager in post. The last registered manager left in December 2015. A clinical services manager had been appointed in February 2016; they were in the process of applying to be 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.

Medicines were managed and administered safely by staff. People told us they had access to pain-relieving medicines when they needed them. Staff were encouraged to report any medicines errors so lessons could be learned.

Risks to people had been assessed and managed appropriately. Regular safety checks had been completed on the building, facilities and equipment used to support people. We saw the hospice was clean.

People and their relatives told us there were sufficient care staff deployed to meet people's needs. Our observations supported this.

Procedures for the recruitment of new staff at the hospice were updated shortly after our inspection to make them fully robust. A system was in place to ensure nursing staff had the correct professional registration.

Hospice staff could describe the forms of abuse people might be vulnerable to and told us they would report any concerns appropriately.

Staff received a comprehensive programme of induction and training. Annual appraisals were recorded but staff said supervisions had not been happening regularly. The clinical services manager was in the process of sourcing supervision training and improving their oversight of staff development.

Care staff members' knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) was good. We saw capacity assessments and best interest decisions in people's files. The service considered and documented whether care provided constituted a deprivation of people's liberty.

Feedback about the food and drinks at the hospice from people and their relatives was extremely positive. The cook was knowledgeable about the nutritional needs of people receiving palliative and end of life care and could describe the needs of individual inpatients.

People had access to a team of healthcare professionals based at the hospice. People's holistic healthcare needs were discussed daily during the week and a consultant could be reached over the telephone for advice at all times.

A programme of refurbishment had been completed shortly before our inspection. The inpatient bedrooms we saw were of a high standard. Other modifications to the building had been made to meet the specific needs of the people using the service.

People and relatives told us staff were caring and respected their dignity and privacy. We saw staff supporting people to remain independent and observed warm and positive interactions between staff and people. Staff respected the wishes of people and their relatives in terms of the subject of discussions they wanted to have and those they did not.

Care plans showed people and their relatives were involved in designing their care and people had signed consent forms when they were able. Care plans encompassed people's spiritual and emotional needs, as well as their physical needs.

The service used national guidance to ensure the palliative and end of life care provided was evidence-based and of a high standard. Staff could recognise when people needed advocacy services and knew how to make referrals if they needed to.

People's care files contained risk assessments and care plans which met their assessed needs. Daily records were shared between the team of healthcare professionals providing care; we saw they were detailed and evidenced people had been supported according to their care plans.

People had access to a range of activities at the hospice. Complementary therapies were available to relatives and staff, as well as to the people using the service.

None of the people or relatives we spoke with told us they had ever made a complaint. The hospice sought feedback about the service it provided and we saw improvements were made as a result.

People and their relatives were very happy with the service provided by the hospice. There was no registered manager in post; however, the clinical services manager who joined the hospice in February 2016 had applied to be registered manager.

Three statutory notifications had not been made to CQC in 2016 that should have been. We also found the system of audit in place did not assess day to day aspects of the service for themes and trends in order to identify improvements. The commitment to high level service audit in relation to national guidance and evidence-based practice was impressive.

Staffing had been an issue in early 2016 and we saw this had been addressed. Efforts had been made to assess staff satisfaction and team-building in the summer of 2016 while parts of the hospice were being refurbished. Staff we spoke with gave positive feedback about working for the service.

The hospice worked well in partnership with external organisations and community healthcare professionals. Staff had worked hard to make the hospice welcoming and part of the local community.

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.

Staff understood safeguarding principles and knew how to report concerns. Risks to people had been assessed and managed. Safety checks were made on the building, equipment and facilities.

Medicines were managed and administered safely.

Sufficient numbers of staff were deployed to meet people's needs. Recruitment procedures were improved during the inspection to make them more robust.

Is the service effective?

Good ●

The service was effective.

Records showed staff received the training they needed to support people effectively. Staff had annual appraisals and a new schedule of supervision was being implemented.

People and their relatives were very happy with the food and drinks served at the hospice. A multi-professional team of staff based at the hospice were available to support people's holistic health needs.

The service assessed people's mental capacity and made appropriate decisions in people's best interests when they lacked capacity. There was a pragmatic approach to Deprivation of Liberty Safeguards.

Is the service caring?

Good ●

The service was caring.

Staff respected people's privacy and dignity and supported them to remain independent. People were involved in designing their care and support.

End of life care provided by the hospice was benchmarked against national standards and guidance to ensure it was up to date and evidence-based.

We observed warm and caring interactions between staff and people and their relatives. Staff knew about advocacy services and in what circumstances people might need to be referred.

Is the service responsive?

Good ●

The service was responsive.

People's care plans were person-centred. Daily records evidenced people were supported according to their assessed needs.

People using the service as inpatients had access to activities, either in the day care unit or their own rooms. Complementary therapies were available to people, their relatives and staff.

None of the people or relatives we spoke with had made a complaint and no formal complaints had been received by the service in 2016.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

There was no registered manager in post at the time of our inspection. The clinical services manager had applied to become the registered manager.

Three statutory notifications had not been made in 2016. We identified issues with audit at the service, although we were impressed by work undertaken to benchmark clinical practice against national guidance.

Considerable effort had been applied to teambuilding and improving communication across the organisation following staff changes at the start of 2016. Staff told us they were happy to work for the service.

The Prince of Wales Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 03 and 04 October 2016. The first day was unannounced. The inspection team consisted of two adult social care inspectors.

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.

We also reviewed the information we held about the home and requested feedback from other stakeholders. These included Healthwatch Wakefield, the local authority safeguarding team and the Clinical Commissioning Group; they did not have any information of concern to share with us. After the inspection we also contacted eight other healthcare professionals involved with people using the hospice. Those that responded all gave very positive feedback.

During the inspection we spoke with people, their relatives and care staff to get their feedback about the hospice. This included 4 people who were inpatients, nine people's relatives, one visitor, the clinical services manager, the medical director, the chief executive, the deputy chief executive/facilities manager, an administrator, the inpatient ward manager, a deputy inpatient ward manager, seven other care workers (including nurses, a student nurse, a bank nurse and health care assistants) and a nurse providing outpatient services. We also spoke with an occupational therapist, a social worker, an activities coordinator and the chaplain, all of whom were based at the hospice.

As part of the inspection we looked at four people's care files, which included their risk assessments, care plans and medicine records. We also inspected three care staff recruitment records, staff training records, appraisal documents, audit and monitoring records and various policies and procedures related to the running of the service.

Good ●

Is the service safe?

Our findings

People told us they felt safe at the service. This was confirmed by relatives. We spoke with one person in the presence of their relative; the relative said to them, "I don't worry leaving you here. I know they will look after you." Another relative told us, "It's absolutely fantastic; I can go home at night, knowing [they are] safe. I know that they will be checking on [them]."

Safeguarding policies and procedures were in place at the hospice. Care staff were knowledgeable about what action they would take if abuse was suspected. One member of care staff said, "We know what to do and hopefully nothing like that would ever happen, but I would always report anything like that." Another stated, "It's always best to report everything."

People and their relatives told us staff supported people with their medicines. One person said, "If I want anything for the pain they get something straight away." A relative said, "They explain everything even down to what tablets they are giving [my relative]."

We checked the management of controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally or causing harm. The clinical services manager told us controlled drugs were obtained from the local NHS Trust who had a Home Office Licence for their supply. This meant that medicines were supplied legally. We saw controlled drugs were appropriately stored and checked on a daily basis. We examined two people's controlled drug records and found there were correct matching stock levels. Other medicines were kept securely and only accessible to staff authorised to handle medicines. Lockable cabinets were also located in people's rooms for the secure storage of medicines. We were told by staff that no inpatients at the time of our inspection were managing their own medicines. We saw medicines were stored at the correct temperature and therefore were suitable for use.

The clinical services manager informed us they had recently changed their procedure for the disposal of medicines. Previously, all unwanted medicines were sent back to the local NHS Trust. They said these were now sent to a private external waste contractor for disposal and explained they were going to implement a recording system to document this system to ensure there was an accurate audit trail. The provider was in the process of updating their medicines policies and procedures to reflect this change.

We observed the administration of medicines. One of the senior nurses was supervising a bank nurse as they administered medicines. The senior nurse was extremely knowledgeable about all aspects of medicines management and the palliative care medicines they administered.

One person's medicine dosage had been decreased by a doctor the previous day. We saw there was none of the reduced dose of medicine in stock and staff had to halve one of the higher strength tablets. We asked staff what system was in place to ensure that medicines were in stock. One member of staff felt that improved communication between medical staff would be beneficial to ensure that nursing staff were aware of any changes in medicines so that these could be ordered in a timely manner. The clinical services manager told us that they would look into the issue as a priority.

Emergency medicines and equipment were available at the hospice, including a defibrillator, in the event of a health emergency. The clinical services manager explained that only medical staff could administer emergency medicine since nursing staff had not been trained in this area. They said the paramedic service would be contacted for any health emergency which occurred out of hours when medical staff were not present.

Staff informed us that emergency equipment and medicines were checked daily. Staff signed a form to state they had checked the emergency equipment. The emergency equipment and medicines were stored behind the nurses' station. This meant staff had immediate access to this equipment and medicines in an emergency. We noted a risk assessment had not been completed to assess the risk of unauthorised access of the emergency medicines. The manager told us that this would be addressed.

There was a system for recording the receipt of national drug safety alerts and any action taken. Staff were encouraged to report medicine errors, so lessons could be learned and practices made safer. The ward manager told us, "There is a no blame culture here – nobody gets into trouble."

We checked staffing levels at the service. The clinical services manager told us the inpatient unit was staffed with one nurse for every five patients plus two or three healthcare assistants during the day, and two nurses and one healthcare assistant at night. During the day there was also a ward manager and deputy manager, both of whom were nurses. Overseeing the inpatient team was the clinical services manager and senior management team. The clinical services manager had been in post since February 2016. They told us there had been an issue with staffing after some staff had left the service at the start of the year; they said, "My priority from coming in was to stabilise the staff team." Recruitment records and our own observations confirmed new staff had been employed.

A multi-professional healthcare team of medical staff, nurses and healthcare assistants cared for people using the inpatient unit. They were supported by a wider team consisting of a social worker, an occupational therapist, an activity coordinator, a chaplain, complementary therapists and volunteers. A position for a physiotherapist was vacant at the time of our inspection. Nursing staff told us there was an 'on call' system for accessing out of hours medical cover and advice. We saw the staff team helped to ensure people's physical, emotional and social needs were met.

People and relatives told us that there were sufficient staff deployed to meet people's needs. One person said, "You ring the buzzer and they are straight there. Nowt (nothing) is too much trouble." A relative told us, "Oh gosh there is enough staff. They come in and check, but they don't go overboard – it's a nice balance." We saw staff carried out their duties in a calm, unhurried manner.

Staff informed us recruitment checks were carried out prior to starting work at the hospice. One staff member said, "They did all the necessary recruitment checks." We inspected recruitment records for three recently employed members of care staff. We saw all the correct checks had been made, including the Disclosure and Barring Service, which assists employers to make safer recruitment decisions. We noted application forms did not record applicants' full employment history and this had not been explored and documented by interviewers. We raised this with the clinical services manager who advised us the application form was under review at the time of our inspection. Shortly after the inspection we were sent an updated application form which had been amended to request applicants' full employment history and a satisfactory explanation of any gaps in employment. This meant recruitment procedures at the hospice were improved to make sure they were fully robust.

There was a system in place to check nursing staff were registered with the Nursing and Midwifery Council

(NMC). The NMC registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK. We spoke with a nurse who told us, "I had to provide my statement of entry (NMC membership) and my PIN number." The ward manager told us of the importance of assessing prospective applicants' values when they attended for an interview. "It's so important, I will ask them a question such as 'If I were to ask your ward manager, what qualities would they say you had?'" This meant the service ensured nursing staff had the correct professional qualifications.

Risks to people's safety had been assessed as part of their plan of care. We saw assessments for risks such as blood clots due to reduced mobility, moving and handling, falls and pressure ulcers. Care plans were in place to help mitigate risks identified and protect people from unnecessary harm. A new nurse call system had been installed and falls equipment such as sensor mats which alerted staff if people were at risk of falling were available. The hospice had reclining chairs with inbuilt pressure relief if people needed them. This meant risks to people were assessed and managed appropriately by the service.

We spent time looking around the hospice building. People and relatives were very complimentary about the environment. Comments included, "It's like a five star hotel", and, "It's first class." A schedule of planned maintenance ensured the facilities were well maintained. Service contracts were in place for areas such as fire safety, Legionella and electrical installations. The hospice was fitted with a sprinkler system. Checks and tests had been carried out on moving and handling equipment. An agreement was in place with the local NHS Trust who serviced their medical equipment. This meant the facilities and equipment used to support people was safe.

A comprehensive cleaning schedule was in place and all areas we viewed were very clean and hygienic. One person said, "It is so clean." There were various hand-washing stations around the hospice. Staff had access to personal protective equipment such as gloves and aprons and we observed staff washing their hands before and after contact with people. This showed the service was taking steps to ensure people were protected from the risk of infection.

Good ●

Is the service effective?

Our findings

People and relatives spoke positively about the skills of staff. Comments included, "The staff are well trained", and, "They know what they are doing. They are all outstanding and give it 100%."

The medical director had oversight of the training and development of the medical team. We saw each member of the team, including the director, was up to date with their mandatory training and had a personal development plan in place.

Three senior nurses were employed. Each of the nurses directed particular areas of the hospice on a rotational basis. One supervised the inpatient unit, another oversaw the day service and the third supported staff with training and development. We spoke with one of these nurses who said, "My role is to work alongside the newer members of the team, specifically trained staff (nurses) and go through competencies and provide training sessions."

Staff told us and records we saw showed there was sufficient training to enable care staff to support people effectively and meet their needs. Comments included, "We have been doing a lot of online training. End of life training – that was a big course, it was really interesting", "We have had training to teach us how we should communicate with patients, how to make eye contact and how to deal with those difficult conversations. If I am not sure what to say, then I will just listen, listening is so important – it always seems to help", "I have just done a bereavement course about how to support a bereaved person. You draw a lot on your own experiences – I got such a lot out of it. A member of the kitchen staff also did the course – I liked how it was open to all, because speaking to patients and relatives is everyone's business", "We also had the opportunity to go out on placement so I went to [name of hospital] and saw chemotherapy being administered. I also spent time with their [local NHS trust] infection control staff which was really interesting", and, "We had training about symptom management with the pharmacist." One of the nurses was a dementia friends' educator. They were organising further dementia care training for staff.

Staff told us induction training was provided. Comments included, "I got an induction, I worked closely for well over a month with [name of experienced member of staff]", and, "I got a two week induction which was far better than my last job where I got three days." Healthcare assistants were required to have a health and social care qualification when they were recruited. They did not therefore need to be signed up to the Care Certificate. However, part of the role of the senior nurse with the training and development role was to support healthcare assistants who opted to complete the Care Certificate as part of their personal and professional development. We observed the deputy ward manager supporting a new bank nurse. They supervised as the bank nurse administered medicines. This meant staff received an appropriate induction to ensure they had achieved acceptable levels of competence in the duties they were employed to perform.

Nurses had undertaken comprehensive competency assessments on a number of areas, including medicines management and administration and use of syringe drivers. A syringe driver is a small pump which releases a dose of medicine at a constant rate. We saw a detailed competency framework had been developed for the nursing staff and healthcare assistants which was used to guide their professional development and ensure they were competent for their roles. This meant there was a system in place to check staff were following the correct procedures and delivering safe and effective care.

Most staff told us they felt supported. One member of staff felt that more support would be appreciated. Other staff told us, "I have never felt anything other than supported," "[Name of line manager] is very supportive, they are always there and will say that they are always there to talk if needed", "[Name of manager] actively cares about us", and, "[Name of line manager] is very approachable. We had a little mini reflection this morning when I said, 'Did I do everything right?' 'Was there anything I should have done or done better or differently?' [Name of line manager] has been really lovely. [Their] door is always open." We spoke to the ward manager who said, "Anyone can come into my office. I never say I'm busy or else the moment is lost. I always tell new staff not to go home when there is something on their mind – it might not be me that's around to talk, but it's important to talk to someone."

Care staff told us and records confirmed that annual appraisals were carried out, although a formal documented supervision system was not fully in place. This was confirmed by the care staff we spoke with. One staff member said, "We don't have formal supervision." Another staff member said, "The supervision is getting underway. I've found someone to do my supervision." The clinical services manager was not sure which members of the care team had received supervision but was in the process of sourcing supervision training for senior nurses and other staff who would who provide supervision for staff members. They were also liaising with another local hospice with the intention of arranging joint clinical supervision sessions for the nurses and healthcare assistants. Senior nurses and members of the wider healthcare team had already sourced their own clinical supervision with peers externally. This meant that whilst care staff were receiving annual appraisals they were not receiving regular supervision at the time of our inspection; however plans to address this were already in place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Where a hospice is a registered care home or hospital, the process for this is to use the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and if any conditions on authorisations to deprive a person of their liberty were being met. Care staff we spoke with were making decisions in accordance with the principles of the MCA. One member of staff said, "Mental capacity is discussed all the time during handovers and MDT (multi-disciplinary team) meetings." We sat in on a handover meeting between a nurse and the wider care team and confirmed this was the case. Care files of people thought to lack capacity to make decisions contained mental capacity assessments and best interests decisions, for example, relating to the use of syringe drivers or stopping antibiotic therapy. Documentation showed appropriate healthcare professionals and family members had been involved in making these decisions in people's best interests. However, we found assessments had not been carried out to ascertain whether people's care amounted to a deprivation of their liberty and no DoLS applications had been made to the supervisory body for people deprived of their liberty in order to receive care and treatment.

We discussed the lack of DoLS applications with the clinical services manager and medical director. They were well aware of the requirements of the legislation and explained applications had not been made as they felt this was in the best interests of the people who had died at the hospice. This is because people who die with a DoLS authorisation in place are referred to the coroner and require an inquest as they are classed as being in detention at the time of death. Police are sometimes sent to attend services when people die unexpectedly with a DoLS authorisation in place and when this happens the body sometimes cannot be moved. This can be very distressing for relatives.

We found the decisions made at the hospice were in line with advice published by the Department of Health in October 2015, in that inpatients using the service who lacked capacity at the time of our inspection had consented to use the service in the past and so it had been assumed they would continue to do so. This had been documented. We also saw it documented that care staff would assist a person who could not leave independently to leave with the support of family members if they felt it was what the person wanted, so the person was not being deprived of their liberty. Care staff had also discussed individual cases with the DoLS assessor for the supervisory body who was in agreement with their approach. This meant the hospice had taken a pragmatic approach to DoLS whereby decisions around liberty were made in the best decisions of people and their families and in line with government guidance.

People told us and our own observations confirmed that staff sought people's consent before providing any care or treatment. One person said, "They always ask." Staff informed us, "We always ask patients for their consent", and, "I always ask before I do anything." We noted consent forms, such as consent to share people's personal information, were completed in people's care files to confirm their consent had been gained.

People and relatives were extremely complimentary about the quality of the meals at the hospice. Comments included, "The food is divine. Everything they bring you is beautiful", "The meals are marvellous, you get a Sunday dinner with Yorkshire puddings and melt in your mouth roast beef, it's like cutting through butter", "If you want an ice pop or cup of tea day or night they get it for you. The food is very good", "The food is beautiful, [my relative] had homemade mushroom soup today", "[My relative has] to have something soft – they are so good, they make the (pureed) vegetables look like actual vegetables – the other day [my relative] had carrots and the pureed carrots just looked like four little carrots, it looks so nice. [The cook] also made cream scones and pureed the scones and put them in a mould and put cream and jam in the middle so it was just like experiencing a real cream scone", "There is a good choice and they have offered us something to eat", and, "Even a first class hotel could not serve better food."

We spent time talking with the cook. They told us, "We don't do tick lists. Things change so much we play it by ear and do it all (provide people with food choices) in the morning." The cook was aware of people's food preferences and said, "I always go and visit patients and find out their likes and dislikes and what they can tolerate and whether they like a small, medium or large portion", and, "We do supper such as sandwiches, cheese and biscuits, cereals and hot chocolate. The emphasis is on what they like and want."

The cook was aware of people's nutritional needs and requirements. They told us, "I went on a course on pureed diets and dysphagia (swallowing problems). I am part of the nutritional group for hospice catering. We meet every three months", "We put butter and cream and full fat milk in – everything is high calorie", and, "We have new crockery it's white with a thick blue band around which makes the meal look smaller and doesn't over phase patients." The medical director spoke highly of the cook, telling us, "[The cook] is a whizz at getting as many calories into as small a portion as possible."

The cook told us and people and relatives confirmed there was an emphasis on home cooking at the hospice. The cook said, "We cook from scratch and do a homemade soup every day." They explained that local food suppliers were used and said, "I buy fruit as needed; at the minute we have strawberries. We also have an allotment and grow our own vegetables, onions, peas and new potatoes. We have a milk man and get fresh milk and free range eggs and we use local suppliers. We use the local butchers."

We saw snacks were available throughout the day. Staff had access to a fridge and freezer where jellies, trifles, yoghurts, ice lollies and ice creams were stored which they could give to people. One staff member said, "The patients like little snacks and supper is also provided. We also have a vending machine." This meant people were supported to eat food that met their individual needs and preferences.

A coloured tray system was in place to indicate who required support with eating and drinking. The cook told us, "We use different coloured trays (at meal times). Red for total assistance, yellow for a little assistance such as cutting up, and green – no assistance. It makes everything more discreet, you're not putting up signs telling everyone the degree of support needed." This meant consideration was given to maintaining people's dignity at mealtimes.

People and relatives informed us people were supported to access health and social care professionals. A family member told us, "[My relative] sees the doctor every day", and one person said, "The physiotherapist has been in today to see how I get in and out of bed."

There was an occupational therapist based at the hospice and the service had recently recruited a social worker who was registered with the General Social Care Council. Part of their role was to provide information and advice about finances and assist people with planning for their future as well as providing emotional and psychological support. A weekly multi-disciplinary meeting was carried out each week to discuss people's plan of care. Handover meetings between nurses and the team of wider healthcare professionals based at the hospice were also held on weekdays. One member of staff said, "The handovers are really good, because they turn into mini MDT (multi-disciplinary team meetings) with everyone joining in." We attended a handover meeting during the inspection. Each person's holistic care was discussed in detail, including their physical, emotional and spiritual health. A student nurse on placement also took part in the meeting and joined in with the discussion. The medical director commented afterwards how pleased they were the student felt comfortable enough to share their views at the meeting; they told us, "We value everyone's opinion as part of the team." This demonstrated the expertise of appropriate health and social care professionals was available to ensure the individual needs of people were met.

The premises had been designed to meet the needs of people who used the hospice. Accommodation for inpatients consisted of single ensuite rooms with showers. There were tea and coffee making areas for people and their relatives to use. A 'reflective' room was an integral part of the building which people and their relatives could use at any time. There was a smoking room available to people in the hospice; staff and visitors could not use this room and the rest of the hospice was a smoke free site. There was a visitors' room available for relatives to stay overnight.

The conservatory had been fitted with a number of 'quiet booths' which ensured more privacy. A bistro style café area was planned for the conservatory. The conservatory had bi-folding doors. The clinical services manager said, "It means that we can take patients out in their bed if necessary." The hospice was in the process of fitting a new assisted bath which had a lighting and music centre fitted. Ceiling hoists had been fitted which care staff said would enable those unable to mobilise to get in and out of the bath. The clinical service manager told us improvements to the service had been planned using nationally available good practice to ensure it met the needs of people using the service. People we spoke with were very happy with the facilities and environment at the hospice. This meant the specific needs of people who needed palliative or end of life care had been considered when planning improvements to the hospice.

Good ●

Is the service caring?

Our findings

People and relatives were extremely complimentary about the caring nature of the staff. Comments included, "Here you feel the staff gently pick you up (metaphorically) – you have peace of mind and confidence", "They come in and chat with you", "It's absolutely marvellous. They can't do enough for you. They are all so nice", "The improvement since [my relative] has come here from [name of hospital] has been fantastic because of the care", "The other day when I came in there was two nurses sat here with [my relative], that was so nice and they didn't know I was coming. If they have time they always sit with patients", "The care has been brilliant – I couldn't have wished for better food or better care", and, "They have such a caring look. They will talk to [my relative] and let [them] know what they are doing, even though [my relative] can't communicate, [my relative] understands."

Staff were committed to ensuring people's needs were met. One member of staff said, "I think we go above and beyond with everything – the patients deserve it." Another said, "You sit there and hold their hands, no one should die alone." While we were talking to one person, a member of care staff came in to inform the individual their shift was ending and they were going home. The person told us, "Isn't that so thoughtful of her, she always does that." The meant staff built therapeutic relationships with people and those inpatients we spoke with appeared comfortable and well cared for.

People told us that they had made decisions about their care, which included advanced decisions with regards to future treatment. One staff member said, "We always ask about end of life planning and the preferred place of care. Some people don't want to discuss this, but we always ask." Another member of staff said, "We do go and see what end of life discussions have taken place on [name of computerised system]." People told us that this enabled them to prepare and make informed decisions about what was important for them and to make the most of their remaining time. One person said, "I want to die at home and if I can't die at home then I want to die here. The staff are very good and they have supported me to write down my plans for the future. They asked me where I would like to be cared for and I said at home."

Literature was available about the hospice for people and their families to read. There were also information leaflets about where to seek external support. Information about the hospice could also be found on their website. People and relatives told us they received sufficient information and felt involved in people's care. Comments included, "They answer those difficult questions", "They explain everything. As a family we are so pleased", "They are going to give me a list of how much (medicine) to take and what to take", and, "They explain everything even down to what tablets they are giving [my relative]." This meant people were supported to have access to information relevant to them to help them make decisions about their care and treatment.

We looked at people's care files and noted that 'This is Me' documentation had been completed. 'This is Me' is a nationally recognised tool that people with a dementia related condition can use to tell staff about their needs, preferences, likes, dislikes and interests. The clinical services manager said people and their relatives liked to be asked this information as it showed them hospice staff were interested in people's personal preferences. A care staff member said, "They have 'This is me' information and I find that so useful, I read it so I know what their interests are. One patient does not like to be fussed over." Another member of staff said, "It's important to relatives, they feel reassured that we know about their relative." This meant staff had access to information to help them deliver person-centred care and treatment.

Care staff at the hospice respected people's privacy. We saw they knocked on people's doors and gave friendly greetings as they entered bedrooms. People and their relatives told us people's privacy and dignity was promoted. One person said, "They are very good with privacy – they don't bother you when you don't want them to, but then they are around if you do want them. There is a good compromise – a good happy medium." We saw staff used 'do not disturb' signs on people's doors. One member of staff said, "We use the do not disturb slides whenever we need to, sometimes patients just want time out."

People and their relatives said members of the care team respected people's dignity. One of the nurses was a dignity champion and was trained to educate others about the importance of respecting people's dignity; they also encouraged other staff to sign up as dignity champions. We saw training materials they had used for workshop sessions and a file they had collated of various dignity-related examples of good practice. In addition, the medical team had completed a project in July 2016 which evaluated the hospice's compliance with the Human Rights Act and guidance from the Dignity in Care Network. Actions had been identified and were in the process of being implemented; for example, a person-centred one page profile transferable between different care settings had been developed. Our observations throughout the inspection showed staff were keen to maintain and promote people's dignity.

We saw people's expressed religious needs were included in their care plans. The hospice staff included a chaplain who was employed one and a half days a week and volunteered for one day a week. The chaplain told us the majority of people admitted to the hospice were of the Christian faith due to the demography of the local population. The chaplain said, "I try to bring a little bit of peace to people's lives. I'm privileged to work here." We asked what happened when people of other faiths used the hospice. The chaplain responded, "What I do is about spirituality, not about faith", and went on to provide examples of people of other faiths who had used the hospice and how the chaplain had either supported them, or sought representatives of their own particular faith, if they wished. They told us, "We have other people we can call on from other denominations." The chaplain also advised care staff on specific religious practices after death for their own faith and for other faiths. This meant people using the hospice had access to spiritual or religious support, should they feel they needed it.

People were supported to maintain their independence by care staff. This was seen as a priority for those accessing the service for both palliative care and end of life care. We spoke with the occupational therapist that had recently started work at the hospice. They gave us examples of how they maximised people's abilities and built relationships with people in order to support them. We observed them supporting people during the inspection in a kind and positive manner. They told us, "It's all about rapport building." People's independence was discussed in the morning handover meeting between the inpatient ward nurse and the hospice's team of healthcare professionals, along with ideas for how to make improvements. For example, one person was having problems eating independently so an action from the meeting was to consult the dietician and the society for sufferers of the person's specific medical condition for advice. This meant inpatients to the hospice were supported to remain as independent as possible.

During the morning handover meeting with the hospice's multi-professional healthcare team we noted that emphasis was placed upon supporting people's relatives and carers, as well as the people themselves. Discussion was held regarding how people and their relatives had chosen to be communicated with regarding people's prognoses. Some people and relatives did not want to discuss this aspect of their care with care workers and some did; when people and their relatives feelings differed, the healthcare team were mindful of the need to respect people's wishes and have separate discussions. One person told us, "My [relative] doesn't want to talk about it, the staff respect [their] decision – they just let [them] be." Another person had a relative with a disability, so discussion was had between the team about the best way to ensure the relative could be transported to the hospice in order to visit. Relatives were encouraged to spend as much time as they wished to with their inpatient family member and it was possible for relatives to stay overnight and have meals together, if they wanted to. Relatives told us, "They not only look after [name], they look after us", and, "They are so welcoming to us, they support and care for us too." The clinical services manager told us, "We've pushed beds together before now. Don't forget, some of these couples have been married for over 50 years and have slept in the same bed all that time." This meant the hospice's staff supported people's relatives, as well as the people using the service.

Staff informed us that pets were welcome at any time. One member of staff said, "Pets can come and stay, it really helps the patients." The medical director told us, "We've had dogs, we've had cats, we've had horses." This meant the service recognised the importance pets had on people's lives and the positive benefit seeing their pets had on the patient.

None of the people using the service at the time of our inspection had an advocate as they had family members or friends who could advocate for them, if they needed it. Care staff we spoke with knew when it would be appropriate to make referrals to advocacy services on people's behalf and which local services they could use. One member of the care staff gave examples of referrals that had been made in the past. This meant people had access to advocacy services if they needed them.

The medical director estimated half of the people accessing the hospice as inpatients did so for end of life care, so this aspect comprised a significant proportion of the care and support provided to people and their relatives. Care records we inspected evidenced the staff of consultants, doctors, nurses and healthcare assistants worked together as a team to provide person-centred end of life care, and our observations supported this. We saw 'do not attempt cardiopulmonary resuscitation' forms (or DNACPRs) were stored prominently in people's care files, so staff knew which people had these in place. Training records showed nursing staff had completed comprehensive training in all aspects of palliative and end of life care. The hospice team also included a bereavement co-ordinator. Discussions in the morning handover between the nurse and team of healthcare professionals included actions to refer relatives to the bereavement co-ordinator prior to a person's death, so that a supportive relationship was already in place when the time came.

The medical director and other members of the medical team placed an emphasis on ensuring the end of life care provided at the hospice was consistent with current evidence-based practice. National guidance on this aspect of care, such as the National Institute of Clinical Excellence (NICE) guideline on care of the dying adult and the report 'One chance to get it right' by the Leadership Alliance for the Care of Dying People had been analysed and compared to current practice at the hospice to identify gaps. We saw action plans had been created and completed to ensure care provided was in line with recommendations; this had involved staff training on communication, symptom management and recognising dying. This meant people accessing the hospice for end of life care were supported according to up to date evidence-based guidance.

Good ●

Is the service responsive?

Our findings

People and relatives informed us that staff were responsive to people's needs. Comments included, "We know that if [my relative] needs anything, they will get it for [them]", "They are good with advice. They ask me if I have any pain", "They've got to the bottom of [my relative's] pain", "The staff go above and beyond the call of duty", "They always ask how I am and they introduce themselves", "The doctors here recognised that something wasn't right when [my relative] came from [name of hospital] and they sent [my relative] back (to hospital)", and, "They are talking about getting [my relative] mobile and getting up and dressed – they are so good."

The hospice had a policy of receiving admissions at any time of the day or night, although most inpatient admissions were planned in advance. We saw an email from a hospital consultant thanking care staff for receiving an admission after 11pm; they had written, '[They] were accepted without question despite the late hour.' On the second day of our inspection, a person attending the day care service became unwell and staff arranged for them to be admitted to the inpatient unit. We saw in people's care files pre-admission and referral documentation which outlined their care and support needs. At the handover meeting between inpatient nurses and the hospice's team of healthcare professionals we noted potential admissions were discussed to ensure people's needs could be met by the service and to plan the support they would require. Medical and nursing assessments were completed by a doctor and nurse together, in order to reduce stress and inconvenience to the person and their relatives. One member of staff said, "It's much better because we go in at the same time and the patient does not have to go through two assessments." Medical and nursing admission documentation was thorough and resulted in an action plan which identified people's care and support needs.

The meeting of care and support needs was planned for by the development of specific person-centred care plans. Care plans we saw in place included those for people's mobility, specific medical conditions, nutrition and hydration and skin integrity. We saw two people's files had best practice guidance for their particular medical condition attached to the front, so that care staff could understand the person's disease process and symptoms fully. All members of the team of healthcare professionals wrote in the same daily records so it was clear the team worked together to meet people's identified needs. Care plans were numbered and records added by the nurses addressed each one in turn so it could be evidenced people were supported according to their care plans. One staff member said, "Patients' care is reviewed every day – all the time."

The hospice worked closely with other services in the local community and acute care setting to support people's holistic care needs. Feedback we received from external healthcare professionals involved with people using the service was all highly complimentary. One healthcare professional told us, "I find the staff very helpful and supportive. I have never run into any problems with The Prince of Wales Hospice and highly recommend them to my patients", and another commented they had received, "Positive feedback via patients in terms of their inpatient and outpatient services."

We saw in people's records the service used a specialist palliative care assessment tool to assess inpatients on a weekly basis. The tool assessed holistic needs, in other words people's spiritual, emotional and psychological needs, not just their physical needs. The medical director said the tool had often identified issues the care team were previously unaware of or changes in the person's need that required support. The hospice used other assessment tools which were person-centred. For example, one person using the service was unable to verbalise their needs, so the care staff assessed their pain levels daily using a specialised pain assessment tool for people unable to speak. Care staff had also used picture cards in order to communicate with this person and had even tasked the hospice's information technology lead to enlarge the picture options to make it easier for the person to indicate their choice. This showed the hospice used person-centred tools to assess people's needs.

The service operated an advice line which was available 24 hours/seven days a week. Advice was provided regarding any issue relating to palliative care such as pain and symptom control, whether particular combinations of drugs were compatible or appropriate and ways to support family members. Nursing staff said if they were unable to answer an enquiry, they would refer the caller to the appropriate member of the hospice multi-disciplinary team. A palliative medicine consultant was on call 24 hours a day covering several local services so nursing staff could seek advice and support if needed. All calls to the advice line were reviewed at the handover meeting between nurses and the hospice's multi-disciplinary team each weekday. Local healthcare professionals we contacted for feedback told us, "They are always happy to deal with questions over the phone and offer advice", and, "I have always found the Prince of Wales Hospice very helpful and offered prompt practical advice. They are also keen to ensure the appropriate person is offering advice." This meant the palliative advice line provided additional support for people, relatives and healthcare professionals in the local community.

We spent time with the lymphoedema specialist nurse. The lymphoedema management service was accessed by people with palliative and non-palliative diagnoses and supported both inpatients at the hospice and people attending for day care. The British Lymphology Society defines lymphoedema as, "The term used to describe swelling that can occur anywhere in the body, but most commonly affects the limbs." The nurse was knowledgeable about the treatments used in the management of lymphoedema. These included a specialist form of massage known as manual lymphatic drainage, the use of compression bandaging and exercises. We looked at care plans of people who accessed the lymphoedema management service and found they were detailed. The lymphoedema specialist nurse told us, "On the first assessment, I take a medical history and ask about their medications and see where the swelling is. This is the diagram we fill in which documents this [swelling]. We also complete a psychological assessment and pain scale." This meant inpatients with lymphoedema could be supported by a specialist service based at the hospice.

No formal complaints had been made about the service in the last year and none of the people or relatives we spoke with had made a complaint. We saw a complaints policy was in place at the hospice and information on making complaints was freely available to people and their relatives. One person told us, "I have no complaints. Nothing could be improved."

People using the service as inpatients had access to various activities during their stay. The activities coordinator was passionate about their role and feedback from people, their relatives and other staff about them was very positive. We asked how inpatients were included in the activities on offer. The activities coordinator said people could be supported to the activities room to mingle with day care patients if they wished, or activities could be provided in their room if they preferred. One person told us, "They have social things like arts and crafts going on. They also have audio books which you can listen to." A relative said, "They have things for [my relative] to do, they have DVD's, knitting and sewing, there's clubs – the list is too long to remember." A wide range of complementary therapies were available to people, their relatives and staff. These included aromatherapy and massage. One relative said, "They care about the relatives. I can go and have a massage and I go their relaxation classes twice a week." This meant the service helped to promote the relaxation and general wellbeing of people and their relatives.

Requires Improvement ●

Is the service well-led?

Our findings

People and relatives were very complimentary about the service provided by the hospice. Comments included, "This place puts the NHS to shame", "Faultless", "10 out of 10", "It should be used as a bench mark", "They are short of nothing", and, "They are absolutely brilliant. You can't fault the service."

The Prince of Wales Hospice opened in 1989 to provide care for people from the Five Towns area of West Yorkshire with a life-limiting illness. It is run by a registered charity which has a volunteer board of trustees. There was no registered manager in post at the time of our inspection as the last registered manager had left in December 2015. The clinical services manager was completing the application process to become the registered manager. They told us the hospice had been through a period of change as some care staff had left the service which had caused staffing issues earlier in 2016. We saw this had been resolved by the recruitment of new staff.

Due to the lack of registered manager, the service had failed to make statutory notifications to the Care Quality Commission (CQC). Services have a legal duty to inform CQC about various types of occurrences, including safeguarding concerns, when the police needed to be called and serious injuries. We found the service had not notified CQC of three relevant incidents in 2016, although we saw all appropriate action had been taken to address each incident. We discussed this with the clinical services manager and directed them towards guidance on this aspect; they agreed the responsibility for statutory reporting had, "Fallen down between the cracks", and committed to ensuring this would not happen in future.

The service had used the time the inpatient service was closed for refurbishment during the summer of 2016 as an opportunity to focus on staff training and development and team-building. The clinical services manager said several members of staff left in early 2016 and there had been issues with staffing and morale. Since then, new staff had been recruited. In order to understand and address the issues, staff were asked to complete a detailed survey which covered aspects such as communication, job security and stress. The outcomes of the survey were compiled into a detailed action plan which the service was working through. There had also been a whole team away day, a leadership workshop for senior managers and a communications group involving staff from all parts of the hospice had been initiated. The induction programme had been updated so new care workers spent time with staff from finance, fundraising and other parts of the hospice so they could understand how their role fitted within the organisation as a whole. One new member of staff said of this, "It gives you an understanding of how it works and how you're dependent on all these departments to provide the clinical care." Regular coffee mornings had been started; all staff were invited to attend to meet and socialise with their colleagues. One staff member said, "We're a small organisation but we found not everyone knew everybody else and what they did."

Staff told us morale had improved during 2016 and they enjoyed their jobs. Comments included, "It's been the best decision I have ever made (coming to work at the hospice). It's what I really wanted to do", "I am proud to say that I work here", "I love my job", "I do believe that I am working with an excellent group of staff. I am happy and proud to be part of such as lovely staff team", "I love it, every day is different", and, "Morale is getting better." This meant the action taken to improve staff morale was having a positive effect.

Staff told us staff meetings had lapsed. The clinical services manager told us that this had been due to the previous issues with staffing levels. They informed us staff meetings had now been planned and booked for the rest of the year. A member of care staff said, "I think that communication could be improved at each level. There is no formal system in place to document changes such as changes to medication, it's just who notices it first. We could do with some kind of nurse/doctor handover record." We fed this back to the clinical services manager who agreed work was needed to ensure this aspect was improved.

The clinical services manager had started a weekly message which was read out to staff at handover meetings for one week to ensure all staff received it. Topics had included sharing good practice, for example, falls prevention and managing delirium, the outcome of the patient survey and the promotion of Dying Matters Week. This meant the service had developed a consistent approach to sharing information and learning with all members of the care team.

A system of clinical audits was in place at the hospice; however, they were high level and did not look for trends in order to identify improvements. We were told any falls or medicines errors were scrutinised on an individual basis by a committee led by the chief executive, at a meeting of the clinical team and by the board. Calls to the advice line were also assessed individually by the multi-professional team at the hospice. However, occurrences of the same types of incident were not assessed together to look for themes. For example, two incidents involving the improper use of bedrails were recorded for April 2016, but there was no regular audit of bedrail use to ensure problems did not happen again. A clinical pharmacist visited twice weekly to carry out clinical checks on prescriptions, however, the service did not monitor people's medicines administration records (MARs). We noted four gaps in MARs had been recorded as medicine incidents in April and May 2016; individual incidents had been scrutinised but there was no regular audit to make sure the problem did not keep happening. Also, there was no audit of advice line calls to identify common themes or problems which might indicate a particular learning need in either the staff answering the call or in community healthcare professionals making the calls. Other aspects not analysed for themes or trends included complaints/compliments and falls; inpatient care records were audited for quality but this was only completed annually and involved a sample of 10. This meant the system of audit in place did not assess the quality of day to day care.

We discussed the issue of audit with the clinical services manager and chief executive during the inspection. They both agreed the type and level of audit needed to be reviewed and improved and gave assurances this would be addressed as a priority.

The service was committed to ensuring care and treatment provided was in line with the latest national standards and guidance. We saw audits to assess whether clinical practice was in line with various National Institute of Clinical Excellence guidelines and with the Mental Capacity Act 2005. Each audit had an action plan which aimed to improve the quality of care provided to people using the service. The service had also considered how findings from a current research project on patient needs assessment could be applied to improve patient care at the hospice. The number of incidences of pressure ulcers, medicines errors and falls were also benchmarked against other services that were part of the Hospice UK network. This meant the service was keen to implement national guidance and relevant research findings and to compare itself to other hospices in order to drive service improvement.

Hospice staff worked with external organisations such as universities, the local NHS Trust and with community health and social care staff. The service provided a placement and mentoring for GP registrars (trainee GPs) and we saw feedback from a GP registrar who had completed a placement at the hospice which was highly complimentary. The hospice was part of a local hospice network and its consultants supported the 'on call' system which was shared between them. The clinical services manager told us the hospice was an active part of the community. They said, "The local community see it (the hospice) as their own." The medical director had visited the hospice chaplain's church to talk about the work of the hospice with the congregation; they told us, "We want to be seen as part of the community." At the time of our inspection the hospice was preparing for two open days as part of National Hospice Care Week. A memo from the clinical services manager to staff stated, 'The key purpose of both these days is to myth bust – hospices are not sad places where people come to die. They are vibrant communities supporting people to live their lives to the fullest.' This meant the hospice was keen to promote the philosophy of the hospice movement to external organisations and members of the local community.

Surveys of people and relatives were carried out with results analysed quarterly. The clinical services manager told us, "We have a rolling programme of surveys. A lot of our patients are very ill and do not want to fill in questionnaires, so we have looked at other ways of obtaining feedback such as diaries placed in patients' rooms which they and their relatives can fill in." We saw diaries in patient's rooms. People and their families used these to communicate with and feedback to the clinical teams. We saw action was taken by the service following feedback. The facilities manager told us following feedback about the noisy flooring, new softer cushioned flooring had been fitted. In addition, the inpatient unit used to have automatic lighting along the corridors. However, people said this sometimes disturbed their sleep as the lights went on whenever staff walked up and down. The facilities manager told us manually controlled lighting had been fitted in response. This meant the service was responsive to feedback and made changes to improve people's care experience.