

## North London Hospice

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### 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?

Good ●

# Summary of findings

## Overall summary

The inspection took place on the 11, 13 and 17 October 2016 and was unannounced. The previous inspection took place on the 19 December 2013 and met legal requirements.

North London Hospice is a registered charity which provides a range of services including inpatient, outpatient, community and day services for adults with life limiting illnesses and palliative care needs for people in the London boroughs of Barnet, Enfield and Haringey. The hospice has an 18 bed inpatient unit. There is also a multi-professional community palliative care team which provides symptom control advice, psychological, spiritual and emotional support, and a palliative care support service based at the hospice that provides practical care for approximately 200 people who live in Barnet, Enfield and Haringey.

Other services offered by the hospice included; complementary therapies, outpatients, physiotherapy, spiritual support and bereavement support for families, friends and carers of people using its services.

The service had a registered manager who was the Director of Clinical Services of the hospice. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was supported in the managing and running of the services by the Chief Executive Officer (CEO), Board of Trustees, Medical Director and other management staff.

People were supported to be fully involved and to take the lead in all decisions about the care and support they received. People were positive about the care and support they received from staff. People said their right to privacy was fully protected, and told us they were always treated with dignity and great respect by all staff. They told us staff were kind and listened to them and respected their wishes and preferences regarding their care and support needs. Each person had a specific up to date plan of care which provided information about their medical, physical, emotional, social and spiritual needs. People's specific wishes were recorded in advance care plans [ACPs].

People's physical, emotional, social and spiritual needs were met by a multi-disciplinary team [MDT]. The staff and volunteers we spoke with from all the services provided by the hospice spoke positively about their jobs. They had a very good understanding of their roles and responsibilities and cared very much about the people they supported and were committed to deliver a high standard of service.

Staff and volunteers received the training and learning they needed to be skilled and competent to provide people who often had complex needs with the care and support they needed. Some volunteers had the opportunity to complete specific training to develop their skills in supporting people with their emotional and spiritual needs.

Management and staff understood their responsibility to comply with the requirements of the Mental

Capacity Act (2005) and the Deprivation of Liberty Safeguards which meant they were working within the law to support people who may lack capacity to make their own decisions. Staff knew when safeguards needed to be in place to protect people who were unable to make decisions about their care. Staff established consent from people before providing care.

Risks to people's safety were appropriately assessed, managed and monitored to minimise the risk of people being harmed and to keep them safe. People told us they felt safe when receiving care and support from the hospice services. Staff received the training they needed to protect people and knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

There was a system in place to record, assess and monitor accidents and incidents. Incidents were analysed to minimise avoidable risks and the risk of re-occurrence.

The hospice environment was welcoming, clean, warm and well lit. Systems were in place to maintain the safety of the hospice and its services. This included addressing maintenance issues, fire prevention and carrying out health and safety checks of equipment and the building.

Systems and processes were in place to monitor standards of hygiene and control of infection and to make improvements when needed.

Systems were in place to make sure people's medicines were managed and administered safely. People's medicines were reviewed frequently to ensure they met each person's specific needs.

The provider's staff recruitment process made sure that staff and volunteers were suitable to work with people who needed care and support. Staffing levels and skills combination ensured enough staff were available to meet people's varied and often complex care, treatment and support needs in a personalised and safe manner.

People told us they enjoyed the meals, were offered choices and had their individual food preferences catered for. Nutritional assessments were undertaken to identify risks associated with poor nutrition and hydration so these could be minimised.

Inpatients and outpatients had the opportunity to participate in one to one and group activities to help minimise social isolation and promote their well-being.

The hospice was responsive to people's feedback and proactive in working in partnership with a number of external professionals and organisations to develop best practice and provide people and those important to them with a range of services that met their individual needs including advice and emotional support.

People using services and their families and friends were provided with a range of information about the hospice services. A variety of leaflets were also available which included details about each of the hospice services, therapies, medical interventions and bereavement.

People knew what to do if they had a complaint. They were confident that they would be listened to and any concerns they raised would be addressed appropriately. Staff were committed to learning from people's experiences and made improvements to the services when this was required.

The registered manager and other senior staff showed clear lines of responsibility and leadership. They and Trustees demonstrated a strong commitment to provide people with a safe and caring service and also to

develop and improve the hospice services when required so people benefitted from effective services that met their individual needs.

A range of comprehensive checks and monitoring systems including regular inpatient and management meetings where all aspects of the services were discussed and reviewed were in place to monitor and improve the quality of the services provided.

## 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 told us they felt safe. Staff knew how to recognise and respond to abuse and understood their responsibility to keep people safe and protect them from harm.

Recruitment and selection arrangements made sure only suitable staff and volunteers with appropriate skills and experience were employed to provide care and support for people.

Staffing numbers were assessed and adjusted to ensure there were sufficient numbers of trained, skilled and experienced staff to meet people's needs.

Risks to people were identified and measures were in place to protect people from harm whilst they received care and support within the hospice or in their own home.

Medicines were managed and administered to people safely.

Good 

### Is the service effective?

The service was effective.

Staff received the training and support they needed to enable them to carry out their responsibilities to provide the specialist care people required.

People were provided with a choice of meals and refreshments that met their preferences and range of dietary needs. Any risks associated with poor nutrition were identified and appropriate care and nutritional support provided.

People's health needs were carefully monitored by clinical staff and referrals were made to a range of other health and social care professionals when this was required.

People were involved in making decisions about all aspects of their treatment and care. People's liberty was not unnecessarily restricted. Staff were aware of their responsibilities regarding the

Good 

Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and their implications for people using the hospice services.

### Is the service caring?

The service was caring.

People spoke in a positive manner about the care and support they received. Staff were kind, compassionate and respectful.

Staff consulted people about the care and support they wanted and needed, gave them time to make their choices and respected the decisions they made. The hospice services were flexible and responded promptly to people's changing needs or wishes.

People's emotional, spiritual and social needs were understood and valued and their end of life choices and wishes respected and supported. Staff recognised and respected people's right to privacy.

Families, friends and carers were offered a range of support and advice.

Good ●

### Is the service responsive?

The service was responsive.

Staff had a good understanding of people's care and treatment and understood people's varied and often complex needs. Staff were responsive to any changes in people's needs so people received care that met their individual needs and wishes at all times.

Staff and volunteers provided people with the information, guidance and support they needed whenever this was required.

People had access to some group and one to one social activities and complementary therapies to promote their well-being and minimise social isolation.

A process was in place for managing complaints, which were logged, addressed appropriately and monitored by the leadership team.

Good ●

### Is the service well-led?

People were positive about the services they received and in the

Good ●

way the hospice was run. There was a clear leadership and management structure which supported and promoted a strategy of development that ensured the hospice services were run effectively and were responsive to people's needs.

Staff and volunteers were positive about the management team and told us they felt listened to and their individual skills and experience were valued.

The service worked in partnership with other organisations to promote, adopt and share best practice so people and those important to them received a service that met their needs.

There were a range of quality monitoring systems to monitor and review people's care and to ensure the environment was safe. The provider took appropriate action to develop and improve the quality of the service.

# North London 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 11, 13 and 17 October 2016 and was unannounced. The inspection team consisted of an inspection manager, two inspectors, pharmacist inspector, specialist nurse advisor who had palliative care knowledge and experience and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we asked the provider to complete a Provider Information Return [PIR]. The PIR 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. The PIR had been completed comprehensively and was discussed with the registered manager during the inspection.

We also reviewed other information we held about the service which included previous inspection reports and notifications. A notification is important information events which the service is required to send us by law.

During the course of the inspection we spoke either in person or on the telephone with eight people who used the hospice services. We also spoke with seven relatives of people using the services. We spoke with the Chief Executive Officer [CEO], Chair of Trustees, 30 members of staff and four volunteers. Staff spoken with included the registered manager, medical consultant in palliative care, practice educator, assistant directors of quality, facilities manager, chef, director of patient and family support, associate director outpatients, a physiotherapist, spiritual lead, nurses, healthcare assistants and other staff including management. We contacted three external health care professionals who had contact with the hospice but at the time of completing this report had not received feedback from them.

We looked at eight people's care records and other records relating to the management of the hospice. These records included; six staff recruitment records, training records, staff duty rosters, accident and

incident reports, policies and procedures, complaints, compliments, health and safety, maintenance, governance and quality monitoring records and reports.

## Is the service safe?

### Our findings

People using the service told us they felt safe when receiving care and support from staff. People using the hospice services and their relatives told us, "Yes, I always felt safe," and "I definitely feel safe, I was really scared before I had contact with them [hospice] but was pleasantly surprised."

There were systems in place to protect people from abuse. There was a safeguarding policy and procedure for staff to follow if they were informed of or suspected abuse. Staff and volunteers we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns and knew about the provider's whistleblowing policy. Staff knew they could report issues and concerns to the appropriate authorities outside the organisation including local safeguarding team, police and CQC if necessary. Staff training records and training plan showed staff had received training about safeguarding people. The hospice had a safeguarding lead who had a role in making sure staff followed appropriate policies and received the safeguarding training they required.

People's records showed that each person had individual risk assessments that included control measures to minimise the risk of harm. Potential areas of risk included nutrition, falls, moving and handling, pressure ulcers, bed rails, infection control, self-care, pain and breathlessness. Community nurses told us they carried out a risk assessment of the environment of the home of each person using the service to identify and monitor any health and safety issues. Records showed preventative action had been taken by staff to lessen those risks and to protect people.

Risk control measures included ensuring staff used appropriate equipment when they supported people with mobility needs to change their position in bed or with transferring from bed to chair. SSKIN [five step model to help prevent pressure ulcers] was implemented by the service to minimise the risk of pressure ulcers. People's risk assessments were reviewed and updated regularly in accordance with people's often rapidly changing care needs.

We saw accidents and incidents were recorded and action had been taken to minimise the risk of similar incidents reoccurring. We found the service had taken action that included working closely with staff including physiotherapists to develop and improve policies and guidance to minimise the risk of falls. The registered manager was aware of the need meet legislation by notifying us of significant events/incidents that affected people using the service.

Security including night time security arrangements was in place to ensure people were safe. We found that although there was a record book for visitors to the inpatient unit to sign we were not asked to sign a record book when we visited the service. Records of people entering the hospice enable the service to keep track of who is in the building and where they might be, which could be important in times of emergency or an incident affecting personal security. The registered manager told us they would implement recording of all the people who visit the service.

The service had systems in place to respond safely to a range of emergency situations including fire. A fire

emergency plan including evacuation procedure was displayed. Equipment including blankets, torches and other items were available for use in an emergency. Staff took part in regular fire drills and appropriate signage identified emergency exits and fire equipment. Front of house volunteers received specific training which included how they should respond in the event of a range of emergencies including the use of panic alarms. The hospice had a lone working policy. A community nurse manager told us about how this policy was implemented by the community team to keep staff safe.

There were various health and safety checks and risk assessments carried out to make sure the premises and systems within the hospice were maintained and serviced as required to meet health and safety legislation and make sure people were protected. These included regular checks of the hot water outlet temperature, gas, electric and fire safety systems, and Legionella bacteria water checks. There were service contracts in place to ensure equipment such as hoists were regularly checked and met legal requirements.

People told us they received the medicines they needed. People using the service told us "If I want some pain medicine they give it. They help me with pain control" "I love the fact that when I'm in pain they try to help me" and "I get sick, [vomiting]. They give me medicines to keep my food down and I can talk to the staff about my medicines."

We found people's medicines were managed and administered safely. Suitable arrangements were in place for obtaining medicines. We saw that appropriate supplies of medicines were available to enable patients to have their medicines when they needed them.

As part of this inspection we looked at the prescription and medicine administration records [MAR] for seven patients. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them. There were no gaps on the MAR and any reasons for not giving people their medicines were recorded. All nursing staff had to complete a medicines competency assessment before they were allowed to administer medicines. Nurses administering medicines wear a red tabard to alert others that they mustn't be disturbed during medicines administration so minimising the risk of making any errors.

The hospice received pharmacy support via a service level agreement with a local NHS trust. A pharmacist visited once a week to review MAR charts and a pharmacy technician twice a week to top up stock medicines. The hospice did not use any patient group directives to administer medicines and no patients were self-administering medicines when we inspected.

We saw medicines were stored securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature and so fit for use. Controlled drugs [CDs] were managed appropriately and the registered manager was the accountable officer [member of staff responsible for the management of controlled drugs and related governance issues in the hospice]. The hospice was a member of the controlled drug local intelligence network [multi-disciplinary group that meets regularly to manage and share concerns about the use of CDs] and submitted quarterly occurrence reports.

We saw any medicine incidents were recorded. These were reviewed by the quality and risk group every month to identify if there were any areas that needed to be improved. People told us they received the medicines they needed.

Staff recruitment policies and procedures were in place. Staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure only suitable staff were employed to

care for people. These included checks to find out if the prospective employee had a criminal record or had been barred from working with people who needed care and support. Staff confirmed they had completed a thorough recruitment process before they were employed by the service. Trustees also received a range of checks prior to their appointment to determine their suitability for the post. A volunteer told us the process of their recruitment had been "very efficient and effective."

There were systems in place to manage and monitor the staffing of the service so people received the care they needed safely. We looked at the inpatient staffing arrangements during the inspection and found that the numbers and skill mix of staff facilitated people's needs being met. The registered manager told us that staffing levels in all the services provided by the hospice were closely monitored and were flexible to make sure people's range of often complex needs were met at all times. They informed us that use of 'Phase of illness' and patient performance indexes were used on the inpatient unit to support the identification of patient dependency and the staffing levels and skill mix needed.

However, we received mixed feedback from staff about the staffing levels. A nurse told us that when more staff were needed they were able to ask for extra staff and this usually was accommodated. Some inpatient staff told us they felt there were not always enough staff on duty and sometimes felt rushed and were unable to spend suitable time with people. They said there had been an increase in the use of agency and bank staff who they felt did not know the needs of the patients as well as permanent staff. Inpatients told us that staff seemed to be busy. A nurse told us "We need more qualified staff on duty, and then I could spend time teaching the junior staff and the healthcare assistants." Management staff told us they were in the process of recruiting nurses to fill vacant posts.

Call bells in the inpatient unit were answered promptly. An inpatient said "I can be buzzer happy when I'm breathless. They come really quickly. I kept buzzing the other day and they said 'Don't keep apologising, we're here to help.'"

The hospice was very clean. An inpatient told us "It's spotless". Soap and paper towels were available at wash basins and staff had access to protective clothing including disposable gloves and aprons. Liquid hand cleanser was available to staff, people using the service and visitors to help prevent and control the risk of infection. Housekeeping duties were carried out by a designated team of staff who completed a comprehensive cleaning programme.

The cleanliness of the premises and infection control was closely monitored. A range of checks were carried out to help prevent and control infection. These included checks of the cleanliness and condition of mattresses, hand washing and inpatient room cleanliness and safety audits. Action plans addressed any deficiencies.

A lead infection control nurse carried out infection control training and produced an annual update about infection control and supported implementation of improvements when required. We found in the inpatient unit there were no toilet lids on the toilets in people's bedrooms. We talked with management staff about this and they promptly took action to address this issue.

## Is the service effective?

### Our findings

People using the hospice services and family members told us they were happy with the care and support they received from staff. They praised the staff and volunteers and told us "Every member of staff have the most incredible skills, they were always calm," "I am very happy and content with the service," "They [staff] help me in all sorts of ways. There were practical things I couldn't be bothered to do but they [staff] told me not to worry and helped me with them," "The staff are a cut above the rest, all of them, the doctor and the staff. I can't think of any improvement" and "They [staff] were extremely professional and dealt with complex issues. They were always clear and helpful and never let me down."

Staff were very knowledgeable about people's individual needs spoke in a positive manner about their experiences of providing people with the care and support they needed within the hospice and in the community. Staff comments included; "I love it here," "We all support each other, the management team are very approachable and if you have any issues, they are quick to take them on board," and "We are a good team with a variety of experience in nursing and in life in general and it all comes together."

Staff told us they received the training they needed to provide people with effective care and support. They informed us that when they started working in the hospice services they had received an induction, which included learning about the organisation and being supported by more experienced staff as they became familiar with the hospice and its range of services. Staff told us the induction was comprehensive and had helped them to be competent and to know what was expected of them when carrying out their role in providing people with the care and support they needed and wanted. A nurse told us the induction had been informative and had made them feel supported. The registered manager informed us that new healthcare assistants completed the Care Certificate which is the benchmark for the induction of new care workers and consists of a set of minimum standards that social care and health workers follow in their daily working life. Volunteers confirmed that they also received an induction which included resilience training which helped them to respond effectively to the challenges of their roles.

Training records showed staff had received training in a range of areas relevant to their roles and responsibilities. Staff completed training and a range of courses in topics that included; moving and handling, safeguarding people, fire safety, first aid, health and safety, infection control, dementia, medication, cardio-pulmonary resuscitation and palliative care. Refresher training took place regularly to ensure staff remained knowledgeable and skilled in these areas and in their specific roles. A member of staff told us "Training is very good here, there is plenty of choice."

A volunteer told us "There have been lots of courses over the years, things like dealing with bereavement. I know if I had a problem I could talk to anyone I rely on the administration manager and the deputy director and I know there is a volunteer co-ordinator."

Records showed that competency checks of nurse's clinical competence in areas such as medicines administration, communicating effectively with patients, male catheterisation and carrying out a range of tasks were also carried out. Nurses were supported with revalidation so they could remain registered with

the Nursing and Midwifery Council [NMC]. A nurse told us they kept up to date by with their NMC registration through reading articles and attending training and completing other relevant learning activities. Learning sessions and study days were available for clinical staff. Topics covered in these sessions included palliative care, bowel obstruction, and medicines. A nurse told us they were undertaking a mentorship module at university. Another nurse told us they had completed a BSc in palliative care at University College and that North London Hospice had funded 50% of the course and enabled them to have study days included in their working week so they did not have to attend the course in their own time. This indicated the hospice promoted the personal development and skills of staff as well as meeting the needs of the service. People using the services and those important to them told us they felt staff and volunteers were competent and knew people well. An inpatient told us "I am confident in the staff without a doubt".

A cross department learning and development steering group considers, monitors and reviews the organisational training budget, learning and developmental requirements and receives feedback from the learning and education programmes sub group about staff training needed by the service. A management development programme provided training for management staff on a range of subjects including leadership, personal development review process and coaching.

The hospice had established a partnership with Barnet and Southgate college to provide an accredited award in Awareness of End of Life Care to develop people's knowledge and skills and to raise the profile of end of life care. Clinicians had access to reference material including Royal Marsden's Manual of Clinical Nursing Procedures and Palliative Care guidelines. The hospice also delivers a programme of external training about end of life care for care homes and for clinicians. The registered manager told us they had provided in response to a request from a care home a specific training programme for staff. Student nurses and medical students have the opportunity to complete placements at the hospice to develop their learning and skills in end of life care.

Staff told us they felt well supported. However, six staff working on the inpatient unit told us that although they felt supported by management staff they were not receiving formal supervision with a senior member of staff. They told us "I have only had one or two but nothing for a couple of years," "We don't get supervision, but managers are always available." Management staff told us and records showed formal group and one-to-one supervision for all staff including inpatient unit staff was in the process of restarting. We saw records that showed staff had received appraisals of their performance and that community nurses had received formal supervision. Management staff informed us staff supervision was flexible and could take place promptly when staff requested support or there were work practice issues. Records also indicated that debrief/reflection sessions were held for staff when this was needed such as following the death of a person using the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we checked to see if the service was working within the legal framework and principles of the MCA and we found staff including management staff knew about the requirements of DoLS. The registered manager informed us that at the time of our inspection there were no people using the service who had a deprivation of liberty authorisation. Staff had received training about the principles of MCA and

DoLS and were able to tell us about how this applied to the service.

Staff told us that people's consent to care and treatment was always sought and when a person was unable to make a decision or consent to any aspect of their care and treatment, best interests decisions were made on their behalf. An inpatient told us "They always ask me if I feel like a wash and they do what I ask. Anything they want to do they ask first, even to change the sheets" People's care plan documentation included records that showed people had been asked for their consent.

People's mental capacity to make decisions was reviewed frequently by the multi-disciplinary staff team. Staff told us a best interests meeting with those important to the person, staff including a range of health and social care professionals would be involved in making a decision in the person's best interests when they did not have the capacity to do so.

We saw that DNACPR [do not attempt cardio pulmonary resuscitation] decisions had been made following consultation and agreement with the person using the service. A person's relative told us a community nurse had checked that a person's DNAR form had been completed appropriately. We saw examples of advance care planning in respect of people's wishes for care and support at the end of their lives. The hospice operates an out of hour's advice line for patients and professionals provided by nurses who work in the inpatient unit. The nurses have access to the on call medical consultant for advice and to discuss action if required. The community team liaise closely with GPs regarding meeting people's care and treatment needs. A person's relative told us "Communication was good. I knew who to call for advice and support. I had an out of hour's number and called a lot at all times of the day and night; they always called me back when I left a message."

We looked at how people were supported with their nutrition. We found people's nutritional needs and preferences were recorded in their care plan records. People spoke positively about the quality of the food. They told us they had choice and their particular dietary preferences and needs were accommodated. We spoke with the cook who was knowledgeable about people's range of nutritional needs and told us they were kept fully informed about people's dietary needs and of changes in those needs.

The cook provided us with examples of when they had cooked and/or purchased specific food items that had been requested by people using the service. They spoke of the importance of providing people with the food they enjoyed and always made sure this was accommodated. They told us that when people ask for a particular food "I never say no." A range of snacks and other refreshments were accessible to people at any time of the day or night. All the people we spoke with told us that they felt quite comfortable asking a member of staff or ringing their call bell if they felt like a drink or snack at any time. We saw an example of this during the inspection when a patient asked for some tea. There was no delay in it being provided. A patient told us "They give me snacks at three in the morning. They don't ever say 'no', and then I go back to sleep". Inpatients have the opportunity to use a fridge located in their bedroom for personal food items.

The cook told us that they asked people for feedback and took action to address any issues raised. They said they would in future record any action they took in response to people's feedback. We saw some positive written comments about the food and patients told us, "When I came in they asked me what type of food I liked", "They give me dessert half an hour later, like I wanted. I've got my own fridge with my food," "The food here is excellent, I couldn't fault it. I had cheese and tomato flan today which was very good and I ate every scrap of it." "I like large portions and that's what they give me. I've stopped losing weight since I've been in here."

People who had difficulty in swallowing had their food pureed. During a staff 'handover' meeting the

nutritional needs of patient who had difficulty swallowing were discussed including the person's risk of aspiration [food/fluid being breathed into the lungs rather than being swallowed]. The staff discussed the need for the person to have oral fluids and pureed diet under supervision.

People's well-being and health needs were met by staff and volunteers who supported people to be as comfortable and stress free as possible. People's health needs and how they were met were detailed in their care records. Staff told us about liaison with a range of services within the hospice such as physiotherapy and externally the Citizens Advice Bureau [CAB] to make sure people's individual needs were met. Volunteers spoke about their role in promoting people's well-being and provided us with examples of how the action they took to meet people's support and social needs. A volunteer spoke of accompanying people on walks and on shopping trips when this support had been requested by people.

The environment of the hospice was welcoming, bright and warm. It was suitable for people's varied mobility needs including wheelchair users. Handrails were situated throughout the hospice to assist people to move freely within all areas. Management staff told us they had plans to develop and improve the environment so it met the needs of people who were living with dementia.

All the rooms on the inpatient unit were single and included bathroom facilities. Several bedrooms led to the garden area, and beds could be wheeled out to this facility when people wanted to spend time outside. The garden was landscaped in an attractive manner and included a range of seating. It provided a peaceful scenic area for people and their friends and family to enjoy.

The hospice also provided a reception area where people could sit and talk with others or be on their own in a setting away from the inpatient unit and to take part in a range of activities if they wished. The hospice arrangements and facilities supported family members and others to spend time with their loved one following the person's death.

Arrangements were in place to make sure that maintenance issues were addressed promptly. During the inspection we saw some areas of the hospice were being refurbished.

## Is the service caring?

### Our findings

We saw many examples of positive engagement between staff and people using the service. Examples of this good quality interaction ranged from staff chatting in a friendly manner with people using the day services, to a clinical member of staff very sensitively telling relatives that their family member had just died.

Patients and those taking part in day service activities were very positive and complementary about the staff and the services they received. They told us "The staff were unbelievable, they couldn't have done any more than they did," "They [staff] are very genuine and can't seem to do enough," "They [staff] made me laugh. They were absolutely incredible," "They are very comforting, I can talk openly about my worries to them," "All the staff I've met are friendly and professional," "They, [staff], are amazing. Very caring and always smiling" and "They [staff] have empathy, and don't shy away from difficult issues and conversation."

There were two relatives of a person using the service who although they were satisfied with the care a person received from nurses and healthcare assistants were not so positive about some aspects of communication from staff. They spoke with the registered manager during the inspection who later told us they had addressed their issues. A person's relative provided us with examples of staff upholding many caring values and told us about the significant integrity that had been demonstrated by a community nurse.

The hospice inpatient and community staff and volunteers were motivated, committed and competent to provide people with a high standard of care and support. Their approach ensured people were listened to; their preferences recognised and supported so people benefitted from good quality end of life care and/or with managing life limiting conditions. We heard people being offered choices and their decisions accommodated. For example people were asked what they wanted to eat and whether they wanted to take part in a group activity. Staff had received training about promoting and maintaining dignity. Management staff told us the service was promoting better engagement with people by implementing the 'Hello my name is' [campaign developed by a terminally ill doctor who found staff did not introduce themselves before delivering her care] to promote better communication between staff and people using services.

People told us that their independence was respected and staff supported them to remain in control of as many areas of their life as possible. Nurses told us "We always ask what the patient wants," "We always discuss everything with the patient and/or next of kin," and "I ask the patient and see what they can do for themselves first." A patient told us "They let me wash myself if I can which I prefer but when I can't, they help me."

Care records included information for staff about how people's independence should be promoted and respected. People had access to walking frames and other equipment to assist them with staying mobile and for transferring to and from beds and chairs. A specialist bath was available for people with mobility needs to use, which a member of staff told us had recently enabled a person to achieve their goal of having a bath.

All the staff and volunteers we spoke with were passionate about their providing people with a high standard of compassionate and supportive care. A volunteer told us "It [the hospice] is a very caring place; I have had friends cared for here."

Staff and volunteers told us about how they encouraged and supported people to be fully involved and make decisions about their care, treatment and other aspects of their lives such as advanced care plans. A volunteer spoke about the importance of giving people the time they need to make decisions and when engaging with them. They told us that was the reason why they did not wear a wrist watch. The volunteer was particularly sensitive and understanding about their role in providing people with a wide range of support that met their individual needs and encouraged their well-being. They provided us with a range of examples of the engagement they had had with people and told us how people had been supported by them to achieve individual aspirations and wishes during the end of their lives. This engagement included sitting with people when they requested not to be alone, and supporting them to access community facilities including local parks and shops to enhance their quality of life.

Staff and volunteers understood people's right to privacy and we saw they treated people with dignity. We saw staff and volunteers engage with people in a sensitive manner when talking with them and when staff assisted them with their care needs. The reception area included a seating area with 'carriage style' sofas for those needing more privacy. Staff we spoke with had a good understanding of the importance of confidentiality. They knew not to speak about people other than to staff and others involved in the person's care and treatment.

All the bedrooms in the inpatient unit are single which promoted people's privacy. Rooms were available for individual therapy and/or for people to consult with staff. A 'quiet' room was available for people to use when they wanted to be alone or meet with those important to them. Signs were available to put on people's bedroom doors when people who chose to spend time by themselves or with family or friends and did not wish to be disturbed. However, one inpatient was not aware that these signs were available and told us "I'd like a 'Do Not Disturb' sign to put on the door sometimes". Staff were seen to knock on people's doors however on one occasion when we were talking with a person using the service we found that a member of staff did not knock prior to entering the person's room.

People were supported to maintain the relationships they wanted to have with friends, family and others important to them. Relatives could visit people on the inpatient unit at any time and spend the night if they wished. Staff and volunteers provided people's family and friends with support when they needed and requested it. They told us this was an important role which benefitted people using the service as well because they tended to worry about the effect their illness had on their family and friends. A nurse told us "I find it satisfying, looking after relatives as well as patients." During the inspection an impromptu wedding took place in the hospice. The hospice had quickly taken steps to make the necessary arrangements to facilitate the event and to make it a special occasion that met the needs and wishes of a person using the service.

After death documentation included the personalised key actions that needed to be carried out by staff to meet the person's individual cultural and religious needs and preferences following their death. The hospice has a viewing room so those important to people could spend time with their loved one following the person's death.

A bereavement support service was available to people's relatives and friends to support them following the death of their loved one. People's relatives confirmed they had been offered bereavement support. Crimson volunteers [volunteers who had attended a minimum of 36 hours of emotional and in depth loss and

transition support skill training] supported by supportive care clinicians provided emotional, spiritual, and social support to people and those important to them. For example providing support for a person by sitting with them, listening to them or enabling them to attend a place of worship if they wanted to, the shops or go for a walk in a local park.

Staff received mandatory equality and diversity training. They had a good understanding of equality and diversity, and told us about the importance of recognising, valuing and respecting people's individual beliefs, needs and differences. The hospice facilitated access to spiritual and emotional support from the spiritual care and chaplaincy team and the social work team. A person's relative told us they had appreciated a nurse asking them about their religion which was important to them.

People who did not express religious or spiritual needs were also able to access support from staff to help them cope and manage their feelings and emotions during an often very difficult time. The service had a non-denominational room with facilities for multi-faith needs where people of all beliefs could practice their faith and access a range of religious books and information about religions. A 'Book of light' remembrance book was annually printed with comments from hand written book of entries made by staff, patients and families/ visitors about people using the service.

People have access to a translation and interpreting service and a portable hearing loop [assistive listening technology for individuals with reduced ranges of hearing] was available to patients and carers to promote communication. We informed management staff that an inpatient told us that they wished staff "name badges were bigger and easier to read."

## Is the service responsive?

### Our findings

People told us that staff understood and were responsive to their individual needs. A person using the service told us that staff were "100% excellent and very responsive, It is a brilliant service." Other comments from people and relatives included; "The doctors are wonderful, nothing was too much trouble for staff, I can only praise them," "[Community nurse] came to see [Person] every week and also phoned. They were absolutely amazing and on the ball," "I couldn't have coped without them [hospice staff], they helped us so much with [Person's] complex medical issues," "[Staff] were responsive they provided a [medicines] prescription and organised a healthcare assistant to bring it to me," "A person rang me after a hospital appointment and asked me how it went," "When I'm uncomfortable they come in and put it right. I can choose to be in bed or the chair no matter what time it is".

All community and outpatient referrals are triaged following a telephone assessment to establish urgent and non-urgent referrals. Visits by clinical staff are then arranged. Each weekday meetings on the inpatient unit take place to agree admissions to the unit. The meeting is attended by the triage nurses who present the patients for admission either as new referrals or from the North London Hospice community team. Patients can be admitted 7 days a week as booked admissions but not out of hours (in the evenings and overnight). People can receive care from the community team and be admitted to the inpatient unit during weekends. Arrangements were in place to make sure people could be rapidly referred from one hospice service to another such as from outpatients to the community service.

Each person receives an assessment using a detailed framework to make sure assessment of people's needs was robust, consistent and specific to each service. People's needs were assessed with their full involvement and when applicable their family participation, prior to them being admitted to the inpatient unit, or attendance of an outpatients appointment or day services and before people received care and support from the hospice community team. Assessments incorporated a range of aspects of people's needs and preferences. These included advanced care plans, pain management, personal care, social and spiritual needs as well as any support family members and/or others important to people using the hospice services needed. Staff told us people's needs were continually assessed. From their admission to discharge. Patient outcomes scale [IPOS] was used to plan an individualised programme of care with people using the hospice services.

People's care plans had been signed by them and were accessible to them, and were developed from the initial assessment of their needs and identified the support people needed with their care and other aspects of their lives. The care plans showed that staff were responsive in developing and changing people's care and treatment when people's needs changed. They incorporated information about a range of people's needs such as pain control, skin integrity, loss of appetite, emotional and spiritual support and included guidance for staff to follow to meet those needs. People's care records were in electronic and paper format which we found corresponded and were equally up to date.

Each person's care and treatment needs and their progress were reviewed regularly by a team of health and social care professionals including the consultant in palliative medicine and care, doctors, nurses and social

workers during multi-disciplinary meetings. Staff told us that during these meetings people's individual needs including treatment of symptoms, such as nausea and vomiting, pain management, spiritual and emotional needs were reviewed and discussed. People using the service confirmed they were fully involved in decisions about their care. We saw an entry in a person's care records made by a 'crimson' volunteer. A crimson volunteer has undertaken specific training in order to interact with patients and make data entries on the system. The entry stated that the patient wanted company and had no family or visitors so the volunteer had spent time with the person talking with them about a range of subjects they wanted to discuss. A patient told us "I have had lots of talks about my care and what I need". Another patient told us "We have a meeting every week with the doctors and a couple of members of my family, and some nurses. We discuss the progress I've made."

The care records we looked at detailed sensitive conversations, ward round discussions, incident forms, and contact with a range of other health care professionals. We saw documentation of a sensitive conversation held with a patient, family member, nurse and doctor. The conversation highlighted the patient's wishes and how these could be supported in the future. A person's relative told us the hospice enabled their family member to achieve their wish of dying at home. We saw from records people had the opportunity to complete advance care plans in which their preferences about the care and treatment and end of life wishes such as a preferred place to receive their end of life care, were documented

Staff 'handover' meetings on the inpatient unit took place several times a day. We joined a handover meeting with nurses and healthcare assistants and found the handover demonstrated sensitivity and good communication between the staff. For example, we heard a discussion regarding a patient's pain control and the element of anxiety involved. Staff discussed different approaches including the use of a heat pad as well as a range of pain relieving medicines. There was also a sensitive discussion about the spiritual and cultural needs of a patient which showed there had been consultation with the person and those important to them to make sure the person's needs and wishes were understood and met. The family's participation in providing the person with the personal care they needed had been supported by the service which provided assistance from staff when this was required.

Staff we spoke with were knowledgeable about people's care plans and the support people required. A patient told us "My symptoms are managed without a doubt and my breathing is looked after. If I say I'm having trouble they check me over and call a doctor. The doctor is brilliant. He stayed with me when I was having a panic attack". People told us they could speak with staff at any time. An inpatient told us that it was easy to talk to any of the staff and they had countless opportunities to do so. Another person using the service told us "If you want something done, the staff will do it if they possibly can.' If they say they will be back in ten minutes, they will be."

The hospice worked with Macmillan Cancer Support with the development of the role of healthcare assistants [currently two were employed] to provide a range of support and care for people receiving a service from community teams across the three hospice sites. The roles these healthcare assistants carried out included a phlebotomy service, urinary catheter care and supporting people with their emotional needs such as those who have anxiety,

People confirmed they were supported to make choices and decisions about their care and their preferences and wishes were accommodated. These included supporting people to achieve their wishes such as being in their preferred place at the end of their life. Staff told us sometimes people chose to travel to their country of origin at the end of their life and staff support them in a range of ways such as providing the medicines they required to achieve this goal. A manager told us that "We say to people, we walk alongside you.' A person's relative told us that a community nurse always provided significant advice and

support including role playing a range of situations that helped them cope and manage to support a person during some very difficult times and conditions including when the person did not want to eat. They told us "Staff worked well with us, they were clear about who was dealing with [Person's] care and my issues."

Outpatient appointments provided people with a range of support and treatment, which included medical consultation, physiotherapy for supporting people's mobility and/or breathing needs, symptom control such as helping people in ways to relieve their pain, welfare support and complementary therapy sessions. The Associate Director for Outpatient and Therapies told us an occupational therapist and an art therapist had been recently appointed and so the service could be more responsive in supporting people more fully.

People had the opportunity to take part in activities and to receive complementary therapies. Other activities included singing, music sessions and visits from therapy dogs to promote people's well-being. During the inspection we saw volunteers spend time talking with people. They also spent time with people during activities such as playing cards and during a tea time event. People who participated in the day service activities told us how much they enjoyed coming to the hospice and taking part in activities. A person told us "I read the papers and talk to my family. I get visitors and there's the telly. I sometimes go to the afternoon tea". Hairdressing facilities were available for volunteers to provide people with a hairdressing service.

Volunteers showed commitment, passion and enthusiasm when speaking about their roles in supporting people using the services. A volunteer spoke about being responsive to people's individual wishes and told us about accompanying a person shopping and then to the hairdresser which had significantly enhanced the person's well-being. They told us about a person who requested a walk in the rain which was accommodated and another person's joy at touching a hedge when out walking with them. They regularly rang people using the day service in response to people's requests for the calls as they had found them to be comforting.

There were systems in place for addressing complaints and compliments. This included listening to people's concerns, recording and taking appropriate action to address complaints and to make improvements to the service when this was needed. Complaints leaflets were included in all service information packs and within patient information display racks. People said they would be quite comfortable raising concerns but no-one had felt the need. Within the last year there had been 141 compliments about the service which included some very positive feedback from people. People told us "I have no complaints, they can't seem to do enough" and "I have absolutely no complaints whatsoever. Some people can't always be pleased with things and will complain, but we were very pleased and happy with everything."

Staff knew they needed to take all complaints seriously and report them to the registered manager. There had been eight complaints within the last twelve months. Records showed complaints had been managed and dealt with appropriately. The quality and risk group reviewed complaints and incidents to consider the learning from them and to take action to make improvements when needed. Improvements to the service were made in response to complaints. For example there had been complaints about issues to do with contacting the hospice, and community teams had been made aware of the need to highlight the correct out of hour's number for people using services and their carers.

People received an information pack when they started receiving a service. A person using the service told us "I had plenty of information. It was easy to understand". Regular newsletters about the service were available to people. They included news about people and fund raising activities. People could also access a range of information in paper format and on the hospice website about the services provided by the hospice and external services to help them and those important to them in making decisions about care and

treatment. Information was also available in a range of languages, large print and braille for those who needed it.

## Is the service well-led?

### Our findings

People and their relatives spoke in a positive manner about the hospice and the way it was managed. They told us "I would give the hospice as many stars as possible, the staff are amazing," and "We were more than impressed with the hospice."

From observation and talking with staff and volunteers we found they were motivated and passionate about their roles in delivering the care and support people needed and wanted during the end of their lives. Staff and volunteers told us they were very happy working in the hospice services, which they said they felt was well run and there was a culture of openness.

Staff told us they received the support they needed to carry out their duties to a high standard. They told us management staff were always available for advice and support. Comments from staff included "Managers are always approachable, they always ask you if you are ok, this is very important in this line of work," "As a team we support each other," "We have a lot of peer support, a close-knit team," "You can knock on their door anytime, they [managers] are fair," and "We can do debriefs if we need them. We have also had external people providing clinical supervision if needed."

The registered manager managed the service with support from senior managers in clinical and non-clinical roles, CEO and the hospice board of trustees. Staff told us that they worked well within their teams and with other parts of the service to ensure people using the hospice services were safe and received the care and support that met their individual needs. Some patients we spoke with did not know who was in charge of the inpatient unit or the hospice. Management staff told us that in response to a survey feedback the inpatient unit were currently developing a 'Who's Who' noticeboard with details of hospice staff and others.

During the inspection the senior leadership team including registered manager, CEO and medical director went on a planned away day to discuss and formulate the future strategy of the service. The CEO told us this would be presented and discussed at the next board meeting. The executive team meets fortnightly to discuss and review a range of areas to do with the service. The clinical directors meet regularly to review issues and the development needs of the clinical services. The management group meets quarterly to review progress of departmental plans, strategy, development and service delivery.

Key performance indicators and service activity are monitored by the board of trustees. Trustees told us about how they focused upon the care of people using the hospice services and regularly received examples from the registered manager of how people had been supported and cared for by the service. A trustee told us that this was helpful in reminding the board of the purpose of the service and their role. The CEO and trustees visited the hospice and other hospice sites regularly and told us they spoke with staff, patients and others about the service during these visits.

Team and departmental meetings also took place and staff told us they had the opportunity to discuss aspects of the service and best practice during these and handover meetings they attended. For example during a recent nursing and facilities meeting nursing practices issues had been discussed including nurses

revalidation. A weekend co-ordinator has been introduced to support 'front of house' volunteers and inpatient unit staff with administrative tasks. Housekeeping staff provisions has been increased to make sure standards of cleanliness remained high.

Staff told us they had the opportunity to feedback to management staff during information communication forums where they could discuss a range of issues including confidentially. They provided us with an example where differences in annual leave amongst staff had been addressed. A member of staff gave us an example of a suggestion they had made which had addressed an issue to do with a piece of equipment. Staff exchange meetings took place every two weeks when a member of staff from each team updates other staff about what is going on within each team such as recruitment of staff. This ensured communication between teams was good and all staff were kept up to date with changes and development of the service. Staff told us they received a monthly newsletter about the service via email. Staff told us "We all support each other, the management team are very approachable and if you have any issues, they are quick to take it on board," "I have recommended other nurses to come and work here," "Everyone here is friendly and approachable" and "All the managers are lovely."

The provider information return showed us the registered manager and others in the leadership team had identified a range of improvements and developments to the service that they were in the process of planning and/or implementing. These included; plans to introduce Schwartz Rounds [provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in the hospice] in early 2017, plans to appoint a part time band 6 nurse for the inpatient unit who will have a focus on tissue viability and to refurbish some areas of the environment.

As part of the process of monitoring the quality of the service, people, carers and staff were provided with the opportunity to feedback their views of the hospice services at any time and annually. Comment cards were also available throughout the hospice for people to provide feedback about the service. People's feedback was reviewed by the management staff and action was taken to address issues and to make improvements when required. This feedback was analysed and shared with the hospice leadership. Action taken recently to address issues raised by people, included refurbishment of the reception area to make it more suitable for meeting people's needs and promoting their well-being. This showed that people's views were listened to and addressed appropriately. Patients we spoke with were satisfied with opportunities to give feedback. People using the service told us "I often give feedback when I'm being washed," "I had a written survey a few days after I came in. Someone asks me every day."

The service had a range of monitoring and governance systems which included checks and a range of clinical and non-clinical meetings such as trustee meetings to examine and review the services provided by the hospice and to ensure improvements and developments were made when needed. Management staff told us there was an annual audit of the whole service which included checks of all areas of the service such as infection control and health and safety. An audit programme was in place that was monitored by the audit steering group of senior staff and included a range of checks such as infection control, hand washing and care. A check of the service had recently been carried out which had been in the style of a CQC inspection to ascertain whether the service was providing a good quality service and to identify areas for improvement.

The quality and risk group met monthly and feeds into the quality safety and risk sub-group of the trustees. It reviewed and monitored clinical and non-clinical matters including patient safety alerts, medical device alerts, important public health messages and other safety information and had standard agenda items such as incidents and pressure ulcers.

The hospice works in partnership with a number of organisations including Clinical Commissioning Groups to promote, develop and improve the hospice service and end of life care, such as providing training in end of life care for care home staff. Medical consultants worked across the hospice, hospital and community settings. They attended Integrated Locality Team meetings, Neurology MDT meetings and the Frail Elderly MDT which identifies people in the community a range of needs including end of life needs and aimed to promote and provide them with effective support to prevent avoidable problems occurring.

The hospice is a member of Hospice UK which champions & supports hospice care, and the National Council for Palliative Care [umbrella charity for all those involved in palliative, end of life and hospice care in England, Wales and Northern Ireland] that produced updates about hospice and palliative care and a range of other services so the service kept up to date with current best practice and guidance. The registered manager told us the hospice was involved in supporting the hospice UK resilience programme. Hospice staff attended local provider networks for Palliative and End of Life Care in the North London Clinical network where best practice and up to date guidance is shared and discussed.

The community team communicated frequently with district nurses and GPs in their role of providing people with the care and support they need. For example people found following assessment to be at risk of falls were referred to the district nurse team.

The hospice had developed a range of links with the community particularly with regards to its fund raising activities. The hospice website detailed numerous community based activities which indicated significant local engagement and support. These included; tours of the hospice, craft fairs, sky diving, will writing, runs, and gala dinners.