

St Catherine's Hospice

# St Catherine's Hospice - Scarborough

## Inspection Report

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# Summary of findings

## Overall summary

St. Catherine's Hospice is a hospice service that is located on the outskirts of Scarborough in North Yorkshire. The hospice offers an in-patient service for people at the end of their life and also for people who require symptom management or psychological support. The hospice has 20 in-patient beds and incorporates a day centre. On the day of this inspection there were ten people receiving treatment in the in-patient unit. Some people who used the day centre had also used the in-patient unit so we spoke with them as part of this inspection.

There was a registered manager in post as the time of this inspection and they had been in post for thirteen years. A registered manager is a person who is registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

People told us that they felt safe whilst using the hospice. Staff had been recruited following robust policies and procedures that ensured only people suitable to work with vulnerable people had been employed and there were sufficient numbers of staff. Staff had undertaken training on safeguarding adults from abuse and other training that provided them with the skills to carry out their role safely and effectively.

There were appropriate risk assessments in place that ensured people's safety, allowed people to take responsibility for their actions and be as independent as possible. People's individual circumstances and lifestyle had been taken into account when their care or treatment plan had been devised. In addition to this,

people who were important to the person had been consulted and their needs and wishes were incorporated into treatment plans. Relatives and friends were able to visit the hospice at any time; they told us that they could stay at the hospice as long as they wished. Bedrooms were spacious and included en-suite facilities, and there was provision for relatives and friends to stay overnight.

People told us that their privacy and dignity was respected by staff and that they felt staff really cared about them. Relatives also told us that they were well supported; this included the bereavement counselling service that was described by some health care professionals who we spoke with as "Excellent".

The service was responsive to people's needs and continually looked for ways to improve. They were taking part in two pilot schemes that were aimed at improving care and treatment for people received at the end of their life. They had also identified that the pre-bereavement service they provided could be improved and, as a result, had introduced a variety of support groups for people and their carers.

There were clinical governance systems in place that monitored people's satisfaction with the service and ensured that the policies, procedures and practices in place were followed so that people received the service they needed. Staff told us that they were well supported by the hospice and that their views were listened to. Clinical staff had monthly supervision that included discussions about medication practices and a 'learning from incidents' exercise.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Are services safe?**

Medicines systems were robust and ensured that medication was stored, administered, recorded and disposed of safely.

There were appropriate risk assessments in place to promote people's safety and people who used the services provided by the hospice told us they felt safe whilst they were being supported or treated by staff. People's best interests were managed appropriately under the Mental Capacity Act (2005) and none of the people who used the hospice had Deprivation of Liberty Safeguards (DoLS) in place. Deprivation of Liberty Safeguards are used to determine whether any restrictions placed on a person amount to a deprivation of their liberty and must be authorised.

Staff had been recruited following robust policies and procedures and there were sufficient numbers of staff employed to ensure people received the care and treatment they needed.

### **Are services effective?**

We saw that information was obtained about the person's care needs prior to their admission whenever this was possible. The registered manager told us that a doctor and nurse completed the person's admission plan when they arrived at the hospice. They spoke to people at the same time so that people did not have to "Repeat their story".

People told us that they felt involved in their care and treatment. They said that their choices were explained to them and we observed staff talking to people about their care options. People told us that the staff had the skills they needed to carry out their roles effectively, and the treatment notes we saw evidenced that doctors assessed people daily to check that their current level of pain control was effective.

The hospice were involved in a variety of pilot schemes that were aimed at improving the service provided to people who needed care or treatment, including end of life care, as well as support for carers.

We saw that people were offered a choice of meals to ensure that their individual dietary needs or choices could be met.

### **Are services caring?**

Staff made sure that people and their relatives were involved in developing their care and treatment plan. Care plans included information about the person's lifestyle, the people who were close

# Summary of findings

to them and their hobbies and interests. This information was used by staff to provide individualised care that met the person's specific needs and wishes. We observed that staff took a very kind and compassionate approach to all of the people in their care.

People told us that their privacy and dignity was respected and that they felt staff really cared about them. One person said, "They always have time to listen – no matter what it is."

Relatives told us that they were also supported by staff. One relative told us, "You can't imagine how wonderful this place is until you've seen it. Everyone smiles. It feels like everyone knows what you're going through."

The staff team included physiotherapists, occupational therapists, social workers and counsellors. There was a weekly meeting to discuss the current needs of each person who was receiving treatment at the hospice and all professionals were involved. This meant that everyone was aware of the person's current care and treatment needs.

The hospice had their own gym where people could spend time with a physiotherapist to improve their mobility or dexterity. The occupational therapist could also visit a person's home when they were due for discharge so that they could ensure their property was suitable for their needs.

## **Are services responsive to people's needs?**

People told us that they were supported to make choices and decisions about their care and these were reviewed regularly. People were asked about their hobbies and interests and then supported to follow these by staff.

Bedrooms were private and had en-suite facilities, and included accommodation for relatives to stay overnight. Relatives told us they were able to stay at the hospice in-patient unit for as long as they wished, including overnight.

There was a folder in each bedroom that contained information about the complimentary therapies that were available for people. There was also information about the hospice's complaints procedure. People told us that they had not needed to make a complaint but that they could raise any concerns with a member of staff and they were confident the issue would be dealt with.

Discussion with staff had identified that the hospice could improve pre-bereavement support and this had led to the introduction of a variety of support groups. Health care professionals told us that they

# Summary of findings

had received excellent feedback about the bereavement counselling service provided by the hospice. Hospice staff had also identified that there was a need for a home care support service and consultation about this was on-going.

## **Are services well-led?**

We saw that there was a strategic plan in place for the period 2012 to 2017. This recorded that the vision of the hospice was “To be the provider of choice for excellent palliative and end of life care, which meets patient need and for which we have the skills and resources to make a difference.”

There were clinical governance systems in place that measured people’s satisfaction with the service provided; these included surveys that were distributed to people who used the in-patient and day services. Staff told us that they were looking at how they could improve the way they distributed surveys to encourage a higher return rate. The quality audits undertaken by senior staff ensured that the hospice’s policies, procedures and practices were being followed.

People were told about the complaints procedure and we saw that any complaints made to the hospice were thoroughly investigated.

There were sufficient numbers of staff employed to ensure that people received the care and support they required. The hospice had their own ‘bank’ of staff so that any staff absences could be covered.

# Summary of findings

## What people who use the service and those that matter to them say

People told us that they felt safe whilst they were receiving care or treatment at the hospice. They said that they felt involved in developing their treatment plan and we observed staff speaking with people about their care options. People told us, “Yes, I am fully consulted, everything is discussed first. Care is reviewed as and when I need it to be.”

People told us that they felt staff really cared about them. One person said, “If you’re going to be sick this is the place you want to be – they can’t do enough for you.” They also said that staff respected their privacy and dignity. One person said, “Staff twigged straight away that I’m a very private person and it makes such a difference.”

People told us that they were encouraged to continue with hobbies and interests and to take part in activities. One person said, “Yes, there’s something every afternoon. I enjoy it. Someone comes to speak to us or sing.”

On the day of the inspection we observed that the hospice had a calm and positive atmosphere and the people who we spoke with confirmed this. One person told us, “We were apprehensive of the word hospice but it’s the answer to our prayer – brilliant. Here, everyone is open and honest. The family feels able to cope and prepare. We are totally supported.”

We spoke with a GP and two community nurses as part of this inspection. They were positive about the care provided by staff. One health care professional said, “I have been very impressed by the staff.”

# St Catherine's Hospice - Scarborough

## 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 of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

We visited this service on 8 May 2014. The inspection team consisted of a Lead Inspector, a second inspector 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 care service.

Before this inspection we reviewed the information we held about the hospice. On the day we visited the hospice we spoke with five people who were using either the in-patient unit or the day service and a relative. We also spoke with

the Chief Executive Officer (CEO), the registered manager and the business operations manager plus other members of staff including three nurses, training officers and administrators.

We spent time observing the interaction between people, relatives and staff. We looked at all areas of the hospice, including bedrooms (with people's permission), therapy rooms, the day centre, office accommodation and the courtyard and garden areas. We also spent time looking at records, which included people's treatment records, staff records and records relating to the management of the hospice.

Following the day of the inspection we spoke with three health care professionals who had involvement with people who used the service.

At the last inspection on 5 November 2013 we found that the provider had met the standards that we reviewed.

# Are services safe?

## Our findings

People told us that they felt safe whilst staying at the hospice. We looked at the staff training programme from April 2014 to March 2015 and saw that the topic of safeguarding children and adults from abuse was included each month. This ensured that all staff were able to attend this training on an annual basis, either as part of their induction training or as refresher training. Evidence of this training was also seen in staff personnel files. There had been one safeguarding incident during the previous year; we checked this documentation and saw that a thorough investigation had been carried out and detailed feedback had been given to the relative concerned.

Staff had been recruited following the organisation's employment policies and procedures. Senior staff had undertaken training on interview skills so that they were able to be involved in staff recruitment. Application forms, employment references, safety checks and evidence of identification had been retained in staff records. We noted that paper records did not include a checklist of the dates that safety checks had been received to evidence that they were in place prior to people commencing work. However, we were later shown this information on the organisations database. This helped to make sure that only people suitable to work with vulnerable people had been employed.

As an additional precaution, the hospice held details of the expiry dates for each nurse's personal identification number (PIN); nurses have a PIN number to evidence that they are registered to practice with the Nursing and Midwifery Council. We checked some of these on the day of the inspection and found that none had expired.

We asked the registered manager about advocacy services. She said that they would refer people to an Independent Mental Capacity Advocate if they lacked the capacity to make their own decisions. The social work team had information that they could give to other people about advocacy services in the area.

We checked the electronic care records for two people who were staying in the in-patient unit. We saw that an assessment of a patient's abilities and support needs had been carried out and that there were relevant risk assessments in place such as those for the risk of falls, mobility, bathing/showering, the use of bed rails and the

use of oxygen. We saw that these were updated weekly, or sooner if the person's needs had changed. This ensured that staff were aware of the person's current abilities and their changing needs for support. However, staff acknowledged that although they may advise people about any identified risks, they might not take this advice. For example, a person might be advised to ring the bell and ask for assistance but may choose to take themselves to the toilet.

Although mandatory training did not include the topic of the Mental Capacity Act 2005 (MCA), some staff had undertaken training on the topics of dementia awareness and Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards are used to determine whether any restrictions placed on a person amount to a deprivation of their liberty and must be authorised. None of the people who received a service from the hospice had any restrictions placed on them or were subject to continuous supervision and control under DoLS.

Medication that had been brought into the hospice when people were admitted was seen to be recorded and stored safely; we noted that medication was recorded on a 'patient own drugs' form by a trained nurse. There was a record of whether the nurse intended to use the person's own drugs during their stay at the hospice. These forms were eventually stored with patient care and treatment plans.

Controlled drugs (CDs) were 'signed in' by two staff but these were not used during the person's stay at the hospice. They were stored securely and were returned to the person when they were discharged if they were still prescribed this medication. CDs and other medication that was not returned to the patient were destroyed on site using a special destruction kit.

There was a clear record of CDs ordered and received by the hospice. Staff told us that CD balances were checked every night and the details were entered into a separate stock book. Team leaders checked the stock weekly and the registered manager checked the stock monthly. This provided a clear audit trail and ensured that errors would be detected within 24 hours. We carried out a random stock check of a CD and found that the balance of medication corresponded with the entry in the CD register.

The pharmacist audited all of the medicines every three months and the CD registers monthly. The hospice carried

## Are services safe?

minimal stock and nursing staff told us that they checked stock levels towards the end of the week to make sure that the drugs they were likely to need over the weekend were available in sufficient quantities. Stock medication was ordered through the pharmacy at Scarborough Hospital on a specific order form used by the hospice. The pharmacist visited the hospice twice a week and medication required by someone on the in-patient unit was ordered on an individual patient medicines form. Staff told us that medication was delivered on the same day it was ordered.

We saw that all of the medication held in stock was 'in date'. If a person's medication was 'in date', they took it home with them. If not, a seven day supply was provided by the hospice. A nurse spent time with the person or their relative to explain what each drug was for and provided written information for people to take away with them. Any changes to a person's medication were clearly recorded.

Staff told us that only trained nurses administered medication. We checked some of the medication administration record (MAR) charts and saw that they were completed correctly with proper use of codes to identify the reasons why any medication had not been given. The MAR chart was written by the doctor; each medicine was written individually with the dose and route of administration noted.

There was a medication room and the medication fridge was stored in the adjacent clinical room. These two rooms were locked at all times. We saw that medication in the fridge was stored at the correct temperature and that daily temperature checks had been made and recorded.

The premises were purpose built only a few years ago and we did not observe any environmental risks on the day of the inspection. The hospice employed maintenance staff who were assisted by a number of volunteers to maintain the premises in a safe condition. We examined the current maintenance records and saw that the electrical installation and fire alarm system had current certificates in place, including a check on fire extinguishers and emergency lighting.

The registered manager showed us the report of a simulation of an emergency situation that had been carried out at the hospice in April 2014. This was based on an severe adverse reaction to intravenous antibiotics. Ward staff were unaware of the simulation until the emergency bell was sounded. The report recorded how the staff had reacted and made some recommendations to improve the emergency planning for the future.

# Are services effective?

(for example, treatment is effective)

## Our findings

We saw that the manager and staff of the hospice were pro-active and were taking part in a variety of pilot schemes in order to improve the service to people in the local area. Staff from the training department were visiting local care homes to advise care staff on end of life care. They said that this had reduced the number of people admitted to hospital by 50 within the first year of the pilot. Another pilot had been funded by the local hospital; four beds were reserved at the hospice for people to move in to for the last seven days of their life. The hospice were looking at the length of each person's stay and determining whether or not the hospice was the appropriate placement. The CEO told us that, even though some people were only in these beds for a few days, they and their families had told them that they appreciated the calm and peaceful atmosphere of the hospice as a place to spend their last few days, and the move from the hospital was "Well worth it".

Referrals to the hospice were made by various health care professionals, including community Macmillan nurses, respiratory team nurses and district nurses. We saw that, when people were referred to the hospice, appropriate information was obtained from the referrer by a team leader or a Macmillan nurse. They asked whether the reason for the person's admission was for end of life care, for symptom management or for psychological support and at this initial stage they asked if the person was aware of their referral, their diagnosis and what the patient's expectations of the hospice were. They also gathered information such as the person's GP, their condition and any other health care professionals who were involved in the person's care. Unless the admission was urgent, staff from the hospice would ring the person and make arrangements for their planned admission. Whenever possible, they tried to ensure that the member of staff who had spoken to the person on the telephone was at the hospice to greet them on their arrival.

The health care professionals who we spoke with confirmed that staff at the hospice asked appropriate questions when they made referrals and that liaison and communication was good, although one person mentioned that this was more effective in some

departments of the hospice than others. They said that the day service and the counselling service were very effective when sharing information but the in-patient unit was not so efficient.

When the person arrived at the hospice staff spent time with them to gather as much information from them and their relatives as possible, including their current symptoms, their current medication, whether they had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) request in place and their social circumstances. This included information such as their lifestyle, their support networks, 'who is at home with you', 'will family (and pets) want to visit' and the people who they wished to remain in contact with. The registered manager told us that a doctor and nurse completed the person's admission plan. They spoke to people at the same time so that people did not have to "Repeat their story".

People told us that they felt involved in their care provision and we observed staff speaking with people about their care options. People told us, "Yes, I am fully consulted, everything is discussed first. Care is reviewed as and when I need it to be" and "How I am each time is looked at and reviewed – I'm part of that." Some staff were observed in quiet and close discussion with people who used the service and/or family members.

We observed that people in the in-patient unit and day centre were comfortable and resting, or taking part in activities, without obvious pain or difficult symptoms causing problems. Daily notes evidenced that doctors saw people daily to re-assess their symptoms and to check that if their current level of pain control was effective. We saw reference in care plans to health concerns that were not necessarily associated with the person's current condition and that these were treated appropriately. People told us that they were able to access other health care professionals when they needed them and that these referrals were made by hospice staff.

We saw a syringe driver in situ being checked with the patient's permission. A syringe driver is a small, portable pump that can be used to administer a continuous dose of painkiller or other medicines through a syringe. The nurse was able to explain what she was doing and what each record meant, and we saw that all records were appropriate. The hospice had invested in nine new syringe

# Are services effective?

(for example, treatment is effective)

drivers which meant that anyone who needed to use one had one available. Nurses working at St Catherine's Hospice received training on the safe use of syringe drivers annually.

We saw that people's care plans included information about their choices for care. One person told us, "I think the staff have made decisions beforehand but they ask me and I have to agree before anything is done. I've been able to review the first decisions and I'm more than happy with what goes on." The registered manager told us that they tried hard to meet people's very specific requests. For example, they had arranged an ice-cream party and had used whisky to provide a person's mouth care. People were also encouraged to have alternative therapies. One person said, "I love having massages – alternative therapies make you feel so much better."

We saw that people were offered different sizes of meals; small, medium or large. The registered manager told us that they also provided 'moulded' meals for people who required a soft diet. These meals provided softened foods that were served individually, rather than mixed together, to preserve the separate flavours.

On the day of the inspection we observed that the hospice had a calm and positive atmosphere. Bedrooms were spacious, en-suite and very private. One relative told us, "This is our own haven to be with mum. We haven't this amount of room at home. It means we can be together as a family without being all on top of one another and mum doesn't get over-faced. It's an amazing place – it feels

serene, not like a care home or a hospital." We saw that bedrooms contained the equipment needed to promote a person's independence. They were spacious enough to allow staff to assist people with specialised equipment such as wheelchairs and hoists.

People told us that staff at the hospice had the skills and knowledge to carry out their roles effectively. They told us that this applied to both nurses and health care assistants. This was confirmed by the health care professionals we spoke with. One health care professional said, "I have been very impressed by the staff" and another said, "We are very lucky to have such a good relationship with them - we work really well together." Two health care professionals told us that liaison and communication between them and the hospice was good but one person said there was room for improvement.

The hospice education department provided a variety of training programmes that could be attended by their own staff and other people. These included palliative care, counselling skills when working with bereavement and loss and end of life care in Parkinson's Disease. Staff also received specific training on supporting young people. Staff told us that they had monthly supervision meetings and an annual appraisal. They said there was regular mandatory training and that they had 'link' nurses who took the lead on a topic, for example, nutrition. Staff who we observed were confident, happy and well informed and there was a strong sense of support amongst the staff by way of mutual support or team discussion.

# Are services caring?

## Our findings

On the day of our visit to the hospice we observed that staff took a very kind and compassionate approach to all of the people in their care, both in the in-patient unit and the day service. People emphasised how caring and kind the staff were. One person said, “If you’re going to be sick this is the place you want to be – they can’t do enough for you.” We also observed that staff responded very quickly to call bells and that no-one was left waiting for support.

Staff were observed to be very focussed when talking to people and their relatives, responding to queries and giving people time and attention. People said, “It doesn’t matter who you speak to, it’s like they’re all here just for you” and “They always have time to listen – no matter what it is.”

Health care professionals told us that the needs of relatives were taken into consideration during the assessment and care planning process, and we saw evidence of this in people’s care and treatment records. One health care professional said that they frequently referred people with complex family situations to the hospice as they knew they were skilled at working in these situations. Relatives told us that they felt that they were supported as well as people who were using the service. One relative told us, “You can’t imagine how wonderful this place is until you’ve seen it. Everyone smiles. It feels like everyone knows what you’re going through.”

People also told us that they appreciated the honesty of staff at the hospice. One person said, “We were apprehensive of the word hospice but it’s the answer to our prayer – brilliant. Here, everyone is open and honest. The family feels able to cope and prepare. We are totally supported.”

In addition to nurses and health care assistants, the hospice also employed physiotherapists, occupational therapists, social workers and counsellors and had their own education department. The registered manager told us that they planned to recruit additional social workers and that this would enable social workers to have input into the day hospice and with discharge planning.

The registered manager told us that the social work team advised people to say yes’ to any of the additional or complementary treatments and therapies that were on offer, as they could change their mind at any time. Physiotherapists and occupational therapists visited

people regularly but consulted with nursing staff to make sure that the time they planned to visit was convenient. The occupational therapist could also visit a person’s home when they were due for discharge so that they could ensure their property was suitable for their needs. The hospice had their own gym where people could spend time with a physiotherapist to improve their mobility or dexterity.

On the day of the inspection we observed that people’s privacy and dignity was respected by staff. People told us that they appreciated the efforts staff made to ensure their privacy and dignity. One person said, “Staff twigged straight away that I’m a very private person and it makes such a difference”, another person told us, “That’s the thing that puts you off going into hospital – but you don’t have any of those worries here” and another person said, “Oh, they look after my privacy more than I do.”

Several people mentioned that the hospice had a holistic approach to people’s care. The staff team included physiotherapists, occupational therapists, social workers and counsellors and the hospice had their own education department. Multi-disciplinary meetings were held each week to discuss people’s individual needs and how these could be best met; these meetings were more frequent if people had more complex needs. This meant that a person’s condition and need for treatment or support was continually reviewed.

We saw that the initial referral form asked if the person had an advanced care plan in place and that people’s wishes for the end of life care were clearly recorded in care plans. One relative told us, “We are completely involved and the staff know mum’s wishes and the family’s wishes.” If people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) notice in place this was clearly recorded in care plans.

We saw that the hospice was involved in a project with AgeUK called ‘Bridges’. This was a bereavement advice and support service that provided emotional support and ‘a listening ear’ and could also provide an advocacy service. Health care professionals told us that they had received feedback about the bereavement support provided by the hospice and had been told it was “Excellent.”

The registered manager told us that there was a consultant or GP on duty ‘out of hours’ so they were able to admit people over a seven day period, and would admit people during the night if this was needed.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

We observed staff discussing care options with people. Everyone we spoke with was very positive about their involvement in decision making around their care, including their end of life care. One person said, "I'm part of the decision making – I am asked before anything is changed." We also saw that, if people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) notice in place, this was clearly recorded in care plans.

People's care plans recorded information about their lifestyle, their hobbies and interests, the people who were close to them and their spiritual needs. People's particular interests had been noted by staff and action had been taken to make sure that people were involved in activities that were important to them. People told us that they had been asked about their hobbies and interests and that there were plenty of activities on offer. One person said, "Yes, there's something every afternoon. I enjoy it. Someone comes to speak to us or sing" and another person said, "There's always a big jigsaw on the go and I keep having a go at the massive crossword." We saw that some people were having their hair done and other people were enjoying hand massages.

The hospice clergy had left their position and the hospice had decided to appoint a spiritual lay person so that support was available for people who used the service and their family and friends, whether or not they had a particular faith. However, the registered manager said that a religious leader could still be accessed if this was what a person wanted.

We saw that there was excellent patient accommodation with facilities for relatives to stay. The rooms were very private; they were not overlooked and there was access to outside space and attractive views. Bedrooms also had individual heating controls so that people's preferences could be met. One person said, "My family can come whenever they want. They're always made welcome and there's always someone for them to talk to" and another person told us, "We can talk more about the things that matter because they don't have to be running around sorting everything out like they do when I'm at home."

Health care professionals told us that family members received excellent support from staff at the hospice and

that they received bereavement counselling that helped them to deal with the loss of their relative. One health care professional said, "Families report that the bereavement support is excellent."

The registered manager told us that there was a folder in each bedroom explaining about the service provided and we saw these on the day of the inspection. This included information about complementary therapies, use of the television, the complaints procedure, the day hospital and information for family carers.

People told us that they felt they could raise any concerns with a member of staff and that they were confident their concerns would be dealt with. However, they did not seem clear about the complaints procedure. One person said, "I can't remember if I've been told how to complain but I'd have a quiet word with staff nurse if there was anything." It may be that staff need to remind people about the folder in their bedroom that contained details of the complaints procedure.

We saw on the annual training plan that staff received specific training on supporting young people; this helped staff to identify the needs of young people whilst they were receiving support in a service that was primarily for adults.

During discussion at a staff meeting it had been identified that there was a need to improve pre-bereavement support. With the aid of a grant from AgeUK and under the umbrella of the Supportive Care Group, the hospice had developed a carers drop-in support group, a carer's education programme and a 'Care to talk' group. The registered manager said there had been a mixed response; more sessions were planned in Scarborough and people who attended would be invited to complete an evaluation. The registered manager said that they tried to get their message into the public arena as much as possible and in a variety of ways. Recently two staff visited a local college to speak to students and staff.

As a response to feedback from people living in the local community, the hospice was making plans to introduce a home care service. We saw the business case and proposed model of care that had been developed, and saw evidence of the meetings that had taken place with appropriate stakeholders.

# Are services well-led?

## Our findings

We observed a positive atmosphere at the hospice with very good interaction between all grades of staff. The staff rota was planned electronically but there was a paper copy where amendments were recorded. The registered manager told us that staffing levels were based on the ratio of one staff member to two patients on an early shift. This meant that, when the hospice was fully occupied, there would be ten nurses or health care assistants on duty. The afternoon shift usually had five staff on duty and there were four staff on duty overnight. The registered manager said that there would always be a minimum of three registered nurses on duty. We observed these staffing levels to be in place on the day of the inspection and that there was a mix of grades; this ensured that patient needs were being met. The day service was staffed separately and volunteers were used in addition to paid staff.

The registered manager told us that there were some staff on long-term sick and on maternity leave. However, the hospice had its own bank of staff that were able to cover any staff absences. The registered manager also told us that there was an on-call system that ensured there was medical support available for staff over a 24 hour period, seven days a week. This also enabled people to be admitted to the hospice at any time, including in an emergency.

The registered manager showed us the strategic plan for 2012 – 2017 that recorded a time line for delivery and the priorities for the five year period. This recorded that the vision of the hospice was “To be the provider of choice for excellent palliative and end of life care, which meets patient need and for which we have the skills and resources to make a difference.” One of the aims was “To put patients at the core of all we do and strive to meet their palliative and end of life needs.” There was a quality, corporate governance and administration policy in place; this stated that all employees were involved in the governance programme. It recorded, “Everyone working within the hospice is an ambassador for the hospice and contributes to maintaining the reputation of the hospice.” We saw that committee meeting notes were circulated to staff so that everyone was kept informed of the topics being discussed and decisions made.

There had been a recent organisational review at the hospice and this included salary changes for some staff. We

noted that staff had been sent regular updates during the review process and in personnel records we saw that each member of staff received an individual letter explaining the outcome of the review and their new salary (where relevant). This evidenced that the staff were valued. We also saw that, when people were promoted or changed their role within the hospice, a new contract had been issued. This ensured that there was a clear record of the person's responsibilities.

The hospice was part of a bench marking pilot which compared St. Catherine's Hospice to other similar services by using the Help the Hospices Quality Matrix. This covered the areas of falls, pressure ulcers and medication. For example, there had been three falls identified up to 31 March 2014 at St. Catherine's and the average rate of falls in similar services was 11.7 over a year. This meant that the hospice had a system in place to measure their performance against similar services and to help them to identify any areas where they needed to make improvements..

Health care professionals told us that staff at the hospice kept up to date with current best practice guidelines and we saw that they took part in a variety of meetings, including attendance at a Help the Hospices 'Fit for the Future' conference. Following their attendance at this conference staff circulated information to other staff about the key principles discussed. One of the areas for improvement recognised was that of dementia care and the hospice recorded that they needed to “Grasp the nettle” to find a way of offering their skills to people with dementia and for people with a learning disability and their carers. This evidenced that the hospice were continually looking for ways to improve.

We saw that various audits were carried out to ensure that the systems in place were being followed by staff. The team leader told us that the medicine trolleys were cleaned monthly and all medication checked to make sure no drugs were out of date. This was all recorded on the clinical room cleaning audit. Other audits carried out included monthly infection control audits, mattresses/mattress covers, hand hygiene audits and housekeeping audits; we saw that these were all up to date. Each department completed their own audits and reported back to the health and safety group, and an action plan was formulated for each area.

We saw that staff were trained to assess health and safety risks and that accidents were recorded on an accident

## Are services well-led?

form. The form detailed the incident, whether or not the patient was seen by a doctor, precautions taken to reduce the risk, whether or not a risk assessment had been completed, any further training required by staff. The person investigating the incident signed this document and it was then passed to the registered manager. We saw that the incidents were tracked and checked regularly by the registered manager to see if there were common themes that could be addressed and that there was also a quarterly review of incidents.

Staff told us that people who use the service and their relatives received a patient questionnaire and that there were separate questionnaires for other hospice services. An administrator told us that they were in the process of moving to one questionnaire to make them more user friendly. The hospice were also looking at ways in which they could be more proactive in getting surveys out to people and encouraging people to complete them. We saw that the results were collated against each individual question and that all comments were recorded. If there were any poor responses the information was sent to the appropriate department. If the person had recorded their name, they would contact them to gather further information and then respond to them when they had investigated. If the comment was anonymous the situation was looked at by the department in question and, if appropriate, improvements or changes made.

We looked at the record of complaints received and noted that there had been one complaint since the inspection in

November 2013. This had been thoroughly investigated and a very detailed explanation had been sent to the complainant. Personnel and training records evidence that all staff had received training on dealing with complaints. A health care professional told us that they had never had a negative report about any of the services provided by St. Catherine's Hospice or the staff that they employed.

We saw that there were systems in place to investigate and analyse complaints and safeguarding issues so that lessons were learned and the same mistakes were less likely to happen again. For example, if any drug errors occurred the staff member was asked to complete a drug reflection form. The person had to write an account of the incident and reflect upon it, identifying any areas for improvement and any additional training needs.

Staff meetings were held on a regular basis and we looked at the minutes from the meeting in January 2014. We saw that health and safety policies, the pilot of clinical supervision, the new modular system for palliative care, the carers support group and feedback to GP's was discussed. Staff also had monthly clinical supervision that included discussions about medication practices and a 'learning from incidents' exercise. Staff told us that they had monthly supervision meetings and annual appraisals. Team leaders were taking part in a group supervision pilot. They had also undertaken training on supervision skills so that they could lead group supervision meetings with the staff they managed.