

St Catherine's Hospice (Lancashire)

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Requires improvement 

Overall summary

St. Catherine's Hospice (Lancashire) is operated by St. Catherine's Hospice. The hospice has 19 beds. Facilities include an inpatient unit, a lymphoedema clinic and a clinical nurse specialist community service.

The hospice provides end of life care and palliative services for adults, whilst also seeing children and young people at their lymphoedema clinic. We inspected all the services provided.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the hospice on 16 January 2019, with a review of personnel files on 17 January 2019 and attendance at community visits on 18 January 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this hospice stayed the same. We rated it as **Good** overall because:

We found good practice in relation to the hospice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
 - Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
 - The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
 - The service had suitable premises and equipment and looked after them well.
 - Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
 - The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
 - Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing and giving medications and patients received the right medication at the right dose at the right time. However, some improvements needed to be made around the safe and effective storage of medicines.
 - The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
 - The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
 - Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other preferences.
 - Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
 - Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
 - The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
 - Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
 - The service delivered a full inpatient service for patients receiving palliative care seven days a week.
 - Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental

Summary of findings

Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers at all levels at the hospice had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and went above and beyond.
- Staff provided emotional support to patients to minimise their distress.
- Staff ensured that patients and those close to them were partners in decisions about their care and treatment.

However,

- The service did not have robust systems in place to offer assurance regarding fit and proper persons and the on-going monitoring of clinical registrations.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, due to a breach in regulation.

We also issued the provider with one requirement notice that affected the well led. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North West)

Summary of findings

Our judgements about each of the main services

Service

Hospices for adults

Rating

Good



Summary of each main service

We rated this service as good overall because we rated safe, effective and responsive as good. We rated caring as outstanding and well led as requires improvement.

Summary of findings

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Good 

St Catherine's Hospice (Lancashire)

Services we looked at

Hospices for Adults

Summary of this inspection

Background to St Catherine's Hospice (Lancashire)

St. Catherine's Hospice (Lancashire) is operated by St. Catherine's Hospice. The hospice opened in 1985. It is a private hospice in Preston, Lancashire. The hospice primarily serves the communities of the local area.

The hospice has had a registered manager in post for over twelve years.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, two CQC inspectors, and a specialist advisor with expertise in hospice care. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about St Catherine's Hospice (Lancashire)

The inpatient unit at the hospice has 19 beds with 11 single rooms and 4 twin rooms. The hospice takes both male and female patients and provides end of life care and palliative services for adults, whilst also seeing children and young people at their lymphoedema clinic. There is also a clinical nurse specialist team that sees patients in their usual place of residence, inclusive of the three local prisons. We inspected all the services provided.

The hospice is registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.

During the inspection, we visited the inpatient unit, the lymphoedema clinic and we also went on three community visits with the clinical nurse specialist team. We spoke with 22 members of staff including registered nurses, health care assistants, reception staff, medical staff, students and senior managers. We spoke with six patients and three relatives. During our inspection, we reviewed seven sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected five times, and the most recent inspection took place in 2016 which found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity (September 2017 to October 2018)

- In the reporting period September 2017 to October 2018, there were 552 patients aged 18-65, 1047 patients aged 65 and over who used the service, with 1332 patients treated for palliative care.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events
- One serious incident with no harm to the patient
- 10 Complaints

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of safe stayed the same. We rated it as Good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. The service followed best practice when prescribing and giving medications and patients received the right medication at the right dose at the right time.

However,

- The service was not properly storing medicines.

Good



Are services effective?

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Good



Summary of this inspection

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service delivered a full inpatient service for patients receiving palliative care seven days a week.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.

Are services caring?

Our rating of caring improved. We rated it as **Outstanding** because:

- Patients were at the centre of everything the staff and hospice did. Patients were cared for with total compassion. Feedback from patients confirmed that staff treated them well and with kindness and went above and beyond. There was a strong, patient-centred culture on the unit from all levels of staff.
- Patients were consistently treated with kindness, compassion, dignity and respect through supportive relationships with patients and their families.
- Patients always received a high level of emotional support to minimise their distress. Staff fully understood that patients' emotional needs were as important as their physical needs.
- Patient wishes for their final days were heard, respected and acted on by hospice staff. Staff went the extra mile to enable dying patients' involvement at chosen celebrations and momentous occasions in their final days of life and no ask was too big. Patients and those close to them were partners in

Outstanding



Summary of this inspection

decisions about their care and treatment. Relatives and carers unanimously spoke highly of the care their loved one had received and reported that had felt fully involved in all aspects of care and had also had their opinions considered.

Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Good



Are services well-led?

Our rating of well-led went down. We rated it as **Requires improvement** because:

- The service did not have robust systems in place to offer assurance regarding fit and proper persons and the on-going monitoring of clinical registrations.
- We reviewed 11 personnel files and found inconsistencies with the information kept in each file, as all the files had varying pieces of information for employment, with few having everything needed and others having very little. For example, there were gaps in the evidence of the disclosure and barring service (DBS) checks having been completed on some staff members and issues with the on-going process of the storage of this information.
- We reviewed a staff file to review evidence of practising privileges for medical staff. We saw evidence of a contract, but saw no evidence of professional indemnity, information from the responsible officer, evidence of an appraisal or relevant qualifications.
- The provider could not assure itself that it had an appropriate process for assessing and checking that candidates held the required qualifications.

However,

- Managers at all levels at the hospice had the right skills and abilities to run a service providing high-quality sustainable care.

Requires improvement




Summary of this inspection

- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospices for adults	Good	Good	 Outstanding	Good	Requires improvement	Good
Overall	Good	Good	 Outstanding	Good	Requires improvement	Good

Hospices for adults

Safe	Good 
Effective	Good 
Caring	Outstanding 
Responsive	Good 
Well-led	Requires improvement 

Are hospices for adults safe?

Good 

Our rating of safe stayed the same. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The hospice set a target of 95% for mandatory training compliance. Figures we were given prior to inspection by the service demonstrated that nursing and medical staff were 100% compliant with the completion of the hospice mandatory workbook and the information governance workbook and that all nursing staff were between 80% and 100% compliant for all mandatory competencies at the end of October 2018. The mandatory workbook covered topics such as health and safety, equality and diversity, communication, managing conflict, infection prevention, nutrition and hydration, spirituality, dignity and respect, consent and capacity, do not attempt cardiopulmonary resuscitation and medical devices. All staff were required to attend the hospice mandatory study day which ran between January and March each year, covering a variety of topics, such as: - moving and handling, basic life support, mental capacity act, tracheostomy training and intravenous medications.

The hospice had an organisational-wide induction procedure covering health, safety and welfare for all staff. This was to ensure that all staff received a tour of the building and were given adequate information about health and safety, as well as welfare facilities. All new

starters received a starter pack relevant to their role. After induction and completion of the mandatory workbook, they were given three months to complete all the mandatory training required. The hospice had two clinical educators who were responsible for the training and education of clinical teams. They attended the clinical governance sub-committee which ensured that training was developed and delivered in line with the needs of clinical services and in response to outcomes of both audits and incidents.

The hospice had a mandatory training and competency framework and compliance was monitored through the training database. All competencies were reviewed on a regular basis to ensure that they met current guidelines and procedures and each competency document had a review date. In key areas such as moving and handling, champions had been identified to monitor the application of training in practice.

We were told that improvements had been made to the induction of bank staff over the last 12 months, with one recent improvement being that bank staff would undertake three supernumerary shifts as part of their induction and they were also required to spend a full day with the education team prior to their first shift. During that time, they would complete the hospice mandatory workbook, some e-learning topics, as well as undertaking competency assessments. Bank staff were also invited to the main hospice induction which covered the aims, values and ethos of the hospice, how they were funded and some mandatory training such as hand washing and fire safety. Staff told us that each member of their bank staff would also have an individual training record so that compliance with mandatory training could be effectively monitored.

Hospices for adults

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The hospice had a safeguarding policy which clearly identified different types of abuse and how to recognise these and contained a clear flow chart to direct staff to appropriate actions to take if abuse was suspected, with the contact numbers and addresses for the relevant agencies, including the local authority.

All the staff we spoke with were confident in identifying any signs of abuse and would report this to a senior nurse, or member of staff. They said they would report it, using the hospice incident reporting system.

Compliance for the completion of safeguarding training for level one and two adults was 97% and 100% for level one and two children's safeguarding.

Only one member of staff within the hospice had been trained to level three safeguarding for children. As children attended the lymphoedema clinic all staff involved in the treatment should have had this training in line with the intercollegiate guidelines. We raised this with the hospice who told us that all staff in the clinic were scheduled to complete the training following inspection.

When staff had safeguarding concerns, they would be discussed with a member of the support team (one of the social workers, or the director of care). The social worker would provide guidance and support, but the staff member would complete the referral to the safeguarding team. The director of care had one-to-one meetings with managers each month and that safeguarding had been added to the standing agenda, enabling the manager and director of care the opportunity to discuss how the process had gone and to pick up any possible ongoing concerns. The director of care told us there was an action plan within the clinical services' improvement plan to review safeguarding processes to ensure processes was in line with best practice

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We observed reception staff advising relatives, carers and other visitors to use the hand gel on the wall before entering the unit. Hand gels were readily available in all areas of the hospice. There were plenty of hand washing sinks to use and lots of dispensers for aprons and various sized gloves, which were all fully stocked.

We observed staff using personal protective equipment before delivering patient care. There were signs to encourage hand washing for patients, carers and visitors. Patients and carers, we spoke with were happy with the cleanliness of the hospice.

We observed all staff following arms 'bare below the elbow' protocols. Staff told us that they were not allowed to come to, or leave the hospice in uniform to minimise the risk of any infection.

If a patient had an infection, staff used signs on the door. Although the curtains in the rooms were material, we were told that these would go to be cleaned as soon as a patient with an infection no longer needed the room and that the room would also undergo a 'deep clean'.

We saw cleaning schedules of tasks that needed to be completed

All the toilets on the unit were well stocked with soap and paper towels and again were visibly clean and tidy.

Two staff members on day shifts undertook the role of overseeing infection prevention control as a supplementary role, which included them completing audits. We reviewed the infection control audit which was completed in April 2018. This used a tool developed by the Infection Prevention Society and covered different areas of infection control. The audit results were compared with the results from 2017, covering a total of ten different areas. The 2018 results showed an improvement in seven areas (inclusive of hand hygiene increasing from 87% to 100%) and a decline in three areas of the audit compared to the 2017 results.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Hospices for adults

On entering the hospice through the glass doors, there was a reception desk in the main waiting area to welcome visitors. The doors to the inpatient unit were securely locked and would be opened by reception staff once visitors had signed in.

There was clear signage throughout the hospice. The hospice had some wide corridors with space to move about it. There were 19 individual inpatient rooms and four twin rooms. The individual rooms all had en-suite bathrooms with showers (except for one of the rooms) with disabled access.

Bed spaces had a cupboard next to the bed area, which once opened also contained lockable storage for the safe storage of individual medicines.

There were two sluice rooms which were clean with, cupboards containing pads and stoma bags, which we saw to all be in date and to be very neat, tidy and organised. We also found adhesive remover in these cupboards, which we raised with senior staff members who removed them. There was a hand washing sink and gloves, aprons and hand gels available for staff to use. One of the sluice rooms was used for storage and staff told us that storage was an issue at the hospice.

There was a clean utility room, which contained medications and controlled drugs, which had swipe card access and CCTV monitoring. There were also two equipment rooms, one of which contained the needle sharps bins which we saw to be sealed and dated correctly. These were collected by an independent company on a weekly basis, when new ones would also be delivered and none of the used ones were seen to be overfilled during our inspection.

The service had a process for reviewing when equipment needed to be serviced. However, in one of the storage areas we found equipment with no review date. Staff told us they would dispose of the equipment. We were told that there was a named individual who oversaw the review of equipment and they kept a log of when these were due. We saw evidence of syringe drivers which had current service dates on them. We also saw evidence that the service had carried out safety electrical testing and oxygen cylinders were stored safely and within the manufacturer's expiry dates.

Behind the reception desk, there was an emergency grab bag, as well as a first aid box. We checked the equipment in the grab bag and found everything to be within the manufacturers' expiry dates and checked regularly.

The hospice had its own mortuary, so patients who died could remain on the premises. The fridge had been kept at the correct temperature and during inspection, we saw a log which had been completed every time the mortuary had been used, which documented details regarding the patient and any detail of personal belongings on them, with each entry signed by two staff members.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

We saw comprehensive risk assessments were carried out for patients and these were documented in the patient records as part of the personalised care plans.

There was daily interaction between the inpatient unit manager and about patient and staff safety. The daily admissions meeting, held Monday to Friday also provided an opportunity for senior staff to consider staffing levels, prioritise patient needs and care planning. We were told that there had been occasions when admissions had been delayed, to enable the organisation to obtain the required number of staff and any special equipment needed. The staffing establishment and skill mix had occasionally been adjusted to meet specific patient needs, for example, extra staff on duty to meet the needs of bariatric patients.

If a patient was identified as being at risk of falls, a falls prevention monitor would be attached to the patient and both bed and chair sensors could also be used.

The unit identified and assessed patients who were at high risk of pressure ulcers or had existing pressure ulcers. If a patient had pressure ulcers, they would have appropriate dressings applied, be nursed on specialist mattresses and would have any ulcers closely monitored, and staff would regularly re-position the patient.

Nurse staffing

Hospices for adults

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

We were told that an increase in staffing levels both within the inpatient unit and the clinical nurse specialist service, had been approved not only to increase the number of patients cared for but also to enhance the quality of care delivered.

The hospice was working closely with another provider to learn more about their approach to reviewing workforce and dependency measurements. This included the hospice learning about an acuity tool, management of a flexible workforce and using care hours per patient day. The care hours per patient day produces a single comparable figure to represent staffing levels and patient requirements.

Bank and agency staffing

Senior leaders told us that wherever possible, the hospice would use bank in preference to agency staff. Agency staff were sourced from a local agency if a service need was identified, such as the staffing establishment not being expected to meet the care needs of patients. The hospice only used agency nursing assistants, not registered nurses due to the specialist nature of hospice care. Staff told us that agency care assistants worked alongside and were supported by permanent members of hospice staff.

Vacancies

Throughout the hospice there were a total of 12 vacancies, with on-going recruitment

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The hospice had three permanent medical staff (non-consultant grades), who were employed directly by the hospice and did not work for any other provider. One of these was full time and two were less than full time. All three of these staff members also provided independent on-call cover for the out of hours provision. There was also one clinical assistant who was a qualified general practitioner, employed by a local practice who provided

out of hours cover. This staff member also had a contract and practising privileges with the hospice. We were also told that the hospice always had a consultant second on call for their out of hours provision.

The hospice had access 24-hours a day, seven-days a week to advice and support from either a consultant in palliative medicine or a non-consultant career grade with knowledge and skills to practice autonomously. In addition, the hospice medical director was available, even out of hours when not on call, for advice (unless they were on leave). The hospice had a first and second on-call rota for out of hours provision covering the hospice inpatient unit and hospice 24-hour advice line.

First on call provision was provided by the hospice non-consultant career grades, trainees in palliative medicine/GP training employed by another provider on rotation or the clinical assistant. Second on-call provision when needed (always provided for trainees in palliative medicine/GP training and the clinical assistant) was provided by the consultant workforce. All were employed by the local acute provider.

The hospice medical director/consultant was based at the hospice full time and the community consultant was also based at the hospice three days of the week. They were also able to provide cover if required. There were times when neither would be available, but we were told that in that instance the hospital based consultants were contactable for telephone advice. There was also access to consultant advice from the four palliative care consultants working across the local area.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

At the time of inspection, the hospice had been using electronic patient care records for a last year. We reviewed seven sets of records during our inspection and found these to be contemporaneous and comprehensive.

Care plan audits were completed in January 2019 to review records and to ensure that personalised care was planned, with evidence of review of falls, pressure ulcer prevention, nutrition and hydration and personal hygiene. There were 10 sets of records reviewed against

Hospices for adults

nine criteria. All 10 records had been appropriately completed against six of the criteria, with nine out of the 10 records having been completed against the remaining six criteria.

Staff told us that consent was gained before any sharing of patient information, both internally and with primary care services would occur. As the hospice used electronic records, if consent was obtained, the summary of care record would be shared with GPs.

Community staff completed patient records and all information was then stored electronically.

We saw evidence that the service completed the appropriate do not attempt cardio pulmonary resuscitation forms. Forms included reasons for decisions, the date the decision was agreed and information to say whether the patient had been involved in the discussion. At the time of inspection, there were no patients who lacked capacity

Medicines

The service followed best practice when prescribing and giving medicines.. However, some improvements needed to be made around the safe and effective storage of medicines.

Medicines, including controlled drugs and intravenous fluids were stored securely. Staff from a local pharmacy checked medicine stocks three times a week and there was a process for staff to obtain medicines outside of these visits. Unwanted or expired medicines were kept secure and separate from other medicines and were disposed of correctly. Controlled drugs were ordered using the appropriate requisition forms and accurate records were maintained. Staff completed regular balance checks and the sample we looked at were correct.

Medicines that were required for emergencies were easily accessible, stored securely and checked regularly.

We reviewed seven medicine administration records and found no gaps. Allergies were recorded on each record we looked at. Some medicines were administered over a prolonged period such as via a patch or an infusion. Regular checks and records were made by nurses to ensure these medicines were still in place until the next dose was due. For medicines that were to be administered at specific times or at varying doses, nurses

documented when these were given. There was information available for nurses for medicines prescribed to be administered on a 'when required' basis so they knew when and how much to give.

A pharmacist visited the hospice weekly to review medicine charts and contributed to patients' care plans in meetings with other healthcare professionals. They were also on-call outside of normal pharmacy opening hours to provide advice about medicines. Doctors had access to GP summary care records to ensure patients' regular medicines were continued on admission if appropriate. Discharge medicines were ordered and received in a timely way and nurses advised patients (or their relatives/carers) on the use of their medicines before they were discharged. If patients wanted more information about the medicines they were prescribed, they could request this from staff.

Staff were aware of how to report medicine errors or incidents and we saw that these were investigated and learning was shared with all relevant staff. The manager was also part of a local network group who met to discuss controlled drug issues and share learning from incidents.

The hospice enabled single administration of controlled drugs to free up nursing time, whilst also improving the response time for patients receiving the medicine.

Some patients at the hospice could self-administer medicines and there was a hospice policy for this. At the time of inspection, there were no patients who were self-administering medicine.

Red tabards were worn by nurses completing medicine rounds, to make other people aware that they were concentrating on the administration of medicines and to prevent disturbance.

The service told us an electronic prescribing module would be available in 2019 and that this had the potential to improve patient safety, as there would be clear, unambiguous prescriptions, warning systems of contraindications and administration omissions.

Medicines that needed to be stored at a lower temperature to keep their efficacy were stored in a fridge. The temperature should range between two to eight degrees and this should be checked daily. We found the monitoring of temperatures was not robust as it did not include checking the minimum and maximum fridge

Hospices for adults

temperatures to ensure the fridge had not gone outside of the temperature range since last being checked. However, since our inspection, the service has sent us an action plan which indicated that extra columns would be added to the fridge temperature checklist, so that staff could document both the minimum and maximum temperature.

Thickener powder which is being used to thicken food or drinks for people with swallowing difficulties was not always being stored securely. There had been a previous patient safety alert released regarding this, as there was a risk of choking if the powder was accidentally swallowed. During our inspection, staff told us that there were no patients prescribed thickener powder, however for anyone who would need this, it would be stored un-securely next to the bedside. We also found that the thickener was being stored in a kitchen which was only locked at night time, or it there was a wandering patient on the unit. We raised this with senior leaders and were told that the thickener had been removed from the kitchen and the hospice were looking at ways to store this securely within patient rooms.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Senior leaders told us that the hospice strongly encouraged a culture of reporting incidents and near misses, with an emphasis on 'learning'. They told us they took an approach of 'fair responsibility' and not a culture of blame.

Staff told us incidents would be reviewed as part of the monthly Clinical Governance team meetings which were cascaded through team meetings and fed back to staff by email. We reviewed team minutes and saw evidence of investigations, outcomes and lessons learned from incidents reported.

Any falls that occurred at the hospice were reported via the hospice's incident reporting system. We were told that the incident investigator would check that all

documentation had been adequately completed and there was a very similar approach that was taken to the management of pressure ulcers. In relation to one particular incident involving medicines, we saw evidence that evidence of Duty of Candour had been completed accordingly. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Are hospices for adults effective? (for example, treatment is effective)

Good 

Our rating of effective stayed the same. We rated it as **good**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service provided care and treatment based on national guidance and evidence of its effectiveness. The hospice completed a range of audits including audits of medicines management, patient safety, infection prevention controls, National Institute for Health and Care Excellence guidance and symptom control. All the on-going work and updates were fed back to the Clinical Governance meeting. Audit results were shared with staff by email and at team meetings. Recommendations from the audits were incorporated into the action plan and monitored by the Clinical Governance monthly team meeting.

Policies and procedures were readily available for all staff. Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence and Royal Colleges. The documents contained flow charts and contact details of relevant agencies, as well as clear guidance for staff. We reviewed eight policies and found them to all be current and in date. In 2014, The Department of Health launched a new approach to the

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care of people who were dying based on the needs and wishes of the person and those close to them. Five New Priorities for Care replaced the Liverpool Care Pathway creating the basis for caring for someone at the end of their life. During our inspection, we reviewed patient records and the five priorities of care. We found that all five priorities (recognition of dying, sensitive and effective communication, involvement in decisions, emotional needs being met and individualised care plans) had been met. We also saw that patients had a clear personalised care plan that reflected their needs and was up to date.

The physiotherapists within the hospice also used virtual reality therapy, also known as virtual reality immersion therapy. This uses virtual reality technology for psychological or occupational therapy. Patients receiving this treatment navigate through digitally created environments, which can be used for psychological or occupational therapy.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Nutrition and hydration assessments were completed with patients and their families on admission. The information was then shared with the catering team to meet individual needs and preferences. The Hospice worked closely with the local NHS trust to meet enteral and parenteral feeding. Pureed and liquidised diet was provided, when required and we were told that the hospice was working towards implementing the International 'dysphagia diet and standardisation initiative'.

The service had started a joint project between clinical and catering staff, "Good enough to Eat" to encourage nutritional intake.

Nutrition and hydration was included in clinical induction training and all staff and volunteers received food hygiene training on induction. The hospice had a five-star food hygiene rating from the local authority. Staff told us that the catering and clinical teams would work together to fulfil catering requests for special events, such as

weddings arranged at short notice. The hospice had its own café on site, in which members of the public could visit. If patients were well enough they could also visit the café.

The kitchen operated until 6.15pm, but there was food and snacks available at other times. The hospice did have some alcohol on site to fulfil patients' needs and wishes in the end stages of their life.

Every day there was a list of the patients in the hospice with coding next to the names to inform all staff offering food and drinks of specific patient needs, or allergies, or whether they needed drinks to be given in a special cup. Jugs of juice or water were given to patients each morning and refreshed at 5pm.

The hospice was developing a policy for the use of intravenous fluids in the community. Staff told us that intravenous fluids could be given on the inpatient unit if deemed appropriate, and any risks, were discussed with the patient and family. If a patient was struggling with increased secretions with the fluids, these could be reduced and slowed down on discussion with the family.

Oral fluids were discussed with the patient and family, and families would be informed of the risks if the patient was struggling to take oral fluids. The hospice delivered regular mouth care and families were involved in this as much as they wanted to be.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients told us they had any pain needs met and they would regularly be offered pain relief. Pain score tools were used to monitor the effectiveness of pain relief after it had been given and a numerical tool to assess pain scores was used when necessary. Although we did not observe anticipatory medication advice being given during inspection, we were told that if patients wanted to self-administer their medicines, there was a risk assessment process to allow them to do this safely and effectively.

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All the patients we spoke to told us that they were given pain relief when they needed it and that staff were responsive to answering the buzzers, when they were in pain.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The hospice had an audit plan for clinical services which was reviewed at the monthly clinical governance meeting. We were told that a member of the medical team had recently undertaken a piece of work to review all relevant and available guidance measuring practice against this. This work was a component of the clinical services' improvement plan with a supporting action plan entitled, 'Clinical Guidelines', which we were told was a live document with ongoing work being completed against this. The hospice had identified that work around the documentation relating to patient falls required review and as a result, the approach was redesigned in liaison with a falls team at local community provider.

The hospice did not use any tool to evidence the impact of care, such as the Outcome Assessment and Complexity Collaborative suite of measuring. The Outcome Assessment and Complexity Collaborative is used to assess whether the care that matters most to people and their families at the end of life was received. However, following the inspection the service shared an action plan to explore range and applicability of outcome measures.

During 2016-2018, data showed that 319 patients referred to the clinical nurse specialist (CNS), team died before receiving an assessment. The hospice had made a reinvestment of finances from an underused service (day therapy) into the clinical nurse specialist (CNS) team (by three whole time equivalent (WTE) posts) to reduce the numbers of people not being reached.

Money used from day therapy was re-invested into the clinical nurse specialist team, and two non-qualified staff joined the team and undertook roles including the management of fatigue, breathlessness and none-pharmaceutical procedures, under the care of the clinical nurse specialists.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The hospice had its own in-house education team. The hospice had a mandatory training programme and in addition to this there was a clinical training and competency framework for clinical staff. All Clinical staff had competency frameworks to follow. Staff told us that they could access a variety of training relevant to their role. Volunteers recruited to the hospice undertook the mandatory training and induction programme within the hospice.

The education team told us about a new mini skills laboratory which would be used for enhancing skills such as resuscitation and male catheterisation. This skills room would also be used for the teaching of student nurses.

The service checked nursing staff registration with the Nursing Midwifery Council yearly. Medical staff had their General Medical Council registration checked, but following our inspection, the hospice was developing a more effective method of monitoring and tracking this information for both nursing and medical staff.

Staff received annual appraisals and could identify their own training needs with their manager. The professional development plan of the appraisal document was reviewed by the knowledge exchange team and courses were developed in response to themes. The service had a training bursary for staff to attend external courses or conferences.

For medical staff (inclusive of the four consultants in palliative care), appraisals were completed by the medical director at the hospice, or by an appropriately trained consultant from the local NHS provider, who would also co-ordinate 360-degree feedback. Proof of successful appraisal was then sent to the head of human resources at the hospice. Part of the appraisal process included the review of compliance with the General Medical Council, as well as evidence of current indemnity insurance. The medical director for the hospice had their appraisal completed by the chief executive.

Appraisal rates

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At the time of the inspection, compliance for the completion of staff appraisals was 100%.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The hospice held a weekly multi-disciplinary meeting with inpatient unit nurses, doctors, therapy staff, social workers and clinical nurse specialists to review care. Staff also told us about a weekly video call meeting that was held with a local NHS acute provider for further sharing of relevant information and updates.

The hospice offered palliative rehabilitation, led by physiotherapy teams. Rehabilitative palliative care aims to empower people with life-limiting and terminal conditions to actively manage their condition themselves, using a multi-professional team. It used a variety of methods to help patients, such as varying activities, mobility assessments and diversional therapies. There was also funding for voluntary rehabilitation assistants, who were then trained and supervised by the physiotherapists.

Staff worked effectively with colleagues in other services such as the falls team from a local community provider to deliver effective care and treatment.

Seven-day services

The service delivered a full inpatient service for patients receiving palliative care seven days a week.

The inpatient unit operated seven days-a week providing care to patients.

The service ran a 24-hour advice line for families and staff members. The clinical nurse specialist (CNS) team operated seven-days a week and they also managed the advice line at the weekends.

Health promotion

Whilst on the inpatient unit we saw a variety of health promotion leaflets available for patients, relatives and carers to take away including information from charities and for topics such as on Alzheimer's disease, multiple sclerosis, oxygen treatment and bereavement and support.

Consent and Mental Capacity Act

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.

The Mental Capacity Act 2005 provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Mental Capacity 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 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 Mental Capacity Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

Staff we spoke to understood how to assess mental capacity and on review of care records, we saw evidence of best interest decisions being documented.

The service had two ward based Mental Capacity Act leads (one nurse and one medical team member). These staff members offered guidance and advice to other staff members on the unit.

Are hospices for adults caring?

Outstanding



Our rating of caring improved. We rated it as **outstanding**.

Compassionate care

Patients were at the centre of everything the staff and hospice did. Patients were cared for with total compassion. Feedback from patients confirmed that staff treated them well and with kindness and went above and beyond. There was a strong, patient-centred culture on the unit from all levels of staff.

Patients and families were at the heart of everything staff members did. Staff responded compassionately when

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patients or their relatives needed help. Support was always given by caring staff, to meet the needs of the patients and their families and feedback from people who used the service was continually positive about the way staff treated people.

Staff identified patients who needed extra support and discussed changes to patients' care and treatment with patients and their carers. The service provided support to families and carers to maintain their own health and wellbeing. We spoke to patients and relatives in the hospice and observed care and treatment both in the hospice and on home visits. There was a strong, patient-centred culture in the unit from all levels of staff. Staff were motivated and inspired to offer care for patients with kindness, compassion, dignity and respect through supportive relationships with patients and their families. We observed all staff members speaking to patients and their relatives and carers with compassion and we observed sensitivity being shown during conversations.

We heard patients being offered food and drinks in an encouraging and caring way and observed staff to always be doing as much as they could, to help patients.

Consideration of patient privacy and dignity was consistently embedded in everything that staff did. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. The hospice had a privacy and dignity policy which detailed expectations such as effective and respectful communication. Privacy and dignity training was completed by all staff on induction, with refresher training every two years. Staff told us that the use of signs stating, 'care in progress' helped to prevent uninvited interruptions. We spoke to six patients and all the patients told us their privacy and dignity was always maintained by staff. Some of the things patients said to us included: - "The staff are all absolutely marvellous"

Following refurbishment, a white board was put in the conservatory to use as a notice board, however staff told us that visitors used it to write feedback messages to hospice staff. We were told that many cards and letters of thanks were also received regularly. During our inspection, the team had received a card that morning which was shared with us and the author was very thankful for the excellent care that their loved one had received.

It was evident that hospice staff endeavoured daily, to provide care tailored, as far as possible, to individual needs and wishes. We were told about the rehabilitation project, which had been introduced in 2017 to encourage patients to continue with interests, for example, the use of the internet, or listening to music. Focusing on patients and families as individuals was an essential component of care at the hospice.

The hospice had obtained some virtual reality therapy. This enabled one patient, with the aid of the goggles, to experience a feeling of being with an animal that had meant so much to them. The patient's loved one was very emotional to see how much it had meant to the patient to experience this one more time.

All the staff at the hospice were passionate about delivering compassionate care, with the patient at the centre of everything they did, particularly whilst making end of life as good as it could be for the patient and their family or carers and they went above and beyond to achieve this. We were told about helicopter ride that had been organised for a child, whose parent was in the last stages of life, as well as other examples of stories involving a princess carriage led by a pony up and down the gardens. The hospice had facilitated champagne weddings on the lawns, christenings and graduations, to enable the patient at end of life to be part of important celebrations. The hospice did not just facilitate the attendance of the patient at the event, but they would also ensure that the patient was helped to feel special and attention to detail, dress and everything that person needed to feel a part of that special day. If needed, patients could also attend events in the chapel on their beds if required. Staff told us about one patient who had been allowed their dogs to come and stay with them and staff did all they could to facilitate any requests from pizza and film nights, to Sunday dinner and gin and tonic in the conservatory. The hospice also facilitated the creation of a mini art gallery for one patient whilst they were on the unit. We were also told about one family member who had come to see their loved one. They had always enjoyed cheese and wine together and the staff came in with a variety of cheese and biscuits and ensured they both had a glass of wine to enjoy that moment together again for possibly the last time.

Following a person's death, bereavement support was offered to all family members. Bereavement support

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included one-to-one counselling, informal drop in sessions as well as bereavement groups. The hospice held quarterly remembrance services with staff and volunteers attending to offer support to people.

One patient we spoke with described the staff as “absolutely marvellous” and all the patients we spoke with told us that the staff could not do enough to help patients and their families and carers. They all felt that their opinions were valued and heard and their wishes respected. All the people we spoke with told us that the staff went above and beyond and patients felt very safe and secure and at home in the hospice.

Patient requests and wishes were always acted on by staff to make them feel at home. One patient we spoke with had asked to move rooms several times and they told us that the staff had accommodated this until they had found the room they felt most comfortable in and one patient told us they felt “they could live there.”

Emotional support

Patients always received a high level of emotional support to minimise their distress. Staff fully understood that patients’ emotional needs were as important as their physical needs.

Staff understood that patients’ emotional needs were as important as their physical needs. Feedback from patients about how they were cared for was consistently positive. Staff showed a deep awareness of the emotional impact of conditions on patients and took account of this during assessments. Staff went the extra mile in their care and support of patients.

During a home visit, we observed patients being given as much time as they needed to ask any questions, or voice any concerns they had and we then observed that patient being given reassurance and support from the health professional conducting the visit.

We saw and heard staff members offering encouragement to patients in a reassuring manner, to alleviate anxiety.

All discussions around aspects of patient care involved family members opinions being heard and valued. Having family members present for emotional support helped the patient to feel less anxious.

Staff welcomed relatives and friends to visit, as this provided the patient with emotional support. The hospice had an open visiting policy, so relatives and loved ones could spend precious time with the patient, often helping to alleviate anxieties of being alone. Staff told us that pets could come to the hospice to be with their owners.

Beds could be ordered for those couples wanting to be together and one of the rooms had a large lounge area, allowing larger families to remain together, yet in the privacy of the one room.

We were told about a patient who did not have many close family members, so one of the volunteers befriended the patient and visited them often, even when the patient was admitted to the unit. Shortly before the patient died the patient had said “it might have been the last month of my life but it has also been the best, thank you”.

Understanding and involvement of patients and those close to them

Patients and those close to them were partners in decisions about their care and treatment. Relatives and carers unanimously spoke highly of the care their loved one had received and reported that had felt fully involved in all aspects of care and had also had their opinions considered.

The hospice worked hard to ensure that families, with consent, were engaged and involved with patient care. This had the added benefit of giving others the ‘confidence to provide care’ following discharge or positive feelings in bereavement about being useful and helpful to their loved one. Carers needs were considered and this started at admission. Colleagues, including doctors and nurses, volunteered at remembrance services and we were told that the bereaved in attendance greatly appreciated their presence.

There were boards by the bed spaces with communication sheets on them. Patients, relatives and carers were encouraged to write any questions they had on the board as they thought of them and staff would reply to these on either a face to face basis, or they would reply on the board for those raising the query to see.

Patients were at the centre of everything staff at the hospice did. Having recognised the importance of patient

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centred care within the community setting, the hospice created two new posts of community support assistants. These posts provided an opportunity for patients to receive support with non-pharmacological interventions in the domiciliary setting. This included help and support with the management of anxiety, fatigue and breathlessness. With the support and supervision of one of the clinical nurse specialists, the assistants would empower patients and carers by enabling opportunities to learn skills together, whilst also building confidence. Active participation of carers in end-of-life-care can also have positive benefits during the bereavement process.

The service told us that feedback in both the cafe and conservatory had shown that patients and families had felt more cared for. Staff told us of a family with young children who were struggling to tell of the bad news that faced them. Staff used all the resources they could find, including effective communication and counselling skills to support the family to deliver the bad news in a way that the children could understand.

Patients, relatives and carers had access to family support services, with a large variety of spiritual and religious needs being accommodated.

To review the impact of care being delivered, the hospice used a questionnaire to obtain patient and carer feedback. We reviewed feedback and saw that loved ones had felt very involved in the patient's care and they had felt supported by staff.

The hospice had a bereavement group that ran in an evening monthly. We were told that the peer-support group had been instrumental in helping bereaved families and carers since the hospice was first set up.

Are hospices for adults responsive to people's needs?

(for example, to feedback?)

Good 

Our rating of responsive stayed the same. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

The hospice was easily accessible and near to the end of the motorways, with access also gained from public transport, such as bus routes. There were two large car parks that offered free parking, one of which had recently been extended to accommodate more vehicles. There were clear signs showing how to get to the hospice, with a pleasant walk over a bridge past beautiful lawns to get to the main entrance. The hospice sits within 11 acres of grounds with a river, wheeled access footbridges, a sensory garden and walks. The entrance was through automatic glass doors, making it very accessible for those with prams or wheelchairs. The garden and lawn areas were peaceful and tranquil, offering patients and their relatives or carers the opportunity to sit in the garden, with many of the rooms having views across the beautiful lawns. On entering the main building, there was a shop, that sold provisions including drinks and snacks. The hospice had its own café which sat to the side of a smaller car park and was well attended by residents, with the money raised feeding back into the hospice services. The hospice ran several events throughout the year from afternoon teas, themed events to evening balls and special remembrance days, all were well attended by local people, strengthening the relationship between the hospice and the local community.

The service told us that there had been a lot of people dying before being able to access the clinical nurse specialist team, but were also aware that the day therapy service had not been well-attended, so the money from day therapy had been reinvested into the clinical nurse specialist team, which had significantly reduced the number of people dying before accessing the service. The hospice did not currently operate a hospice at home service, but this was something they were very keen to do in the future and so were trying to prioritise introducing this service as a need with commissioners.

The inpatient unit responded rapidly to admissions, with an average admission waiting time of just two days. The unit also accommodated the 24-hour advice line used by professionals and service users bringing an instant response at critical moments, whilst being able to make decisions to admit, or to refer to the clinical nurse specialist team to act responsively to crises.

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The hospice could cater to varying faith needs. There was a chapel in the hospice, which could be adapted to accommodate varying religious, or non-religious ceremonies and the hospice were able to support different cultural and religious beliefs. We were told about how staff within the unit helped to support a young patient with a learning difficulty in making choices about food and activity, whilst balancing this with the family's religious and cultural beliefs.

The clinical nurse specialists also supported prisoners from a few local prisons and there had been some outstanding feedback from prisoners' families about the service.

Some of the rooms we saw were extremely large, offering plenty of light and garden views. All areas of the hospice were made to look as homely as possible and there were fresh flowers to decorate the surroundings. Staff told us that two of the volunteers had done floristry, so they arranged the flowers. There were counter-pains that had been made to make the bed space look more inviting.

The hospice had tracks on the ceiling, for the use of hoists to assist in the moving of patients with limited mobility. This was also evident in the bathroom, which was a large room with a deep bath with decorative pictures in the room, to help aid relaxation. The hospice could facilitate any bariatric patients and specialist beds could be hired and then constructed in the rooms. To maintain patient and staff safety, the hospice reviewed the management of these cases, which included necessary equipment, such as beds, hoists, slings and chairs, as well as a review of the environment to enable enough space for staff and patients to move about and to ensure the safe escape in the event of fire. The management of bariatric patients also included a review of staffing ratios.

We had sight of the separate ambulance area within the hospice. This enabled patients to be admitted by ambulance in privacy, without needing to enter through the main entrance. The ambulance entrance was in a quiet part of the hospice and it had a beautifully decorated ceiling to help patients lying down on trolleys to feel more at ease on arrival.

Meeting people's individual needs

The service took account of patients' individual needs.

For relatives, carers and loved ones, there was a large lounge area, with doors leading to an outside area. Within this area, there were comfortable chairs and drink making facilities and provisions available for them to use, inclusive of snacks, fruit and biscuits. There were also bed-settees next to the beds for those relatives and carers who wanted to stay alongside the patient. There were also toilet and shower facilities available to those staying with their loved ones. Other facilities at the hospice included free unlimited access to televisions, Wi-Fi and phone charging facilities, as well break out rooms for peace and tranquillity. There were also highly ventilated inside and outside smoking facilities for resident patients. We were told that all the facilities had been developed because of patient and family experiences.

The hospice had access to a beauty therapist and there was a hairdressing room and hair dressing services also available. For those with relatives in other countries, staff could obtain laptops for patients for video calls to relatives abroad and we were told about one patient who was given the opportunity to do this at the same time each day.

In a quiet part of the hospice, there was a viewing room, which had comfy chairs and was made to look like a lounge to offer some further comfort to those going to view their loved ones. This was attached to the mortuary, which meant others would not be exposed to potentially upsetting situations. Families were asked what they wanted to follow the death of a loved one as part of the advanced care planning. We also saw evidence that staff took account of patients' spiritual needs within end of life care plans. Although we saw some dementia friendly toilet seats and hand rails in the lymphoedema clinic, not all areas of the hospice were dementia friendly. We were told that two of the clinical nurse specialists had completed the dementia friendly training, but not all staff had completed this.

The hospice had signed up to the Trades Union Congress, 'Dying to Work' campaign. The Trades Union Congress aspires to having terminal illness recognised as a 'protected characteristic'. This would enable an employee diagnosed with a terminal illness to benefit from a 'protected period' where they could not be dismissed because of their condition. The hospice was proud to receive positive recognition by the Trades Union Congress.

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A mandatory training programme entitled 'Looking Beyond Difference and Seeing the Individual' was in progress. This was to make colleagues more aware of their own potential for 'unconscious bias and to ensure that care was always delivered in a way that is in-keeping with a patient's background or characteristics.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The hospice operated at about 92% capacity and the average length of stay varied between 11 to 22 days. Senior staff told us that there could be problems discharging patients. To assist with the improvement of discharge there had been a discharge educator appointed to assist with the complexities of discharge and continued health care. Their role was to work with staff to assist and support with discharge, but without deskilling the other staff members. It was reported that the discharge process was much more responsive and efficient for patients.

The daily admissions' meeting managed access and flow. The multi-professional team would assess all the referrals, advice line calls, and waiting lists. A project was undertaken on the inpatient unit, which aimed to improved access and flow, particularly by achieving smoother and better discharge outcomes and by improving responsiveness to pain management enabling patients to settle more quickly.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The hospice had a complaints policy, which we reviewed and saw it was relevant, up-to-date and clearly outlined the complaints process and how to manage different types of complaints.

Complaints

Between the period of September 2017 and October 2018, there were a total of 10 complaints received by the hospice, all managed under the formal complaints procedure. Out of these 10, seven were resolved by the

target time frame of 25 working days and two were upheld (in part). On review of the complaints, the hospice found no common themes in the complaints and they were all made for a variety of reasons and the hospice had provided valid responses in relation to these.

One complaint had been ongoing for a few years and was still under review by the Parliamentary and Health Service Ombudsman, but the hospice had reviewed the issues raised and felt they had done everything they could, so this remained under investigation. We saw documentation relating to this incident and it was apparent that the hospice had remained open and honest throughout the process, ensuring relevant agencies had also been informed.

All complaints were reported to the board and that there was learning taken from each complaint as each case allowed for continuous improvement.

All staff received mandatory and update training on the management of complaints and lessons learned were always fed back to team members.

Compliments

Between the period of January 2017 and December 2017, the hospice received a total of 230 written compliments. The hospice produced a monthly summary of themes that were gathered from the compliments to share with staff. The themes that came from the compliments within that period included comments: professionalism, honesty, caring, compassion, effectiveness, informative, reassuring, responsive, kind, friendly and 'nothing is too much trouble.' The hospice also received numerous verbal compliments, as well as those that come from social media. Any themes gathered from compliments were shared with the Knowledge Exchange Committee each quarter.

Are hospices for adults well-led?

Requires improvement 

Our rating of well-led went down. We rated it as **requires improvement**.

Leadership

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Managers at all levels at the hospice had the right skills and abilities to run a service providing high-quality sustainable care.

The hospice was led by a chief executive supported by a team of five directors covering a range of portfolios including knowledge exchange, community and income and finance and business. The service was clinically led by the director of care, the medical director and the inpatient unit manager. As a charity the chief executive was accountable to a board of trustees led by the chair. There were 13 trustees on the board, from a mixture of backgrounds, some of which were from a clinical background, for example, a consultant physiotherapist, general practitioner (GP), physiotherapist and nurse managers, with the addition of a recently appointed member who had previously been a chief executive officer within the NHS.

Staff from the hospice had various other internal and external lead roles. The chief executive chaired the North-West hospice group and was a hospice UK board member until 2017 when he commenced a PhD on 'leadership and change in English hospices'. The director of knowledge and technical was undertaking a masters' in leadership and management and chaired the regional education strategy group and the medical director leads on a regional 'early identification' project and one for do not attempt cardio pulmonary Resuscitation. The director of care was also a senior member of the local controlled drug local intelligence network group.

Many of the staff had worked at the hospice for several years, including some of the managers and senior leaders. Leaders were all very enthusiastic and very passionate about the work the hospice did and how palliative care was delivered to patients and families. Staff we spoke with told us that managers of all levels were visible, approachable, supportive and would always listen to staff if they wanted to discuss anything. Staff told us there were very positive and effective working relationships. Staff told us that both the chief executive officer and the director of care came down on the unit very frequently and the chief executive officer would often work alongside staff to keep in close touch with day-to-day challenges.

In the last five years 100% of managers had completed the formal six-month Institute of Leadership and

Management training course and we saw that between 2012 and 2018, 23 members of staff completed the 'outstanding leadership and management' course delivered by leadership consultants.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There were colourful posters in various areas of the hospice which displayed the hospice's vision and mission. The main vision being: 'We want everyone in Central Lancashire facing life-shortening illnesses to experience a good quality of life and when the time comes, comfort and dignity in death'.

The hospice was clear about its vision and goals and it worked collaboratively with the NHS, local councils, organisations, charities, businesses, supporters and communities to meet local need. The hospice set out its plans in its five-year strategy and annual business plan structured around the four themes of patients and families, knowledge exchange, community and income, finance, business and technical with their three goals being quality, quantity and sustainability. The posters clearly demonstrated what the hospice did and how they did it. Staff we spoke with were familiar with the vision and values. The hospice's mission and business plan was displayed in every office and we were told that all staff contributed to the development of it through twice yearly seminars.

Plans were also underway for the newly developed Patient and Families sub-committee to strengthen its impact on the way that services operate. The hospice also had a feasibility study planned called 'building our future' in partnership with a local university to involve the board, staff, volunteers and stakeholders working together to produce options for a complete re-build the facilities by 2025.

The hospice's sustainability programme would involve innovations such as: appointing a digital marketing officer and new expert trustees to communications, care and finance; new high calibre promotional videos; a new finance system, opening the parkland and building on the continued success of The Mill, which attracted 80,000 visits last year.

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Other innovations planned for the coming year also included the launch of the hospice's first research strategy, the outcome of the feasibility study for next generation, embedding the extended clinical nurse specialist team, launching a compassionate communities project and an extension of The Mill cafe.

To further improve services, the hospice had been working alongside the local university to look at rebuilding facilities for the next generation. This would include planning improved access and flow patterns for more patients and more varied socio/medical requirements. The service was bidding for a hospice at home service which would have an impact on smoother patient experiences along with access and flow between services.

There were plans for the introduction of an 'urgent response clinical nurse specialist' in the aim of further increasing responsiveness and capacity. During 2017, a staff survey and workshops found that the values that staff considered most important in the delivery of care were: care, compassion and commitment. We were told that the draft 2019 business plan included a new awards system for staff who truly demonstrated these values.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff described the culture within the service as open and positive, with leaders being easily accessible and supportive. All staff we spoke with told us how much they enjoyed working at the hospice.

All the staff we spoke with told us that all staff, regardless of role, were encouraged to voice their opinions and ask questions, whilst feeling supported to do so. They reported there to be a positive, supportive, open and honest culture amongst staff within the hospice. We were told that people were always treated fairly and that people were very caring towards each other, treating each other with respect and every staff member we spoke with remarked on the real sense of team working throughout all areas of the hospice. Staff felt they could turn to anyone for advice, help or support and felt a real sense of 'togetherness' in all areas.

The hospice had a total of three freedom to speak up guardians. Staff were aware of the role and who and how to contact them and staff said they would feel comfortable in raising any concerns with managers. All staff members were encouraged to challenge, or raise concerns, should any discriminatory comments or behaviours be observed.

Governance

The service used a systematic approach to continually improve the quality of its services. However, the service did not have robust systems to meet the fit and proper persons regulation and the on-going monitoring of clinical registrations.

Leadership in governance was shared. Under the board of trustees, there were seven committees and nine sub-committees, as well as working groups. The board's governance committee and the chief executive officer were responsible for corporate and information governance. The board's patient care committee, medical director and director of care lead on clinical governance. There were also clinical governance and information governance sub-committees. The clinical services improvement plan was monitored through the clinical governance sub-committee and the board's patient care committee.

Directors met monthly and all managers met up together quarterly in addition to service and clinical governance meetings. Board meetings were held four times a year and an action tracker was kept, to monitor progress and developments.

A detailed clinical services' improvement plan supported the ongoing development of responsive and compassionate care. The plan included responses from incident reports, complaints, compliments and observations.

During inspection, it became apparent that there were inconsistencies with what information had been kept in personnel files. There were also issues with governance systems not providing enough assurance regarding nursing and medical qualifications.

We reviewed personnel files from a variety of staff members, from the chief executive officer to volunteers, to review governance processes in the recruitment of volunteers and staff members and ensure compliance

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with the fit and proper persons regulation. We reviewed 11 personnel files and found inconsistencies with the information kept in each file, as all the files had varying pieces of information for employment, with few having everything needed and others having very little. For example, there were gaps in the evidence of the disclosure and barring service checks having been completed on some staff members and issues with the on-going process of the storage of this information. We were told that these checks were completed and we did see evidence of this for some staff members, but not for all.

There were also two issues with character references having been made from close family members, or friends (although one of these staff members had not yet commenced in post at the time of inspection). We also found that there was no evidence of the medical director having medical experience fundamental to their role and a lack of evidence of competencies for medical staff members. At the time of inspection, we also reviewed a staff file to review evidence of practising privileges for medical staff. We saw evidence of a contract, but saw no evidence of professional indemnity, information from the responsible officer, evidence of an appraisal or relevant qualifications. We did see evidence of nursing registration checks having been completed, however the process was not as robust for medical staff.

As a result of our fit and proper persons employed review, we could not be assured that there was a process in place to make sure that all the relevant information had been gathered and reviewed when employing new staff members. The provider could not assure itself that it had an appropriate process for assessing and checking that candidates held the required qualifications, or had completed the necessary disclosure and barring service checks prior to employment.

All the issues we found whilst on site were brought immediately to the attention of the director of care and the chief executive officer, which highlighted gaps in governance processes in relation to employment and staff information.

Directors and senior staff immediately began to address these issues whilst we were still on site and following our inspection, the hospice created a detailed action plan to address the gaps and to ensure a more robust recruitment process for future staff, whilst also reviewing

and updating the recruitment policy and undertaking an audit of current staff files. We were told that there would be a spreadsheet maintained as evidence that all the required checks had been completed to match up with the 'live' check-list.

The service had also planned a masterclass for March 2019 on updating for trustees and senior officers on governance.

Managing risks, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The hospice had an overall risk register. There was clear detail as what the risks were, which area they had been identified and when and what the risks and control measures in place were. The hospice's risk register was a standing item on the agenda and was regularly updated by the board and its committees.

Senior leaders identified the biggest risks for the hospice as staffing, finances and reputation. The hospice used an incident reporting system, which was directly overseen by the Director of Care. Staff we spoke to were familiar with the reporting of incidents and told us that they were actively encouraged to report any incidents.

We reviewed the minutes of the Board of Trustees meetings held in October 2018. We saw evidence that key performance indicators were discussed. There had also been discussion around some of the other committees, with a review of the on-going action tracker. Senior leaders told us that trustees conducted independent inspections four times a year to try to gather honest views and opinions, as well as seeing everyday challenges.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Information systems supported quality patient care and treatment. Information was kept securely and maintained the confidentiality of patients and information was only shared with relevant agencies after patient consent had been obtained.

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There were several computer stations with intranet and internet access available throughout the service and there were sufficient numbers of computers for staff to access information. The computer systems were password protected and staff we spoke to were aware of how to protect access to computer systems and patient identifiable information.

There were notice boards in various parts of the hospice which had the values and mission and other information to be shared with staff members.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The hospice engaged well to meet the needs and requirements of their patients and families and celebrated the good working relationships with the families they cared for. We saw evidence of areas where patients and families could thank and praise staff for their care.

The hospice considered feedback from the local community and service users as invaluable in informing of the service of what was working well and areas to be enhanced. There was a Patients and Families Sub-Committee chaired by a trustee who was a national champion for patients.

The communications team promoted positive feedback by using internal notice boards and weekly meetings to bring staff attention to positive comments (called 'Herograms') to encourage positive behaviours or actions leading to expressions of gratitude or recognition. The communications team had developed a video to be released on the website for wider public and stakeholder engagement.

Patients and their relatives completed the 'I Want Great Care' survey. The survey used a continuous, real-time collection of patient feedback and views on patient experience and outcomes. This was available in paper form in the welcome pack and was also given out by clinical nurse specialist team. The survey could also be completed on the hospice website, with results posted on the hospice website. Themes and comments were considered at Board level, clinical governance and

patients and families sub-committees. Feedback from the survey was fed back to staff members, or teams and there was also an emphasis on learning from good feedback so that the service could keep doing the things that work well for people.

In 2017, along with a national hospice charity, the hospice were leaders in the 'open up hospice care' campaign which aimed to raise awareness about hospice care being for everyone, regardless of age, gender, sexuality, ethnicity, disability or illness or socio-economic group. Highlights of the media campaign for St Catherine's included the chief executive officer and a patient appearing live on a television programme. Another example given was of another patient who shared their experience as a bereaved homosexual partner reaching 62,000 people on social media via St Catherine's channels alone. We were told that this patient also took part in a corporate round table event in London focusing on the lesbian gay bisexual transgender community and hospice care.

In June 2018 the hospice support team hosted a multi-faith event in a marquee within the hospice grounds, welcoming 12 religious groups who shared information with members of the public and health and social care professionals. It celebrated the spiritual diversity of the area, whilst educating and informing visitors about different religious beliefs and practices. We were told that the inclusive remembrance service had transformed attendance which had almost doubled in two years.

The hospice participated in a national hospice charity's benchmarked staff survey every two years and the results were available for all staff and trustees to see. The most recent results had been outstanding. The hospice engaged with the public and the community through their volunteer befriending service and the popular quarterly remembrance services.

The hospice was a recognised trainer for the gold standards framework hospice support training programme, which is a quality improvement training programme that aims to improve supportive care for all people as they near the end of their lives, enabling them to live well and die in the place and way of choosing. Staff from the hospice were also involved in delivering syringe

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driver training to staff from a local community provider and the hospice operated a course called 'don't know what to say' which was delivered free of charge. Staff told us that this course was always fully booked.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a positive focus on continuous learning and improvement for all staff and the service tried to learn something from every situation and eventuality.

For 2019, the hospice had a programme of workshops planned, called 'doing the right thing'. We were told that these would involve cross-sections of the workforce and trustees working together in an innovative way to enhance communication and joint-working. This had emerged from a staff suggestion to change from 'departments' to 'teams' and staff surveys that identified key values and risks.

To educate others in specific care relating to end of life, the hospice, although not officially accredited, was considered a preferred provider for education and training by others. Training included the advance care planning and communication skills programme by Health Education England. This was a two-tier programme involving a train the trainer two-day course and a one-day programme for staff from various locations, including a hospice, hospital and the community. Attendees ranged from hospital consultants and senior nurses, to community health care assistants and nursing home staff.

St Catherine's had a formal memorandum of understanding with the local University and was seeking accreditation as a gold standard framework trainer. The hospice was also accredited by a local college to provide level two and three end-of-life care training and we were told there were negotiations underway with the local university to provide master's level education in end-of-life care.

In 2018, hospice staff achieved lots of awards and nominations, some of which included: - long service awards, the local newspaper award 'health heroes' gave awards to one of the clinical nurse specialists from the inpatient unit, nurse of the year and an inpatient unit stores volunteer also winning the unsung hero award. There were also awards and nominations from a radio station, a horticultural award with the hospice park winning first place in both the business category for the local area. The Mill Café was a Lancashire finalist in a building of the decade award and one of the trustees also won a national volunteering award. We were also told that in a local newspaper, a member of the hospice team had won nurse of the year on two occasions. Senior leaders told us about the plans to expand the community clinical nurse specialist team as part of a three-year pilot with a local medical practice (the first of its kind in the country). This would involve devising end of life training programmes for staff of all grades at the practice. All the clinical nurse specialists would complete the prescribing training, enabling them to prescribe at the point of care. There were also plans for the clinical nurse specialists to train the 20 shop managers to be able to effectively respond to bereaved people who may decide to open up to them.

Outstanding practice and areas for improvement

Outstanding practice

- The hospice had obtained some virtual reality therapy. This enabled one patient, with the aid of the goggles, to experience a feeling of being with an animal that had meant so much to them. The patient's loved one was very emotional to see how much it had meant to the patient to experience this one more time.
- There were endless examples given of times when the hospice ensured it facilitated memorable occasions and different celebrations, going to the most extreme measures to ensure that the person at end of life was part of such special and treasured memories, but in doing so, would also ensure that the patient was made to feel in anyway necessary, dressed and ready for the occasion.
- Patients were at the centre of everything staff at the hospice did. Having recognised the importance of patient centred care within the community setting, the hospice created two new posts of community support assistants. These posts provided an opportunity for patients to receive support with non-pharmacological interventions in the domiciliary setting.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that there are effective recruitment and selection procedures and that the appropriate checks for both employees and directors are completed.
- The provider must ensure that there is a process to check that staff have appropriate and current registration with a professional regulator, or where applicable, an accredited voluntary register.

Action the provider **SHOULD** take to improve

- The provider should consider where pads and stoma bags are stored.
- The provider should review the safe and secure storage of medicines.
- The provider should review its process for acting on National Patient Safety Alerts.
- The provider should ensure that all staff treating and assessing children have completed training in level three safeguarding children.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulation 5 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)-Fit and proper persons: directors

The provider did not ensure that there was an effective recruitment and selection procedure and that the appropriate checks for both employees and directors were being completed.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)-Staffing

The provider was not able to demonstrate that registered health professionals continued to meet the professional standards which were a condition of their ability to practice, or requirement for the role.