

St. Oswald's Hospice Limited

St Oswalds Hospice

Inspection report

Regent Avenue,
Gosforth,
Newcastle upon Tyne,
NE3 1EE
Tel: 0191 285 0063
Website: www.stoswaldsuk.org

Date of inspection visit: 11 August, 4 and 7
September 2015
Date of publication: 26/01/2016

Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

This inspection took place on 11 August and 4 and 7 September 2015 and was unannounced.

We last inspected this service during December 2013. At that inspection we found the service was meeting all the legal requirements in force at the time.

St Oswald's Hospice provides specialist care for people with life limiting illnesses, including day and inpatient services for children, young adults and adults. It provides nursing care. It has 19 beds and had 13 adults and six children living there at the time of this inspection.

The service had a registered manager who had been in post for five years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us they received an exceptional quality of care from all the staff at the hospice. They said staff were wholly and genuinely

Summary of findings

committed to meeting all their physical, social and emotional needs, in highly person-centred, imaginative and flexible ways. They described a culture that was positive and life-affirming. Typical comments received from relatives included, “This is a marvellous place, even if you were a multi-millionaire you couldn’t pay for the care you get here”; “They’re like a second family, they wrap themselves around you to support you”; and, “They go above and beyond what you get in the community.”

There were very good staffing levels which allowed staff to meet people’s needs in a safe, timely and personalised manner. Extensive use was made of a large team of trained, experienced and dedicated volunteers (many of them qualified) in all areas of the service. This gave hospice staff the space to work with people in a particularly individualised way, and added considerably to the well-being of people and their families. People felt they were fully involved in all aspects of their care and treatment, and that their views were paramount in how their care was given.

The service had a well-defined, dynamic management structure that provided strong, effective and innovative leadership. There was a well-articulated vision for the next ten years’ development of the service. This focussed on breaking away from the traditional model of the hospice, as there was a recognition that many people were not currently receiving the support and care they needed in their own homes. By taking services out into the community and working in partnership with other hospices, hospitals and agencies, the service was developing new ways of supporting a much wider range of people with their end of life care needs.

End of life care was given in sensitive and appropriate ways that acknowledged people’s rights and preferences. The service promoted a ‘focus on living’ approach to care, which supported people and their families to appreciate and enjoy the time they had together and enhance their feelings of well-being. People were given a wide range of social stimulation and activities, supported by trained activities specialists in well-equipped on-site facilities, and could access complimentary therapies. As part of the ‘focus on living’ approach people were encouraged to develop skills and enjoy new experiences. A relative told us, “My perception of places like this was that it was a place you came to die. I’ve changed my perception, it’s far from that.”

There was a shared commitment by all staff to the service’s values of ‘care, compassion, dignity and love’. We found these values to be clearly demonstrated in the approach of staff and in the care given to people and their families. Staff morale was high and they told us that all the management team actively listened to their views, gave them the support they needed and made them feel valued and respected.

The staff team were highly qualified and very experienced. The service had its own training team and ensured staff were kept up to date with all training needs and supported in keeping the knowledge and skills updated. New staff were given structured induction and close mentoring. Regular supervision and annual appraisal were used to support clinical and non-clinical staff.

People using the service and their relatives told us they felt safe and well protected whilst in the service. Staff had been trained to recognise and report any possible issues of abuse. No safeguarding incidents had occurred in the unit since the last inspection.

The service carefully assessed all risks to people using the service and took appropriate measures to control risks. However, people were able to take risks necessary for them to maintain their independence.

All accidents and incidents were recorded and analysed, to allow for lessons to be learned and appropriate steps taken to prevent recurrence.

Regular checks were made regarding the safety of the building and equipment. Staff were given training in safe working practices and were provided with any necessary personal protective equipment to keep them safe. Effective systems were in place to monitor the control of infection.

Robust staff recruitment systems were in place which ensured that only applicants who met the service’s high specifications regarding qualifications, experience, character and caring abilities were employed. This included the recruitment of volunteers who were subject to the same processes as staff employed by the service.

The safe management of people’s medicines was given a high priority. Medicines were prescribed, recorded, stored, administered and disposed of in safe and appropriate ways.

Summary of findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. Staff had been trained in this important area and were aware of their responsibilities regarding protecting people's rights. The registered manager submitted appropriate applications to the local authority for authorisation to place restrictions on certain people's movement, in their best interests.

Effective systems of communication were in place to enable people to express their needs and wishes clearly. People were asked to give their formal consent to their care. Where they were deemed to lack capacity to do this, appropriate 'best interest' decisions were made on their behalf, in conjunction with family and professionals.

People were given appropriate support to take a nutritious diet.

People's general and specific health needs were kept under constant assessment and met, by treatment within the service or by referral to other professionals.

People said their right to privacy was fully protected, and told us they were always treated with dignity and great respect by all staff and volunteers. Staff demonstrated a commitment to maintaining confidentiality of people's personal information.

Every effort was made to enhance people's independence whilst at the service. Appropriate mobility and communication aids were available. People were given choice in all aspects of their daily living and were encouraged to express their individuality.

People were fully involved in assessing their care and treatment needs and their wishes and preferences were incorporated in planning how those needs were to be met. Regular reviews of people's care were held and people were encouraged to take full part in discussing how their needs were being met.

Systems were in place for responding to concerns and complaints, but we found no complaints had been received about in-patient services.

The service worked closely with other professionals and agencies to ensure people's holistic needs were fully met.

Robust systems were in place to continually monitor the quality of the service being provided and to identify and implement areas for further development. Staff at all levels were genuinely committed to a culture of excellence and demonstrated this in their day-to-day work.

There was clear evidence of close and effective partnership working between families and carers, and between the service and external professionals.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. Risks to people were assessed and appropriate steps taken to minimise harm to people, without restricting their independence.

There were high staffing levels and good support from trained volunteers which allowed staff to give people safe and timely care.

Staff had been trained to recognise and respond to any actual or potential abuse. No incidents of abuse had occurred.

People's prescribed medicines were safely managed.

Good



Is the service effective?

The service was effective. There was a highly trained staff group which had the necessary skills and experience to meet people's needs effectively.

Staff were given the support and supervision they needed to carry out their roles.

People's rights were protected under the Mental Capacity Act 2005 and no one was being deprived of their liberty unlawfully.

People's health needs were carefully monitored and appropriate referrals made to other professionals, where required. People's nutritional needs were understood and met.

Good



Is the service caring?

The service was particularly caring. People and their relatives told us that staff treated them with exceptional kindness, care, dignity and respect at all times.

Staff were highly pro-active in their approach to care. They demonstrated compassion in every aspect of their work and 'went the extra mile' to make people feel valued and supported.

An extensive range of imaginative activities and social stimulation was offered, including on-site access to many complementary therapies. People were given information about a wide variety of support services.

There was an emphasis on genuinely holistic care that valued every aspect of the person and gave opportunities to develop and enjoy their time with their families. People's spiritual needs were recognised and if appropriate met by a chaplaincy team with multi-faith links.

People were encouraged to be as independent as possible, make their own decisions and maintain control of their lives.

Outstanding



Is the service responsive?

The service was responsive. People and their families were fully involved in assessing their needs and planning how their care should be given.

Good



Summary of findings

Staff delivered people's care in a person-centred way, treating them as individuals and encouraging them to make choices about their daily lives.

No complaints had been received regarding the service.

Is the service well-led?

The service was particularly well led. The management team gave strong, effective and innovative leadership and provided a clear strategy for the long term development of the service. The management team was dynamic and pro-active in introducing new ways to meet the needs of people in the wider community.

There were clear management structures and lines of accountability. Staff told us the service was very well managed, that they were treated with respect and were actively involved in decision-making.

Robust systems were in place to monitor the quality of the service being provided. The views of people who used the service, their families, staff and other professionals were regularly canvassed and used to identify where improvements were necessary.

All staff shared an outstanding commitment to excellence in every aspect of their work.

Good



St Oswalds Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 11 August and 4 and 7 September 2015. The inspection was unannounced.

The inspection team was made up of one adult social care inspector; a Pharmacist inspector; an expert-by-experience; and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the

notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities, clinical commissioning groups and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we toured the building and talked with three people using the service, six relatives, a visiting social worker, and two visiting professionals. We spoke with 18 staff, including the registered manager; the chief executive; the human resources and finance directors; the managers of the adult inpatient and children's inpatient units; the chaplain; the learning and development, facilities and therapeutic activities managers; and eight nurses and support staff. We 'pathway tracked' the care of four people and two children, by looking at their care records and talking with them (or their relatives) and staff about their care. We reviewed a sample of 10 people's care records; four staff personnel files; and other records relating to the management of the service.

Is the service safe?

Our findings

People using the service told us they felt safe and protected whilst in the hospice. One person told us, "I feel very safe and comfortable, here." A relative said, "My child is looked after, they are safe and cared for."

The service had policies and procedures regarding the safeguarding of adults and children that were in line with the local authority policy and expectations. The local authority safeguarding 'threshold tool' was used to determine what issues should be raised formally, and regular contact was made with the safeguarding team to discuss issues. Clear records were kept of all safeguarding events. We noted there had been no safeguarding events in the previous twelve months. Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns, and were fully aware of the service's 'whistle-blowing' (exposing bad practice) policy.

The registered manager told us human rights and anti-discriminatory practice were enshrined in the philosophy of the service. They told us, "Palliative care is holistic. Human rights are central to everything we do." All staff were given anti-discriminatory training. Staff gave us examples of how they treated everyone as of equal status, including prisoners accompanied by prison warders, and asylum seekers, for whom interpreters were provided. Staff told us of the multi-cultural days that were held in the service to foster links and understanding between people of different faiths and cultures.

The service had a policy on the management of risk. This policy accepted that risks could not be completely eliminated and aimed to achieve an 'acceptable' level of risk that allowed people to retain autonomy over their lives. A pro-active approach identified and prioritised risks to the person in areas such as moving and handling, nutrition, transport and falls. In addition, various clinicians conducted assessments of risk relevant to their specialisms. Each person had an individual risk care plan that incorporated control measures to minimise harm. Examples of these included the use of sensor mats to detect movement, bed rails and increased staffing levels for observations. A 'risk management group', consisting of directors and senior managers, met regularly to analyse and learn lessons from recent events. The risk management group also oversaw the safety of the

premises, as part of its wider function. Daily observations and weekly audits were undertaken to check the safety of the building. A fire focus group co-ordinated fire safety issues, including scheduling and evaluating fire drills and liaising with external agencies including the fire and rescue service.

The service had a business continuity plan in place. This planned for a wide range of possible scenarios, such as severe weather, utilities failure and fire. An emergency team was identified.

All accidents and 'near misses' were recorded on 'adverse incidents' forms. These included the investigations carried out, outcomes and lessons learnt. For example, following a minor accident it was established no first aider had been on duty and the first aid box was depleted. Following this immediate action was taken to address the issue and further monitoring arrangements established to minimise the risk of a repeat occurrence. A quarterly report regarding adverse incidents was made to the Trustees.

Staff were kept safe by the use of personal protective equipment such as disposable gloves and aprons, antiseptic hand gels, and by regular training in areas such as health and safety, moving and handling and infection control. They were regularly reminded of safety issues via leaflets, quizzes and on computer screen savers. The service had robust internal and external systems in place for monitoring the risk of infection. An infection control group met regularly to monitor the effectiveness of measures to prevent infection. Audit and advice was also supplied by infection control advisors and a contracted microbiologist. The facilities manager explained the importance of maintaining as homely an environment as possible brought with it extra demands on housekeeping staff. These were met by ensuring good staffing levels, providing appropriate equipment and carrying out regular checks of the environment.

The service was staffed appropriately. The adult service unit manager told us they did not use a dependency tool as they had found this to be contentious and subjective. Instead, levels were set by the manager and senior nurse of each unit, based on knowledge of the needs of those people due to stay and their experience. The staffing ratio in the children and young adults unit was one staff member to each child through the day, plus a care co-ordinator; and one staff member to two children overnight. Staff told us this level was effective in meeting

Is the service safe?

people's needs. They told us the roster was flexible and other staff could be called upon at short notice, if required. People using the service and relatives told us that they felt there was always plenty of staff on duty.

Robust staff recruitment policies and procedures were in place. These included checks with the Disclosure and Barring Service and former employers; checks regarding professional registration and qualifications, identity, right to work, and employment history. Interviews were well structured, properly recorded, and demonstrated a commitment to employing appropriately qualified persons of good character.

Arrangements were in place for checking and confirming people's medicines on first admission to the hospice. When patients were discharged we saw that detailed information about their current medicines was given to the patient, including changes made during their stay in the hospice. Medicines were prescribed by the in-house medical team.

There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines

management. Nursing staff told us that they received training in medicines management and also specialist equipment such as syringe drivers. Their competency for administering medicines was assessed at regular intervals.

Medicines were kept safely. Medicines were kept securely in a locked drug trolley or in a locked treatment room and were only accessible to staff authorised to handle medicines. There was a system for ordering, receipt and disposal of medicines in place. Controlled drugs were ordered, received, stored, checked and disposed of in accordance with the required legislation. Arrangements were in place to ensure that medicines incidents were reported and fully investigated and we found there was an open culture around reporting medicine errors.

All the people we spoke with told us they received their medication regularly and they were observed whilst taking their medication. People told us they were involved in decisions about their medication and about pain control.

Is the service effective?

Our findings

People told us the staff had the skills to provide the support that they needed. One person said, “The level of care is fantastic. The staff know what they are doing.”

The staff team had a high level of knowledge and skills. Senior nurses and some other nurses held degrees in palliative care, and one nurse was studying for a Master’s degree in this specialism. Most auxiliary nurses and care assistants held National Vocational Qualifications in health and social care at levels two and three. The training and development manager told us there were currently no identified gaps in skills for the staff team. Nursing staff on the adult unit were assigned link nurse roles and were able to demonstrate how they had developed the knowledge and skills necessary to have an impact on effective best practice. For example, one staff nurse described to us their lead role in aseptic ‘non touch’ nursing techniques and told us of the education programme they had developed, which was being rolled out to all qualified staff. A second staff nurse explained their lead role in mentoring student nurses on the unit.

New staff members received a comprehensive induction to the service and their role. All new staff were required to have a minimum of nine months’ previous experience in care settings. As part of their induction, staff nurses worked supernumerary to the roster for their first month, and auxiliary nurses and care assistants for their first week. New staff were provided with ongoing mentoring by experienced staff whilst completing their competency assessment programme. The new Care Certificate was in the process of being introduced for all future new appointments.

The service had its own education department. This provided many of the training resources required in-house, including support for accredited training and the education programme for auxiliary nurses and care assistants. A four year clinical education training programme was in operation, based on the Royal College of Nursing palliative competencies. There was a rolling programme of palliative care training, delivered by the service’s own nurses and doctors. Areas covered included pain management, symptom control, sexuality and working with grief and loss. A holistic approach was demonstrated and the needs of

people’s families were also addressed in this training. Management development was a structured process, with a clear framework of induction, learning needs assessment and specific developmental needs addressed.

A relative told us, “The staff are very well trained and the facilities are excellent.” Another relative said, “The staff are well trained and so supportive – we ran out of the patches my child needs and they just sorted it all out and got them for us.” A third relative commented, “I think there is enough staff and they seem very well trained.”

All staff received regular training in areas required by health and safety legislation. A computerised system flagged up when staff members were due ‘refresher’ training and informed the relevant managers. Any additional training required to meet the needs of a person admitted as an inpatient was identified and given, where possible, before admission.

The service had a ‘performance and capability’ process that identified where staff skills and/or abilities fell short of the standards required. Concerns were discussed with the staff member and resolved (informally and with support, where possible). The service was committed to the education, training and development of staff, to meet both the staff member’s and the organisation’s objectives. As part of this, where a staff member was up to date with all mandatory training, they were able to apply for study leave and funding for further training. Examples included staff working towards degrees and diplomas.

Staff were provided with supervision on a quarterly basis. Additional clinical supervision was available for specific roles and tasks. We were told the service’s learning and development team made an external coach/skills developer available to all staff, but particularly to new managers. Supervision was seen as part of the wider appraisal process, as was the revalidation of doctors and nurses, in line with current professional guidance. Workshops were provided to assist nurses in collating the rigorous evidence they needed to support their revalidation. Appraisal included feedback from staff at all levels regarding the staff member’s performance and skills.

Every effort was made to ensure people using the service were able to communicate their wishes and needs as effectively as possible. Staff and volunteer staff were given training in effective communication, including a course entitled, “Help! I don’t know what to say.” On admission,

Is the service effective?

the child (or their family), young adult or adult using the service was asked if they had any specific requirements that would improve communication with them. They were given examples of the support available, including the use of hearing aids, interpreters and the use of modern assistive technology. A visiting professional told us, “The communication here is very good. I call in at all times, mostly unannounced, and staff are all very helpful, open and transparent and the records are very clear.”

We found evidence that mental capacity assessments were conducted and recorded both in the adult unit and children’s unit. The issue of whether the person had the mental capacity to consent to their care was established at the first contact with the person. Thereafter, capacity issues were discussed in the weekly case discussion for each person and included in every care plan drawn up. Where a person’s decision making capacity could not be assumed a formal mental capacity assessment was carried out, in line with the regionally agreed ‘Deciding right’ framework. Where adults or children were identified by staff as lacking the capacity to be involved in decisions such as Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), we saw that family members were consulted and decisions taken in the person’s best interests.

The registered manager was aware of the service’s responsibility to ensure no person was deprived of their liberty unlawfully. They were able to demonstrate they had acted appropriately in line with the law in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act 2005. Staff told us their social work team was accessible and responsive to concerns and issues raised by them.

The children and young adults unit had a behaviour management policy. This allowed for physical intervention only as a ‘last resort’ to protect the person or others around them from harm. We were told a specific behavioural management plan would be put in place where such behaviours could be anticipated. The learning and development manager had been trained in the management of violence and aggression, and told us they gave staff ‘de-escalation’ training as a means of avoiding the need for physical intervention.

Policies were in place for obtaining the formal consent of people to their care. These were in line with Department of Health guidelines and recognised the “fundamental legal and ethical right of the person to determine what happened to their own bodies.” We were given evidence of consent for children by parents and carers and we observed that consent sought and gained from young adults in the unit was provided. Adults told us that staff always asked for their permission before entering their room or providing assistance with mobility, eating and drinking, bathing and other personal care.

Staff we spoke with were aware of quality of life issues relating to nutrition and hydration at the end of life. They told us people were screened on admission using the Malnutrition Universal Screening Tool, and weekly thereafter. Care plans included the advice received from dieticians. People said the food was very good. They told us there was a choice of menu and said they could ask for alternatives to the menu and, if the kitchen had it, they would happily provide it. A relative commented, “The food is fantastic. It looks appetising and there’s plenty of it’. We observed everyone had a jug of water or juice beside their beds.

People we spoke with said that all of their physical, emotional and practical health needs were being met, including having access to their GP, hospital, dentist, chiropodist, optician and hairdresser. One person told us, “Whatever is needed is provided – GP, physio, you name it.”

We found evidence of advance care planning and specific ‘Deciding Right’ outcomes were used to capture patient choices and plan for future anticipated emergencies. Emergency health care plans were evidenced on both adult and children’s unit and DNACPR documents were prominent in care records.

The hospice was purpose built, fully accessible for people with a disability, with all clinical facilities on the ground floor. Whilst it was equipped with the equipment necessary to meet people’s clinical needs, the registered manager told us every effort was made to ensure the service was as homely as possible. People told us that they were happy with their room or with the bay where they were staying.



Is the service caring?

Our findings

People were very positive about the care provided and told us they found all aspects of the service to be caring. One person said, “The staff are marvellous.” A second person told us, “They (staff) pop in when they are passing to have a chat. I can’t fault anyone and the lads are lovely, too.” Another person said, “They need to use a hoist with me but they are so careful and are always asking if I’m comfortable.” People using the service consistently used words such as “fantastic” and “fabulous” when describing the staff team.

All the relatives we spoke with said that staff treated their family member with great kindness, care, dignity and respect. One told us, “They go above and beyond what you get in the community.” Another relative said, “They’re like a second family, they wrap themselves around you to support you.” A third told us, “They don’t just care for my child, they care for us all. They were like a rock for me and our family when I had a serious illness last year. I have the trust that I can walk away and trust them with my child’s life. I wouldn’t trust others, but I trust these (St Oswald’s staff).” Another relative said, “It’s like home-from-home, staff are lovely, you can tell they care. They never make you feel like you’re in the way. When my child is here, it gives me time for a bit of ‘us time’ and to recharge my batteries.” Another comment received from a relative was, “This is a marvellous place, even if you were a multi-millionaire you couldn’t pay for the care you get here.”

We were told of particular staff kindness by one relative. This person told us, “My child wanted to see Michael Buble, and we tried everywhere but couldn’t get tickets. I just mentioned it to the staff and, unknown to us, they got in touch with his agent and they got front row tickets for the family. My child met Michael and was given an album, bag and t-shirt – they go above and beyond for people.”

All the staff we spoke with showed the same commitment to meeting people’s holistic needs. One told us, “We all bend over backwards for patients; we will do literally anything for them. Nothing is a bother at all.” Another staff member told us, “This is not just a job - it touches your soul.” In a staff survey (April 2015) 94% of the 79 staff who responded said they were ‘extremely likely’ to recommend St Oswald’s as a care provider to family and friends.

We found the atmosphere in the service to be friendly, calm and welcoming. All staff gave good eye contact, smiled and acknowledged visitors as well as those people receiving a service. Comfortable sitting areas were available, with complimentary drinks available. A chapel was open to all for quiet reflection or prayer, and the chaplain and their team of volunteers were visible and available at all times. The chaplain told us their support was available to everyone, whether or not they had a particular faith, and that the chaplaincy team was there “to share the journey” with people. The chaplaincy brochure stated, “Your own minister or faith leader is very welcome to visit. We can make contact for you and support you to practice your faith in the way you wish.”

Staff demonstrated great sensitivity and empathy. The registered manager told us, “Every member of staff wants to be here, and want to give the best personalised care. We recognise people are frightened on admission: they have lost their sense of control, so we welcome them, help them settle, give them choices and re-empower them.” A staff member said, “We help people recognise their feelings of anger and frustration are normal. We don’t fudge things; we help people accept them as they are.”

Talking with staff on both units provided us with a real sense of their passion and dedication for the children and people they cared for. All staff told us it was a priority to ensure they were treated with compassion, dignity and respect. We observed this in practice, when for example, we saw nursing staff sensitively helping a person with their meal, and children being offered comfort when distressed.

The nursing team was pro-active in their approach to care. Staff carried out two-hourly checks of each person (hourly, at night). They checked people’s well-being, asked about pain and other symptoms, assisted changes of position and offered help with personal care needs, and ensured call bells, drinks and other possessions were within reach. This meant people did not usually need to call for help. We observed staff interacted well with people, and people responded to staff. Staff, people and relatives all recognised each other and were very comfortable in each other’s company. We observed two children having lunch in the children’s dining room. We saw staff interacted sensitively with children, encouraging, supporting and empowering them to eat lunch. The children were smiling and appeared very comfortable with staff.



Is the service caring?

The service had an equality and diversity policy. This stressed its commitment to ensuring that everyone who engaged with the hospice was treated with dignity, fairness and respect, irrespective of age, gender, race, sexual orientation, religion or beliefs. It gave clear examples of behaviours deemed to be unacceptable, including verbal or physical abuse, bullying, personal ridicule and unsolicited advances. It made clear to people how they should report any perceived harassment or discrimination.

People were asked for their views regarding the service in a range of ways. All people new to the service were asked for feedback after their first month and three-monthly thereafter. The service published a regular 'You said – We did...' bulletin, which thanked people for their comments and suggestions and told them of the changes implemented as a result of their feedback. Examples included lowering the height of 'speed bumps' in the road outside the children's unit, and improving the delivery of food to ensure it remained at an appropriate temperature.

The service was supported by a large number of volunteers. These included nurses, ward helpers, bereavement support workers, complementary therapists, and activities staff. Other volunteer roles for supporting people and giving added value to the service included drivers, gardeners, florists, catering staff and administrators. All volunteers were recruited using the same rigorous standards as permanent staff, given appropriate training and were given support by a dedicated volunteer manager. As one nurse told us, "They help us go the extra mile, and do more of everything."

People and their visitors were provided with a wide range of information about the support and services available to them. This included pamphlets about in-patient and out-patient services; bereavement support; and advice and information for relatives, carers and friends. People were also able to access a detailed and informative hospice website.

People's rooms were spacious and clean and people were encouraged to personalise their rooms with items of furniture, photographs, pictures and electronic devices such as lap tops. One person told us, "The room is fantastic, it's spacious, bright, clean, and I have a lovely view outside." Another person said, "Just look at the trees outside, they're beautiful. My visitors take me outside and I sit in the garden. I'm very happy and very comfortable".

Staff told us their 'focus on living' approach to care enabled people to work towards learning new skills and achieving life ambitions, such as flying a glider or going fossil hunting. Activities such as creative writing, art, relaxation techniques, flower arranging, pottery, music and singing groups were available daily, supported by skilled and trained volunteers. People were supported to express themselves as individuals. One person was helped to make boxes for their children, containing soft toys, stories and photographs. Another person compiled a scrap book for their first grandchild, with the involvement of all their family. A relative told us, "My perception of places like this was that it was a place you came to die. I've changed my perception, it's far from that."

Although the service did not have a policy on advocacy, people were provided with advice and guidance on how to access advocacy services, and staff frequently acted as informal advocates. We saw evidence of the use of Independent Mental Capacity Advocates (IMCA). IMCAs are a safeguard for people who lack the capacity to make important decisions such as where to live and about serious medical treatment options. They may represent a person who has no one independent of the service, such as a family member or friend, to represent them.

Staff were fully aware of the importance of maintaining confidentiality. As one staff member told us, "People can talk to us freely, sometimes about things they have never shared before, even with their families. We have a responsibility to protect that degree of trust." People's privacy and dignity were similarly protected. We were told people were addressed by the name or title they preferred. Doors were held open only with the express permission of the person. People were given access to a wig service and advice on clothing, to preserve dignity and address body image issues.

Maintaining people's independence was given a high priority by the service. Occupational therapists assessed people's needs for mobility aids such as wheel chairs, 'rise and recline' armchairs and standing aids, and used the well-equipped therapy room for physiotherapy and exercise programmes. The need for other aids was assessed and sourced, with examples such as adapted crockery and cutlery. The latest technology was also accessed, including the 'possum' environmental control (operated by blowing/sucking or by rocker switch) and 'eye gaze' (hands-free computer operation) systems. All



Is the service caring?

bedrooms had daybeds for relatives to use and there were guest bedrooms within the children and young people's unit where relatives could stay whilst their child was receiving treatment.

Staff demonstrated a sound knowledge base in specialist palliative care in-keeping with roles and responsibilities and the service specification. Senior nurses held degrees in palliative care. People identified as being in the last days of life were cared for using a specific Quality Assurance Tool (QAT) which was developed following the withdrawal of the Liverpool Care Pathway from practice, July 2014. This QAT

was supported by core care plans. The QAT included daily reviews and regular re-assessments of the patient's condition. Bereavement support was offered by the service's Family Support Team. This was provided for as long as the person or family required it, and was available both at the hospice and at the home of the bereaved person. Group support with other people who had experienced bereavement was also available and people were signposted to other charities such as the Child Bereavement Trust.

Is the service responsive?

Our findings

People told us they felt the service was very responsive to their needs and wishes. One person said, “They listen to me, ask me what I want, when I want it and nothing is any trouble to them.” A second person said, “The chef came in to see me to ask about what I like to eat and what portion size I would like.”

Relatives we spoke with confirmed the responsiveness of the service. One commented, “If there’s something anyone wants, they will do their best to get it.” Another relative said, “The staff are fabulous – they look after my child and me. Everything is on hand: if the medication isn’t working, they can contact my GP or hospital doctor and then change the medication. It saves me a trip to hospital and distress for my child.” A third relative told us, “Personal care is second to none.” Another relative said, “They always ask me what my child likes, how he needs to be comforted, what his bedtime routine is.” Each room and bay had a nurse call system within reach of the person. People and relatives told us the call system was always answered quickly, and we observed this happening in practice.

People and relatives confirmed that visitors could come at any time, and that they were made to feel very welcome by staff. People said their visitors could stay as long as they wanted.

A visiting professional told us, “This is an excellent place. They are caring, kind, attentive and responsive and they are sensitive to the needs of relatives, too. I am really positive about the care provided here: it’s very person-centred.”

We observed the service provided person-centred care, responding to people’s and children’s needs, giving them the time and support they required, and supporting the practical and emotional needs of family members and siblings. Staff and people interacted well, with staff listening and responding to their needs and those of their relatives. Observation and documentary evidence showed staff cared for people in a way that respected their individual choices and beliefs.

Referrals were made by a range of professionals, including hospitals, GP’s, MacMillan and District nurses. The decision to admit was based on a multi-disciplinary assessment, which identified the service need, urgency and reason for referral. The service carried out its own multi-disciplinary assessment of needs upon admission.

We reviewed the assessment and care planning documentation for two children. Each child had an individual clinical passport, essential information document, risk assessments and individual detailed plans of care, including feeding and caring routines. The ‘DisDat’ communication tool was used as a base line assessment tool for identifying how the individual child expressed distress. Hourly the care and activities with the children were recorded and an evaluation of care provided was summarised on every shift.

People told us they and their relatives had been fully involved in drawing up their care plans and in decisions about care. The registered manager told us parents of children admitted to the service were required to stay with their child for, as a minimum, the first two days and nights. This enabled them to provide emotional support to their child, and to advise staff on their normal caring routines and the child’s likes and preferences.

We noted the system of planning people’s care on the adult unit included the use of ‘core care plans’. These are pre-printed care plans into which the person’s name was added. There was scope for individualising these care plans, by the addition of extra information unique to the person, but a significant number had not been so adapted. The core care plan included questions to be asked of the person (for example, ‘Establish the person’s preferred comfort position’) the answers to which were not always recorded. We discussed this issue with the registered manager and unit manager, who accepted this approach to care planning was outdated. They told us they had investigated other models and were moving to the use of the Outcome Assessment and Complexity Collaborative (OACC) model, as this would better demonstrate the measurable and positive outcomes the service made to people’s care. We judged that these records were not a true reflection of the outstanding quality of the highly personalised care that we observed, and that people and relatives described to us; we had confidence the new system would more accurately reflect this highly individualised approach to care.

When we spoke with people who used the service they told us they were fully involved in the management of their pain. People said that their pain was regularly and effectively monitored on an individual level and they felt it was well managed. One person told us, “I have been in other hospitals and this place is the best you can get.”

Is the service responsive?

Recognition of symptoms and management of these was clearly evident in the records of adults using the service. When pain was an identified problem, a paper 'pain sheet' was used to record the location and description of pain. However, we did not see the use of specific pain management assessment tools when intervention was provided. There was a record on the computer system, but this was not supported by a validated measurement scoring method to assess and monitor the effectiveness of the intervention provided. This meant that it was not possible to ascertain from records whether the effectiveness of pain medication was assessed. Our observations and discussions with people using the service and staff confirmed that people felt their pain was well managed. However, reporting and analysis of effectiveness using a recognised tool was not available to support this at the time of our visit.

We reviewed 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms. The decisions were dated and approved by a consultant, lead clinician or GP. Reasons were clearly documented on the form, with clinical information included, and discussions about DNACPR with the person and relatives were recorded in the person's notes.

Weekly reviews were carried out for people admitted as in-patients. Outpatient reviews took place every three months. A relative said, "We have regular meetings where we discuss my child's practical, social and medical needs with staff here and other professionals."

The children and young person's unit offered music therapy, crafts and sensory rooms on site. There was a wide range of stimulating toys and we observed children being supported by staff to play with various toys.

People told us they were encouraged to make choices, including whether to remain in their rooms or socialise, what and where to eat, how they spent their day and what activities they wished to participate in, if any. They told us all choices were fully respected. One person told us, "They give you choice, here: when you get up, whether you want a bath or a shower – the Jacuzzi bath is just fantastic – it's all about you and what you want."

All the people and relatives we asked confirmed that they would have no hesitation in making a complaint to staff or the registered manager if there was a need to do so. However, no-one had ever made a complaint. One person said, "You would never need to complain because you just need to mention or ask for something and they just sort it for you – they're marvellous." Complaints records showed no complaints had been made about the service in the previous twelve months.

Both the children and young adults unit and the adult unit had a dedicated social worker attached. They met each person and explained their role in the person's care package, discharge package and the ongoing support available to them.

Is the service well-led?

Our findings

The service had a registered manager who had been in post for five years.

People and their relatives told us the registered manager and other managers and senior staff were visible, accessible and known to them by name. They told us they felt able to ask questions of all staff. People, their relatives and staff all confirmed that senior management operated a genuine 'open door' policy. The registered manager said, "Approachability and visibility is key to how we work."

Our observations over three days of inspection clearly indicated the staff were highly motivated, enthusiastic, kind, friendly, supportive and involved. Team work and communication between staff was good, as was communication with people and their visitors. Staff told us they felt fully supported by the management of the service. One staff member said, "We have great management. You always feel you are listened to." Staff morale was high. One staff member commented, "There hasn't been a single day I haven't wanted to come to work. This is the most open and friendly organisation I've ever worked for. Everyone shares. I can approach anyone in the management team with any issue. We get all the support we need." Pastoral support and reflective practice was encouraged and took place regularly. Staff told us this was an effective method of ensuring staff well-being

A clear management structure was in place, known to all staff. A board of trustees oversaw the service, with day to day operation delegated to a chief executive officer. All staff belonged to one of the five directorates (care services, finance, corporate services, human resources and fund raising) and the registered manager told us this enabled clear lines of authority and communication.

The service had an outward looking strategy. The chief executive described the decision made by the management team in 2014 to attempt to recapture the vision that had resulted in the setting up of the hospice, and ask the question 'what makes first class palliative care today?' The consensus was the need to "break down the walls" of the hospice and move services out into the community. This would enable work with client groups such as people living with dementia who it was felt received generally poor end of life services. Links had been made with local hospital units which had identified their

end of life care tended to be technically orientated, rather than person centred. The service was also developing a training and development centre to offer a combined education programme with other hospices and further education colleges in the region. It was involved in designing a National Vocational Qualification course in 'partnership working' with, for example, housing associations and charities. In addition, the service was involved in forming a local 'hospice alliance', with the aim of enabling local hospices to share management experience and expertise in areas such as facilities and fund raising. A ten year plan had been put in place to deliver the organisation's strategy and a 'change management' programme was in place to facilitate these developments.

We found the pursuit of excellence to be demonstrated throughout the organisation. One example of this was the attendance of the training and development manager at every new training course as part of the auditing of all training to ensure effective learning outcomes. Staff were encouraged to challenge and debate course content, with the aim of sharing their learning and helping the development of course content. This enabled the speedy re-shaping of content, emphasis and delivery method, where required. Another example was the recognition that the revalidation of nurses, which the Nursing and Midwifery Council states is the responsibility of the individual nurse, required the service to take responsibility to shape and support the revalidation process. A third example was staff challenging the assumption that it was the responsibility of the learning and development team to implement all new policies, and ensuring all management and staff took responsibility for this area. A manager told us, "We are passionate about our systems being effective: it's so much more than just 'ticking a box' to say we have done something." The chief executive told us, "The commitment of staff is extraordinary. I have an excellent team. They have the 'fire' to want to constantly improve the service."

There was a clear commitment to continually improving the service. The senior management team was working with an external trainer to develop its effectiveness further, with a focus on making mutual expectations clearer and more specific. A manager told us, "Meetings are focussed and produce outcomes. Working groups are reviewed and re-jigged, where necessary. Focus groups have specific tasks and are then disbanded. We aim for clarity and effectiveness." Individual staff confirmed the openness of

Is the service well-led?

the service to questioning established practice and suggesting positive changes. One staff member commented, “You are always given credit for new ideas, and we are encouraged to find new ways of working.” A manager said, “Everything is always under review.” This enabled the service to introduce innovations such as the ‘feedback’ bank, which gave people the opportunity to express their views about the service using Facebook and Twitter, as well as more traditional letters and feedback forms.

Staff confirmed the service demonstrated openness in its workings, with comments such as, “We have a ‘no-blame’ culture” and, “There is a reporting culture, here. We don’t cover things up.” We were told communication between staff at all levels was based on mutual respect and commitment to the service’s values. One staff member said, “In meetings, every one listens to each other and respects each other’s views.”

The registered manager told us the extensive use of volunteers played a major role in bringing the community into the service. This included those volunteers who worked in or with the service directly, but also the 1200 people who regularly volunteered their services in the charity shops and other fund-raising projects in the community. We were told, “They are our ambassadors in the community, and give us very valuable feedback.”

We were told of the recent ‘Vision day’ held for all staff to relook at the values of the service. The consensus of the whole team was that the values of ‘care, compassion, dignity and love’ best summed up the commitment of the service.

The service used a wide range of tools for monitoring the quality of the service provided. A clinical governance and

quality committee of trustees and senior managers met at least quarterly to oversee the monitoring process. Various audit groups met monthly to consider the results of audits in areas such as people’s advanced decision-making; clinical passports; discharge information; medical reviews; Mental Capacity Act practice; provision of food and drink; hand-washing; and moving and handling. Audits were seen to be rigorous, to question practice, and to result in clear action plans. Staff were encouraged to be involved in all areas of auditing practice, both directly and through the use of regular clinical audit e-bulletins to all staff. The views of people using the service and their relatives were gathered by a range of monthly, quarterly and six monthly surveys of the views of new patients and longer term users of the service. A staff consultation group met and reported every two months.

We found clear evidence of close partnership working between families and carers. A handover form used on admission and discharge demonstrated the partnership working with parents and carers and helped maintain a seamless approach for the care of the child. The service also worked in partnership with children’s services in the community, with local authorities and with secondary care services. We noted the service had made links with local organisations such as banks and department stores for support and resources.

We noted the service was a member of or affiliated with numerous local and national associations and development bodies, including the Palliative Care Network, Northern Region Palliative Care Group, Regional Hospice Chief Executives Group, Together for Short Lives and Hospice UK.