

St Andrew's Hospice Limited

St Andrew's Hospice, Adult and Children's Services

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

We undertook this unannounced inspection on the 17 and 18 March 2015. The last full inspection took place on 23 July 2013 and the registered provider was compliant in all the areas we inspected.

St. Andrew's Hospice, Adult and Children's Services, is situated in a residential part of Grimsby and provides supportive and palliative care services. The service can provide in-patient care to a maximum of 12; eight

placements for adults and four for children. In addition, the service can provide day care for 16 adults and four children. The service is currently undergoing a new build on the same site which will replace the building used for the adult service. This will be ready for use at the beginning of April 2015 and will increase the number of in-patient placements for adults from eight to 12. The children's service remains the same. All bedrooms are for single occupancy and the new build has ensured all

Summary of findings

bedrooms have en suite facilities with specialised beds and equipment. All bedrooms in the current and new build have access directly into the gardens and patios. There is a range of bathrooms, communal rooms and therapy facilities to meet the needs of people who use the service. The children's unit is light, bright, colourful and appropriate for their needs.

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

We found there were safeguarding systems in place, which consisted of staff training and policies and procedures to guide staff if they had concerns. This helped to safeguard adults and children from the risk of harm and abuse.

We saw staff were recruited safely and in sufficient numbers to care and treat adults and children in order to meet their assessed needs. Staff completed training considered to be essential by the registered provider and also had access to specific training relevant to their roles within the service. There were support systems for staff which included supervision and staff meetings. These measures provided staff with the skills and confidence required to support adults and children with life limiting illnesses.

We found people received their medicines as prescribed. Prescription sheets and care plans regarding medicines were correctly completed. Medicines were appropriately obtained, stored, administered, recorded and disposed of.

We found adults and children had their health care needs met and they were supported to make their own choices and decisions about treatment. When adults were assessed as lacking capacity to make decisions, best interest meetings were held with relevant people to discuss options. Assessments and care plans were produced to provide staff with guidance in how to provide care and treatment which met their preferences.

Adults and children's nutritional needs were met. There were choices and alternatives for meals and we saw catering arrangements were flexible.

We observed staff provided care and support in a kind and compassionate way and promoted privacy and dignity. Staff provided explanations and information about treatment. There was a range of therapies and activities to support people and their family, to include them and to prevent a feeling of isolation. People confirmed this during discussions with them.

We found the service was clean and hygienic. A member of staff had been designated a lead role in infection prevention and control (IPC). Once located in the new build, they were to complete a full IPC audit and develop protocols for managing specific infections.

There was an open culture to encourage adults and children who used the service, their families and staff to raise concerns in the belief they would be addressed. There was also a quality monitoring system to ensure people's views were listened to, lessons were learned from incidents and practice was improved.

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.

People were protected from the risk of harm and abuse. Staff had received safeguarding training, knew how to recognise signs of poor care and abuse and knew how to escalate any concerns.

People received their medicines as prescribed and there were arrangements in place to manage medicines safely.

Staff were recruited safely and in sufficient numbers to provide care and treatment to meet people's needs.

People were cared for and treated in a safe environment. Risk assessments were completed and areas of concern were managed safely.

Good



Is the service effective?

The service was effective.

People's nutritional needs were met and they were provided with a choice of meals and alternatives.

People's health care needs were met. They were supported to make their own decisions about their health care needs and treatment options. There were systems in place to assess capacity and make best interest decisions when people were unable to make treatment choices.

Staff completed a range of essential training and in areas specific to the needs of people they cared for. There were induction, supervision, appraisal and support systems for staff.

The premises had been adapted to meet the needs of people who used the service. The new build, ready in April 2015, will provide excellent day care and inpatient facilities.

Good



Is the service caring?

The service was caring.

Staff demonstrated a caring and compassionate approach in their interactions with adults and children.

Staff on the children's unit had been innovative and spent time developing a monitoring tool and putting this into practice. This had a direct positive impact on a child's wellbeing.

The staff had developed an 'at home' service to support children and parents and to ensure children accessed the service.

A range of methods were used to include and involve people and their carers in the services provided.

The end of life care provided to adults and children was provided in a sensitive and compassionate way.

Outstanding



Summary of findings

Staff had developed effective support systems for adults and children who experienced bereavement.

Is the service responsive?

The service was responsive.

Adults and children had their holistic needs assessed and plans of care were produced to guide staff in how to meet them. The care plans for children were very person-centred. The information in the care plans for adults could be more comprehensive and located in one place.

There was a multi-disciplinary approach to reviewing the care and treatment plans of adults and children.

There was a range of therapies and activities for adults and children to participate in to meet their interests and needs.

There was a complaints policy and procedure and various means of ensuring people were able to raise concerns.

Good



Is the service well-led?

The service was well led.

There was a well-defined vision and positive culture in the service. All staff were aware of this and demonstrated sound values.

The management infrastructure showed there were clear levels of responsibility and accountability. Meetings were held with the Board of Directors to ensure they had oversight of the service.

There was a quality monitoring system in place that consisted of audits and surveys. Action plans were produced to meet shortfalls.

There was learning and improvement from incidents that occurred within the service and an open culture that encouraged staff to report concerns.

Staff had developed links with other agencies which enabled them to work in partnership to develop the service provided to people.

Good



St Andrew's Hospice, Adult and Children's Services

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 registered 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 17 and 18 March 2015 and was unannounced.

The inspection was completed by one adult social care inspector who was accompanied by a specialist professional advisor (SPA). The SPA was a pharmacist.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

During the inspection we observed how staff interacted with adults and children who used the service. We spoke

with five adults and one child who were using the service. We spoke with the nominated individual, the registered manager, a doctor, the adult services manager, three senior registered nurses, two registered nurse and two nursing assistants. We also spoke with the health, support and wellbeing manager, the professional development and quality lead, two staff from the human resources department and one catering assistant.

We looked at five care files which belonged to three adults and two children who used the service. We also looked at other important documentation relating to adults and children who used the service such prescription and administration sheets.

We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, the training record, the staff rotas, minutes of meetings with staff, newsletters, surveys, quality assurance audits and maintenance of equipment records.

Is the service safe?

Our findings

People told us they felt safe in the service, they were well looked after and there was enough staff to support them. Comments included, “Generally they are straight down when you ring the bell”, “Yes, I feel safe; I’ve had no falls in here”, “They couldn’t do anything better”, and “Yes, the staff look after me.”

People said they received their medicines on time. Comments included, “Oh yes, I get my tablets on time. There are no issues there” and “Nurses always give me my medication on time and tell me what they are giving me and what it is for. They also ensure that medication is given at a time tailored to suit my needs.”

The service had safeguarding and whistle blowing policies and procedures; all staff knew where these could be located. Training records showed staff had completed safeguarding training. In discussions with staff they were clear about what constituted abuse and poor practice, they knew the different types of abuse and they described the signs and symptoms that would alert them abuse may have occurred. Staff were also clear about the reporting systems in place and which agencies would need to be informed. They said, “We would body map any physical signs”, “We would escalate any concerns to managers and work with child care services” and “We would report to the nurse in charge, document concerns and sit with the patient.” One of the doctors said, “There is a well-established safeguarding team for advice and emergency duty team numbers are available.” These measures helped to prevent abuse from happening and provided staff with information and guidance on what to do if they suspected abuse had occurred.

We found risk assessments had been completed for areas that posed a risk for adults and children. These included pressure damage, falls, nutrition, moving and handling and specific health associated risks for individuals. A senior nurse told us, “We have morning handovers with management and heads of departments to discuss any issues from the previous night and plans for the day. We look for potential risks and any issues that could occur.”

The recruitment system in place was robust and showed checks were carried out prior to new employees and volunteers starting work in the service. Staff in the human resources (HR) department told us the recruitment process,

after advertisement, involved scrutiny of application forms, shortlisting candidates to ensure they had the skills they were looking for, an interview, and employment checks. These included references from previous employers, a check of the professional registration status of nursing and medical staff to look for any conditions regarding their practice, and the disclosure and barring scheme (DBS). The latter provides information about whether the potential employee has been barred from working with vulnerable adults and children. We saw recruitment records confirmed this process worked in practice. New staff were given job descriptions and terms and conditions of employment to ensure they were aware of expectations.

Staff rotas showed us there were sufficient staff on duty to meet the needs of adults and children who used the service. The in-patient staff team consisted of medical cover each day, the registered manager, an adult services manager, registered nurses and registered children’s nurses of different grades, advanced nursing assistants, nursing assistants, catering, maintenance and domestic staff. There was also a range of staff to provide additional services to adults and children, and their families. For example, the service had 34 hours a week for complimentary therapy, 25 hours a week for physiotherapy/occupational therapy, 20 hours a week chaplaincy support, 37 hours a week for ‘creativity’, and four staff for social work and family support. There were staff to support children and parents in their own homes, to run a lymphoedema service and to facilitate hospital discharges to St Andrew’s. There was a team of staff for professional development, HR and administration. The service enlisted volunteers to work in a range of roles and student nurses completed placements there in a supernumerary capacity.

The registered manager told us there was an on-call rota for management cover out of usual working hours. In discussions, staff confirmed there were sufficient members of staff on duty during the day and night to meet the needs of adults and children who used the service. In the children’s unit, the ratio of staff to children was one to one. A senior nurse told us, “We are trying to develop a dependency level tool at present to look at the complexity of needs some of our children have and the impact this has on staff numbers.”

Medicines management practices were examined on the eight bedded adult in-patient unit and the four bedded children’s unit. We found adults and children received their

Is the service safe?

medicines as prescribed. There was a comprehensive range of medicines management policies and procedures which covered all aspects of medicines management. We found medicines were correctly obtained, stored, administered, recorded and disposed of. The adult service manager told us each bedroom had a small locked box to store patient's individual medication but these were not used at present due to design faults. However, we saw the new build had lockable facilities built into cupboards in each bedroom so medicines could be stored there when it became operational at the beginning of April 2015.

We found one issue relating to the recording of a controlled drug. This was to be checked out by the registered manager. We noted there could be confusion regarding the code used when people were on 'home leave'. This was recorded as 'X', however there were times when medicines were administered every 72 hours and staff also used the code 'X' to show the days in between doses when the medicine was omitted. It was also noted that opened bottles of liquid medicines were not always marked with the date of opening. These points were mentioned to the registered manager to address. When asked what improvements could be made, one member of staff told us keeping more stock medicines may prevent waste.

We saw registered nurses and nursing assistants completed a medicines competency pack during their induction. This covered general medicines, controlled drugs and the use of

syringe drivers. The adult services manager told us, "New starters are allocated a mentor and it is a requirement that they must demonstrate competency during their probationary period".

We found the building was safe and equipment used was serviced appropriately. There was a health and safety committee with staff representation and a facilities manager to ensure the environment and equipment used met safety and legal requirements. We saw there was a procedure to manage safety alerts and to put in place any actions to address them and disseminate the information to the appropriate staff. There were access codes for entry into the children's unit to limit accessibility and a general reception to the adults unit staffed by volunteers during the day.

We found the service was clean and hygienic, cleaning schedules were in operation and staff had access to supplies of personal protective equipment such as gloves, aprons and hand gel. Some foot operated bins did not work effectively and there were limited hand hygiene stations. However, the new build resolved these issues and provided new equipment and hand wash facilities. A senior nurse had been designated lead responsibility for infection prevention and control (IPC) and was to complete a full audit and develop IPC protocols for managing specific infections once in the new build.

Is the service effective?

Our findings

People told us they were happy with the care and treatment they received. They also said they enjoyed the meals provided. Comments included, “Medical staff are fabulous and so helpful and responsive to my requirements”, “The doctors come around and they know what I want”, “The nursing and care staff are wonderful and they often call in to see me for a chat and to make sure that everything is alright for me”, “The food is wonderful and presented just how I like it”, “The food is marvellous although I don’t eat a lot; I asked for scampi and chips for dinner and they did it for me”, “The food is very good; they fetch a sheet daily and you put down what you want; there is plenty to eat and drink” and “They put a jug of fresh water there every day.” We spoke with one older child in-patient who told us they were very happy with the nursing staff and confirmed they looked after him well. They said, “They (staff) always give me my favourite food, chips, and they are very good.”

We found people received medical treatment and nursing care which met their assessed health care needs. There was a range of staff on site each day to provide care, treatment and advice to adults and children. The medical team provided 10 sessions per week in order to review treatment and medicines prescribed to people. This enabled medicines to be readjusted to ensure adults and children received treatment as and when required rather than just at designated medicines ‘rounds’. Nursing staff completed, ‘rounding’. This consisted of hourly, recorded checks on each adult and child to ensure personal care needs were met, pain relief was managed, pressure area care completed, fluids and call bells were in reach and people were generally not in need of anything. There was a lymphoedema service for people to access (lymphoedema is a condition of localised fluid retention and tissue swelling caused by a compromised lymphatic system) and ‘better breathing’ sessions.

We found adults and children’s nutritional needs were met. People’s nutritional needs and any special diets were identified during assessment, recorded and passed on to catering staff. Some adults and children had specialist nutritional needs, which were met by nursing staff in consultation with dieticians and speech and language therapists. We were told that after admission people were visited by catering staff who gathered information about

their likes, dislikes and preferences. This was confirmed in discussion with catering staff and people who used the service. Menus were repeated over a four week cycle and choices for food and drinks were provided. Catering staff told us it was important they provided meals that encouraged people to eat especially when they were not feeling well. They said they always tried to accommodate people’s wishes. They provided a range of fresh juices, milk shakes, smoothies and hot drinks. They were also able to cater for specialist diets such as gluten-free, diabetic and pureed meals. The service had information on diets to meet people’s religious and cultural needs.

We saw the dining room in the adult unit was beautifully set out with fresh flowers on tables, polished drinking glasses, serviettes and place mats. The room was light and airy and provided a pleasant place for people to eat their meals. People told us they had the option of eating their meals in the dining room or in their bedroom if they preferred solitude. Meals for the children’s unit were prepared in the main kitchen and delivered in a heated trolley for staff to serve to the children. This enabled staff to provide a portion size appropriate to their needs.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people subject to a DoLS at the time of this inspection. The registered manager and adult services manager was aware of DoLS criteria and knew how to submit an application to the local authority if required.

In discussions, staff were clear about how they obtained the consent of people they provided care and treatment to. Comments included, “We ask people and always respond to what they say” and “We use non-verbal means and visual aids for some people such as cards and technology, for example iPads and light writers.” The nurses on the children’s unit described how they obtained and recorded parental consent for treatment and therapy. A member of the management team had a lead role in the Mental Capacity Act 2005 (MCA). They told us staff had completed training in MCA/DoLS and some had completed training in chairing best interest meetings. Some people who used the service had made lasting power of attorney (LPA) provisions for health and welfare. Staff were also aware people had the right to refuse treatment and this could be

Is the service effective?

made in advance (ADRT) in case capacity was affected by their condition. Staff told us LPA and ADRT records would be held on file when people were admitted to the service. We saw some people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in the care files. These had been discussed with the person or their relatives when they were transferred from hospital to St Andrew's to ensure they still applied, although in one instance we found this discussion could have been completed in a more timely way.

We spoke with the professional development and quality lead about the support and training available to qualified nurses and nursing assistants. They said staff received one to one supervision and had annual appraisals; this was confirmed in discussions with staff. The professional development and quality lead described the list of training considered as essential by the registered provider and we checked staff training records to confirm this had been completed.

Staff also had access to a range of service specific training such as palliative care, care of the child after death and pain management. In addition, there was clinical training for qualified nurses in the use of specific equipment and personal and professional development such as mentoring and management courses. Some staff had completed 'train the trainer' courses or had specific expertise and were able to cascade information and training to colleagues and people who used the service. The role of the nursing assistant had been extended to an advanced status (ANA) for some staff and they were given delegated responsibilities which included wound care and catheterisation. We noted there were no competency assessments for wound care techniques; we mentioned this to the registered manager to address.

Staff completed an induction which consisted of an introduction to the culture of the organisation, its mission

statement and policies and procedures, an orientation to the adults and children's units, mentoring by senior colleagues, completion of workbooks, supernumerary shifts and observation of their practice. In addition, there was preceptorship (a period of additional support and guidance) for newly qualified nurses or those returning to nursing after an absence. Registered nurses and nursing assistants had to complete a 'medicines competency pack' during induction. We noted this initial competency training was not repeated and staff were not re-evaluated on an on-going basis. The adult services manager told us this was under review and regular medicines management training and competency assessments would be introduced for existing staff.

The design of the building was appropriate for people's needs. Corridors were wide and there was sufficient space and equipment to meet people's needs. The new build was almost complete and the finishing touches were in hand regarding furniture and equipment. The new build provided excellent facilities in relation to communal seating and dining space, kitchens, therapy and creativity rooms, clinical rooms, an air-conditioned medicines room, laundry facilities and storage. The new in-patient unit had individual en suite bedrooms with walk-in showers, toilets and sinks, specialist beds and equipment such as hoists, suction machines and oxygen that was discretely housed behind panelling to prevent a 'clinical' look to the room. A hand held remote enabled the occupant to control the bed, lighting, TV, nurse call and window screens. Each bedroom had patio doors to the garden areas, a fridge and drinks making facilities. Bathrooms located near bedrooms were designed with ceiling track hoists and sensory equipment. There was also office space and meeting rooms for St Andrew's staff, integrated community teams and chaplaincy.



Is the service caring?

Our findings

People told us they were very well cared for and supported by the staff in the service. They also said staff treated them with respect and promoted privacy and dignity. Comments included, “Every time I buzz, the staff appear immediately and are brilliant”, “The staff are very nice, very helpful; I couldn’t wish for anything better”, “The staff are smashing and are doing a grand job. I have no qualms about them; they know what they are doing”, “I have my own room – I like my privacy” and “The staff are very good; nothing is too much trouble.” People told us staff enabled them to make choices about their care and treatment by providing them with information. They said, “I see the doctors and talk about what I need” and “The attitude is, if you want to stay in bed all day then that’s fine.”

Staff described how they promoted privacy, dignity and choice. They said, “We involve people in how they want things doing”, “We keep the room private and use the ‘do not disturb’ sign” and “We would liaise with families if there were any issues and always check out the patient’s gender preference for carer.” The generally terminology all staff used to describe care and treatment demonstrated a sensitivity to the needs of adults and children.

We observed a kind and compassionate approach from staff. Members of staff said, “Everybody does their utmost to look after patients”, “I love working at the hospice; it is a breath of fresh air and has a lovely, calm atmosphere”, “The patient is at the centre of the care we deliver and we aim to support them to fulfil their last wishes” and “There is time to speak to the patients.” We were told that when people used the in-patient service, their pets were able to visit them to provide comfort. On the children’s unit staff said, “We include children in the admission process; they are fully involved in planning their care, balancing decisions and choices. Children have as much freedom as possible to make their own decisions.”

Staff were able to develop relationships with adults and children who attended for day care, regular respite stays and during end of life care. Staff on the children’s unit described how they also provided support to children and their families in their own homes. They said this was a new development to help make the transition between the child’s home and St Andrew’s easier and smoother. The support ranged from providing information to several hours of home care during the day or in the evenings to provide

respite for parents. The staff said, “We see this as a supportive role for parents” and “We wanted to make sure children had access to the service.” To date there were ten children who received this support in their own homes.

Staff on the children’s unit described how they worked with the parents of one child who were concerned about their physical health. They developed a document to monitor the child’s pain and the spasms. The parents were able to use this in discussions with consultants who were able to devise a successful pain regime that best met the child’s needs and promoted their wellbeing. Staff said, “We were determined to get it right and we’ve never looked back.”

The service provided end of life care for adults and children. An ‘end of life care patient charter’ for adults and a ‘together for short lives charter’ for children and young persons were on display to reinforce the care people and their families could expect to receive at the service.

People’s preferences for their end of life care and parent’s preferences for their children were recorded along with specific instructions when required. This was either recorded in written files, on an electronic care records system or on handover sheets used when nurses changed shifts. We were told the aim was to ensure people’s preferred priorities of care (PPC) were included in each person’s end of life template within the electronic care records system when staff in the community or St Andrew’s staff had the initial conversation with people. This would enable the information to be recorded and accessed by all healthcare professionals involved in people’s care and also to be updated if required. The PPC would then be copied to written files for internal use. We saw there was information about how to care for a person’s body in a sensitive way following death, respecting cultural and religious needs.

We saw there were facilities to accommodate family members to stay with adults and children during respite stays or at the end of their life. This could be in either specific family accommodation or within the person’s bedroom on sofa beds. The new build had two en suite bedrooms, one with twin beds and a family room with a double and single bed. There was a living room and facilities to prepare drinks. The registered manager showed us facilities named, ‘the special room’ used to care for the body of a child following their death. We were told this was managed sensitively to ensure parents and family members were able to spend time with their child following



Is the service caring?

their death. The registered manager told us they were able to care for the child's body until the funeral if that was the wish of the family. The new build had accommodation for parents sited next to the special room.

Written and computerised records demonstrated the care and treatment that was provided to adults and children and also their involvement in planning the care they received. We saw the care and support provided to people included family members via a 'family support team'. The bereavement plans and therapy sessions supported family members of all ages and relationships to talk about important issues. We saw part of bereavement plans enabled a check to be made on the level of involvement people and their carers wanted from staff. There was a carer assessment information guide and an assessment tool for assessing carer support needs. A chaplain was involved when requested and provided spiritual care, support and guidance. We saw people who used the day service were involved and consulted about plans for the new build. The registered manager said, "Day unit patients trialled equipment, chairs and beds and we had working groups who visited other hospices for ideas."

Social events for carers and family members of adults and children with life limiting illnesses took place to foster

social support and to provide information to people. There was also a regular 'caterpillar session' for children of the adults who used the service and siblings of the children who used the service. A doctor was available for the sessions to answer any questions.

We saw there was a large contingency of volunteers who supported the service either by providing direct support to people who used the service, assisting in the day care unit, helping to maintain the grounds, working in reception, fund raising and serving in St Andrew's charity shops.

Confidentiality was promoted and protected. We saw records, both written and computerised, were held in a secure and confidential way. Care files were held in an office, which was locked when not in use and computerised records were password protected and accessed by individual staff with swipe cards.

There was a website providing information and guidance about the services provided at St Andrew's and people were encouraged to visit before using the in-patient service. There was also a range of information leaflets, a DVD and booklets, some of which were developed together with clinical commissioning groups. These included, "My future care plan" and "When someone dies."

Is the service responsive?

Our findings

People told us staff provided person-centred care. They also said there were activities and therapies for them to take up if they wished. People knew how to make a complaint and confirmed they felt able to raise concerns if required. Comments included, “I have a special bed and mattress to stop me from getting sore”, “They keep a record of what I drink and what passes through”, “I have no complaints whatsoever but if I had I’m sure it would be dealt with” and “There are things to do but I prefer to sit and watch television; my family visit most days. I can’t think of anything they could do better.” One person described how they had been given a high risk pendant to wear around their neck in case of falls so they can alert staff when required but remain independent.

Adults and children had their needs assessed on admission to the service and sometimes prior to admission. The assessment included identifying concerns in relation to general health, the impact of their life limiting condition, pain management and medication. A specific pain assessment tool was used to gauge levels of pain people had and to assist with pain relief management; the assessments were kept under review. Also assessed were people’s emotional, psychological, social and spiritual needs. Assessments and treatment plans were completed by physiotherapists and occupational therapists as required. On the children’s unit we saw assessments were updated at every re-admission for respite care to ensure any changes in need were documented straight away.

The registered manager told us about a new assessment tool called, ‘Your Holistic Needs Assessment’ which was currently being rolled out locality wide. This will form the basis of people’s assessment and be completed by people themselves with support from staff in community teams or St Andrew’s nursing staff. The assessment enabled people to grade their physical symptoms, their thoughts and their feelings about their illness and the impact this had on them. It also prepared them to think about questions to ask medical, nursing and other caring professional staff. There was a section to be completed with staff which identified concerns and what action was needed to address them.

The assessments helped staff to formulate personalised plans of care to meet the needs of adults and children. The children’s unit had plans of care for use during an in-patient stay and also for use when the child was at

home. We saw two of these care plans and they were very comprehensive and personalised to the child’s individual needs. The care plans for adults who used the in-patient service were less personalised. Currently information about people’s care plan needs were stored in three different places. These included the electronic care records system, which had care plan templates to use for all areas of assessed need which were then personalised with people’s individual information. The second system was written care plans held within care files. The third system was handover sheets printed out for each shift change of staff. These three systems provided information and guidance for staff in how to care for people but resulted in plans of care that were disjointed and in some cases, incomplete. This was mentioned during feedback to the management team to address the inconsistencies. The registered manager told us training rollout for staff not currently fully familiar with electronic care records system was planned but had been put on hold due to the move to the new build. Despite the three systems, it was clear staff knew people’s needs very well and provided personalised care which met their needs in a kind and caring way.

In addition to conventional medical treatment, people had access to a range of complementary therapies such as Reiki, aromatherapy, hot stones, reflexology, Tai Chi, massage, meditation and relaxation. Assessments and plans for complementary therapy were included in the main care file. We saw one for aroma steam therapy which detailed the therapist had consulted with the person, discussed the outcomes to be achieved and matched these with specific oils to be used at designated times.

The day service offered social stimulation, a place to sit and talk, creativity and craft work, music therapy, bingo sessions, pet therapy and access to the medical and nursing team. There was also support to create memory boxes, life story work and hand casts. The registered manager told us that following the move into the new build there was to be a change to the programme to include more sessional work. Adults admitted to the in-patient unit could access these facilities.

People were able to have visits from a minister of their own church or use the chaplain facility provided by the service.

Reviews of care and treatment and discharge planning were completed with a multi-disciplinary approach. This

Is the service responsive?

enabled health and social care professionals involved in people's care and treatment to discuss issues with them and plan care and treatment with them which met needs in a holistic way.

There were systems in place to help people have a smooth transition between services. The electronic care records system was linked to hospitals and community health care services. This enabled communication and the sharing of records (with the person's consent) with health professionals such as GPs and hospital staff and minimised the need for duplication of information and repeated requests for basic information from people who used the service. This was also useful when people transferred between hospital and community services.

The service had a liaison nurse whose role, in part, was to facilitate discharges from the hospital to the service. They visited the person in hospital and liaised with staff and relatives to help the discharge process go smoothly.

When adults and children were admitted to the service, there was a system to agree the transfer of medical responsibility from local GPs to medical staff within the service. This was documented and held in each person's care file. We saw discharge summaries were received from hospital medical staff when people were admitted to the

service directly from there. We also saw discharge summaries for GPs which were completed by medical staff at St Andrew's when people returned home after a short respite stay. These described the treatment the person had received in the service and whether any follow up was required. One of the doctors told us, "We complete a paper discharge summary when they leave and fax this to the GP; its working well."

We saw there was a complaints policy and procedure. Staff knew how to deal with complaints and told us any complaints received would be handled by the adults' services manager or the registered manager. They said there was a complaints form available to give to people if they wished to make a complaint. Staff said they would try to resolve things quickly for people if they received any complaints or concerns. They said, "We don't get many complaints; if there are niggles we sort them out before they get to complaints." There were comments and suggestion boxes in reception and folders within both units for adults and children who used the service, and visitors, to give feedback and make suggestions. The registered manager told us any complaints or suggestions would go through the hospice governance system to make sure Governors had oversight.

Is the service well-led?

Our findings

People who used the service told us they had met the registered manager and other staff from the management team.

We spoke with the registered manager about the culture of the service and how this was transferred to staff. They told us staff recruitment and induction was important to ensure staff had the right qualities and skills for working at the service. The registered manager said, “I am very proud of this organisation. We involve people, consult with them and listen to them; we also make sure staff are involved. We have an open culture where information is shared” and “We view complaints as positive to see how we can do it better.” We saw the service had signed up to the Royal College of Nursing/Royal College of General Practitioners End of Life Care Patient Charter and Together for Short Lives Charter. St Andrew’s vision was to, “Provide excellence and choice for everyone affected by a life limiting illness” and its mission statement was to, “Strive to make each day count for people of all ages with life limiting illness and to support those who care for them.” We saw the vision and mission statement permeated all grades of staff. It was observed in practice during their interactions with adults and children who used the service.

There was a defined structure to the organisation with a Board of Directors and tiers of senior managers, managers, staff and support services. Staff told us they felt able to raise concerns and make suggestions and these would be addressed. Comments included, “I feel very supported by management; there are on call arrangements for medical staff and they will come in at end of life situations”, “There is a good training budget allocated for staff”, “You can raise concerns and yes, they would be sorted out”, “I am aware of the whistle blowing policy but I feel the structure of management would deal with issues”, “We are able to challenge each other”, “The nurses are thorough and question us; they check any differences between notes and electronic information” and “There is good team work despite age and personality differences.”

There was a quality monitoring system that consisted of audits and surveys, the results of which were discussed in meetings and reported to the Board of Directors. We saw an audit programme for 2014 to 2015 had been developed for different areas of the service such as human resources, support services, adults and children’s service, health

support and wellbeing service and for cross service audits such as electronic recording, communication and medicines. We saw a selection of audits for areas such as hand hygiene, cleaning, volunteer recruitment, documentation of people’s preferred priority of care, return to work interviews and collection boxes. Each audit had the date of completion, the methodology used, an analysis of the results and recommendations to improve practice. A member of the management team who had the lead for professional development and quality told us the audit system was under review to ensure staff had an improved understanding of the audit process and that the audits covered the areas required.

We saw evidence that monthly medicines audits were carried out by a pharmacist which covered storage, controlled drug record keeping and some examination of prescription sheets. The adult services manager told us a pharmacist would in future be part of the multi-disciplinary team. They said, “They will provide greater clinical input by reviewing patient’s prescription sheets on a regular basis.”

We found there was a culture of learning from accidents and incidents. For example, we saw documentation which showed drug incidents and errors were recorded on an error report form. This was reviewed by a quality review group so that an appropriate action plan was prepared and implemented to prevent reoccurrence. A flow chart had been produced to guide staff in the action they had to take following a drug error or significant event. There was a log of significant events which detailed when the incident had been discussed in meetings, what recommendations had been made and when these had been signed off as completed. The registered manager told us, “We want staff to feel able to report incidents.” One member of staff described how practice was changed regarding the documentation of people’s allergies following a ‘near miss’ incident. They said, “One person was allergic to Paracetamol; we have changed the way we document allergies now. We have a procedure to follow for any near misses and we bring these up in team meetings. Staff are emailed about it, we have significant events meetings and we learn from them.”

We were told the service held post-bereavement analysis to look at how the person experienced dying and whether this could be managed differently to improve practice and support to other people and their families in the future.

Is the service well-led?

There were meetings and workshops at various levels to discuss issues such as policy, accidents and incidents, practice issues and training, to exchange information, to plan strategy and review work programmes, and to develop action plans. Each month governance meetings were held which brought together information from these various meetings and discussed any actions required. Staff also received newsletters as another means of receiving information. The registered manager told us an intranet service was to be further developed to ensure staff had electronic access to a range of information and policies.

People who used the service and their carers had the opportunity to attend meetings. We saw the minutes for a meeting held on 25 February 2015. These indicated the topics discussed were varied and included, an update on the new build, catering questionnaire results, new posters for complaints, compliments and comments, newsletter updates, fundraising and transport. We saw newsletters had been replaced with, 'You said – We did' information sheets. The one for February 2015 described the suggestions people who used the service had made in meetings, carers groups, and comments and suggestion boxes. They also described what action had been taken to address them. We saw an action plan had been produced as a result of a patient survey. The registered manager told us adults who used the respite service were asked to complete a survey following their stay and relatives were

asked to complete a survey following the death of their family member. These measures showed us people were able to express their views, they were listened to and action was taken.

We saw a staff survey had taken place in October 2013 and an action plan produced that ran throughout 2014. This detailed when actions had been completed.

We saw staff within St Andrew's worked in partnership with other services and agencies. For example, they had worked closely with the North East Lincolnshire Clinical Commissioning Group (CCG) during the development of a local strategy for end of life care. Office space within the new build was to be shared with local community teams providing end of life care and support such as the McMillan nursing service and the Haven Team. The latter consisted of the Marie Curie night service and the Care Plus service. The registered manager said, "Service development is not done in isolation anymore; there is integration of community and in-patient services." They told us they had worked with the local hospital trust to establish a neonatal pathway and support for parents. There were links with the local authority children's services and safeguarding teams.

Staff told us they worked in partnership with local undertakers and sought advice and guidance from them regarding the care of children following their death and whilst they remained in the care of St Andrew's staff until their funeral.